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Health and Wellbeing Board

Date: **TUESDAY, 26 SEPTEMBER 2017**

Time: **2.30 PM**

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

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

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

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

Co-Opted Members
The Hillingdon Hospitals NHS Foundation Trust
Central & North West London NHS Foundation Trust
Royal Brompton & Harefield NHS Foundation Trust
Hillingdon Clinical Commissioning Group (officer)
Hillingdon Clinical Commissioning Group (clinician)
LBH - Deputy Director: Housing, Environment, Education, Health & Wellbeing

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Health and Wellbeing Board Reports - Part II (Private and Not for Publication)

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

Minutes

HEALTH AND WELLBEING BOARD

27 June 2017

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

	Statutory Voting Board Members Present: Councillors Philip Corthorne (Chairman), David Simmonds CBE (Vice-Chairman) and Douglas Mills and Nick Hunt (In place of Bob Bell), Dr Kuldhir Johal (in place of Dr Ian Goodman) and Stephen Otter **Statutory Non Voting Board Members Present**: Tony Zaman - Statutory Director of Adult Social Services and Statutory Director of Children's Services Sharon Daye - Statutory Director of Public Health (substitute) **Co-opted Board Members Present:** Shane DeGaris - The Hillingdon Hospitals NHS Foundation Trust Nick Hunt - Royal Brompton and Harefield NHS Foundation Trust (substitute) Caroline Morison - Hillingdon Clinical Commissioning Group (officer) (substitute) Dan Kennedy - LBH Deputy Director Housing, Environment, Education, Health and Wellbeing **LBH Officers Present**: Kevin Byrne (Head of Policy and Partnerships), Gary Collier (Health and Social Care Integration Manager), Glen Egan (Office Managing Partner - Legal Services) and Nikki O'Halloran (Democratic Services Manager) **LBH Councillor Present:** Councillor Beulah East **Press & Public: 2**
1.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence had been received from Councillors Bianco, Burrows, Lewis and Puddifoot, and Dr Ian Goodman (Dr Kuldhir Johal was present as his substitute), Mr Rob Larkman (Ms Caroline Morison was present as his substitute), Mr Bob Bell (Mr Nick Hunt was present as his substitute) Ms Robyn Doran, Ms Maria O'Brien and Ms Allison Seidlar.
2.	**TO APPROVE THE MINUTES OF THE MEETING ON 14 MARCH 2017** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 14 March 2017 be agreed as a correct record.**
3.	**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 1 to 14 would be considered in public. Agenda item 15 would be considered in private.

4.	**BOARD MEMBERSHIP UPDATE** *(Agenda Item 5)* It was agreed that, in addition to the proposal for Ms Morison to replace Mr Ferrelly, an additional recommendation for Mr Dan Kennedy to replace Mr Nigel Dicker on the Health and Wellbeing Board membership would be considered. It was noted that further changes would be made to the Hillingdon Clinical Commissioning Group representation on the Health and Wellbeing Board in the near future. **RESOLVED: That the Health and Wellbeing Board agree that:** **1. Ms Caroline Morison replace Mr Neil Ferrelly as the Hillingdon Clinical Commissioning Group Non-Voting Co-opted (Officer) Substitute member on the Board; and** **2. Mr Dan Kennedy, Deputy Director Housing, Environment, Education, Health and Wellbeing, replace Mr Nigel Dicker, Deputy Director Residents Services, as a Non-Voting Co-opted member of the Board.**
5.	**HILLINGDON'S HEALTH & WELLBEING STRATEGY 2018-2021** *(Agenda Item 6)* The Chairman advised that the Board had sought to establish one strategy and one reporting process for Hillingdon. A reduction in the volume of paper reporting to the Health and Wellbeing Board could be achieved by sharpening the content of the reports. The strategy report would provide the 'what' and the Better Care Fund report would provide the 'how' to complement each other. It was acknowledged that the draft strategy was work in progress which reflected the discussion from the Transformation Board. The Sustainability and Transformation Plan (STP) had been framed as part of the strategy but had not included enough emphasis on health outcomes or on the use of resources to deliver those outcomes. Much of the content had been generic and could have been applied to any area and, as such, consideration would need to be given to providing a sharper focus on the demography of Hillingdon and specific health issues that were faced by different areas of the Borough. For example, air pollution, respiratory disease and obesity were very local issues and should be addressed, identifying where the issues were most prevalent, what factors were contributing to the prevalence and what action could be taken to address these issues locally. The strategy needed to look at how these issues impacted on the lives of local residents and what improvements they could expect to see. It was noted that Healthwatch Hillingdon was not a provider, as had been implied in the report. It was agreed that the report that would be considered by the Health and Wellbeing Board on 26 September 2017 would include more local detail so that consideration could be given to approving the report for consultation. The Chairman would liaise with officers between now and the September meeting. **RESOLVED: That the Health and Wellbeing Board:** **1. noted the progress in developing the Hillingdon's Joint Health and Wellbeing Strategy 2018-21.** **2. agreed to further work being undertaken across partners to develop the outline draft and establish an implementation plan, with a view to a consultation draft coming back to the Board at its meeting on 26 September 2017.**

6.	**BETTER CARE FUND PLAN 2017-2019** *(Agenda Item 7)* It had been proposed that the Better Care Fund Plan continue to focus on older people, especially in relation to delayed transfers of care (DTOC). Care Connection Teams (CCTs) were being established and a joint market management and development approach had been adopted. Collaboration between adult social care and the CCTs had started, exploring scope for joined up working. On 9 March 2017, the Department of Communities and Local Government (DCLG) had published funding allocations for the additional Improved Better Care Fund (IBCF). This IBCF funding had been committed to stabilising the local social care provider market which would have a direct impact on the health and care system's ability to support admission avoidance and reduce hospital delays. It was proposed that the additional allocations of £4.1m in 2017/18 and £2.9m in 2018/19 be used to meet this aim, which would in turn lead to reducing pressures on the NHS. Rigorous reporting would be required to monitor the impact on pressures and consideration would need to be given to being more explicit about the benefit derived by Hillingdon Hospital. It was noted that there were correlations between Scheme 3: Better care at end of life (EOL) and Scheme 5: Improving care market management and development. Although these schemes were thought to be a good way forward, it was suggested that further consideration needed to be given to the EOL arrangements put in place during the interim. Work had been postponed on the palliative at home service to prevent fragmentation but the integrated home care service would be taken forward and would be effective from November 2017. It was recognised that the Better Care Fund schemes would include joint work on out of hospital activity, including the Discharge to Assess (D2A) scheme. **RESOLVED: That the Health and Wellbeing Board:** **a) approved the approach to the 2017/19 BCF plan and the outlined schemes as described in the report.** **b) approved the proposed use of the Improved Better Care Fund (IBCF) and note its intended impact.** **c) directed officers as to how it wishes to consider the final and completed BCF plan, e.g., including narrative document and planning template, once the submission deadline has been announced, which was likely to be before the end of the summer.** **d) delegated authority to make any further minor amendments prior to submission 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 Health and Wellbeing Board, the Chairman of HCCG's Governing Body and the Chairman of Healthwatch Hillingdon.**
7.	**BETTER CARE FUND: PERFORMANCE REPORT (JANUARY - MARCH 2017)** *(Agenda Item 8)* The last four quarters had been challenging but had seen Hillingdon's performance remain the same/improve on the previous year. Challenges were still faced in relation to issues such as readiness for seven day discharge and these would need to be taken forward and resolved. The H4All patient activation measure and reablement had been successful as a result of the hard work of the officers involved. The budget had been agreed to help move the work forward.

	With regard to hospital discharge, it was noted that the Healthwatch Hillingdon (HH) report received at the Health and Wellbeing Board meeting on 14 March 2017 had highlighted this as a challenging issue. Since that report had been published, HH had been working closely with Hillingdon Hospital and, although steps had been taken, it would be a while before the impact of these improvements would be seen. It was noted that the report provided some local issues such as the impact of substance misuse issues on delayed transfers of care (DTOCs). Progress had been made by the hospital, and within the system as a whole, but there were more complex issues that now needed to be understood and addressed. Hillingdon Hospital currently discharged 60-70 patients each day and this number was growing year on year. A myriad of initiatives had been introduced to solicit patient feedback to then improve their experience and speed up the processes. Mr Shane DeGaris would provide a comprehensive report on these issues and the action taken to address them to the meeting on 26 September 2017. Concern was expressed about the issues faced by hospital staff when communicating with patients that lacked capacity. This was being looked at by the hospital and it was recognised that this could delay discharge even further. It was suggested that dementia and challenging behaviour needed to be included in the Better Care Fund Plan 2017-2019 as it was at the heart of DTOC and put pressure on the whole system. **RESOLVED: That:** **1. Mr DeGaris provide a comprehensive report on the initiatives and improvements to DTOC resultant from patient feedback and engagement to the Health and Wellbeing Board meeting on 26 September 2017; and** **2. the Health and Wellbeing Board notes the content of the report.**
8.	**PHARMACEUTICAL NEEDS ASSESSMENT** *(Agenda Item 9)* Following consultation, the Pharmaceutical Needs Assessment (PNA) would need to be published by 2018. The assessment came at a critical time and would help in the production of a robust framework. Consideration was given to the impact of the removal of the essential small pharmacy scheme and whether pharmacies' financial viability would be compromised. As such, it was agreed that the PNA review should take account of communities that were not located near a pharmacy. **RESOLVED: The Health and Wellbeing Board is asked to:** **1. note the requirement to prepare and publish a refreshed pharmaceutical needs assessment (PNA) for Hillingdon by 1 April 2018.** **2. consider and agree the proposed plan to review and publish Hillingdon's PNA by the required deadline, including the requirement to undertake a minimum 60 day consultation.** **3. agree to delegate the final approval of the arrangements for the statutory consultation to officers in consultation with the Chairman of the Health and Wellbeing Board, including approval of the draft PNA for consultation.** **4. the PNA review should have regard to any communities which, because of geographical locations, were more than a 15 minute walk from their nearest pharmacy.**
9.	**HILLINGDON CCG UPDATE** *(Agenda Item 10)* Hillingdon Clinical Commissioning Group (HCCG) was taking action to improve the quality of primary care and provide access on a 24 hour basis. In addition, feasibility

	was being considered, based on current findings. Choosing Wisely was an initiative that sought to advance a national dialogue on avoiding wasteful or unnecessary medical tests, treatments and procedures. HCCG had started an engagement exercise to solicit feedback from the health sector as well as from local patients about repeat prescriptions and the use of local pharmacies. It was noted that wider education would be needed in relation to these proposals once in effect and that surety would be needed to ensure that the right decisions were made, especially in relation to those experiencing hardship. The CCG Governing Bodies would meet in July/August to assess the volume of information received as a result of the consultation. This information would then be triangulated across NWL. Consideration would need to be given to clear review points and processes to enable measurement of the impact. It was noted that this collaboration at scale was beneficial for small hospitals like Hillingdon Hospital. The Hillingdon Choosing Wisely consultation would close on Friday 30 June 2017. Improvements had been made as a result of joint working between the Accountable Care Partnership (ACP) and the Care Connect Teams (CCTs) in relation to more challenging patients being supported in the community. It was noted that the health partners in Hillingdon were coterminous but that they operated within a broader system. As such there was value in undertaking the more challenging conversations just once across North West London (NWL) rather than borough by borough (the changes made to paediatric services across NWL through Shaping a healthier future was an example of this). There was an ongoing balance between collective working across NWL versus local changes. The report set out the HCCG's financial position at the end of 2016/2017. NHS NWL Collaboration of CCGs needed to save nearly £135m in 2017/2018 in order to balance its budgets. It was queried: what proportion of this saving would be expected from HCCG, given that the organisation had already made significant efficiency savings; and how challenging it would be to adhere to common approaches and standards across NWL. **RESOLVED: That the Health and Wellbeing Board noted the update.**
10.	**HEALTHWATCH HILLINGDON UPDATE** *(Agenda Item 11)* The Shaping a healthier future review had resulted to changes in the provision of maternity services in North West London (NWL), particularly for Ealing. The report identified the impact of these changes and showed that Hillingdon residents were generally pleased with the new service, whereas the experience of Ealing residents was significantly different. It was noted that consideration should be given to the impact on different groups when looking at changes to service provision in NWL. Looking forward, capacity would need to be reviewed to accommodate future maternity demand at Hillingdon Hospital. The Board was advised that expectant mums were asked to provide a first and second choice hospital. There were a number of Ealing mums that had not been given Hillingdon Hospital as their first choice and, as such, were not happy with the process. It was noted that travelling to Hillingdon Hospital would not be easy for Ealing residents and that consideration should be given to liaising with TfL about required changes to the transport links (although it was understood that this type of change could take up to

	two years to implement). Hillingdon Hospital had been capped at 5,000 births and a £30m investment was needed to build a new wing to deal with an increase in capacity. Although a large number of appointments were carried out locally, the births would take place at the hospital so this would need to be watched carefully. There had been improvements to the parking at Hillingdon Hospital. Staff and patient/visitor parking were now segregated and this had prevented the queues of traffic from building up on Pield Heath Road. It was suggested that online access to prescribed medications needed to be taken account of in the Pharmaceutical Needs Assessment. **RESOLVED: That the Health and Wellbeing Board noted the report.**
11.	**UPDATE: STRATEGIC ESTATE DEVELOPMENT** *(Agenda Item 12)* This report now provided a broader context than it had previously, where it had solely looked at whether s106 health spend was on track. Hillingdon Clinical Commissioning Group (HCCG) had been working closely with Council colleagues to establish the impact of the Hayes Town Housing Zone on local health services. Negotiations had also progressed between Shakespeare Medical Centre, HCCG and the Council in relation to the proposed relocation of the practice to new premises on the former Woodside Day Centre site. It was noted that a recent scrutiny review of GPs in the Borough had highlighted a number of options with regard to GP facilities and the Naylor Review had looked at how efficiently the NHS used its land and property. Consideration would need to be given to how processes could be sped up as the Naylor recommendations could impact on the issues being considered in Hillingdon. It was acknowledged that a practice on the St Andrews Park development was now a missed opportunity. As such, the next report would need to identify alternative and honest options available in Uxbridge to meet the increased demand. HCCG had been successful in securing funding to refurbish some recently vacated space at the Yiewsley Health Centre site into additional clinical accommodation. Although this would create additional capacity for primary care provision at the site, a long term solution for the site would still need to be explored with the support of CNWL. It would be important to ensure that the work of the Strategic Estates Group was not replicated. **RESOLVED: That the Health and Wellbeing Board notes the progress being made towards the delivery of the CCG's strategic estates plans.**
12.	**CAMHS UPDATE REPORT** *(Agenda Item 13)* The Anna Freud Centre for Families had been involved in undertaking several elements of its co-production programme as part of the overall CAMHS pathway redevelopment project. A summary report would be available to commissioners by the end of July 2017 and a report regarding the commissioning of the new service would be considered by the Health and Wellbeing Board at its meeting on 26 September

	2017. This report would include recommendations on the approach to the commissioning of the reconfigured service. It was disappointing that, despite a lot of time and money being invested to improve this very important service, there had been little change in the CAMHS performance and waiting times. **RESOLVED: That the Health and Wellbeing Board:** **a) noted ongoing progress towards a new approach to commissioning CAMHS services which were to be developed and were subject to approval by HCCG and LBH;** **b) noted the current performance against CAMHS waiting times; and** **c) consider a report, which included recommendations on the approach to the commissioning of the reconfigured service, at its meeting on 26 September 2017.**
13.	**BOARD PLANNER & FUTURE AGENDA ITEMS** *(Agenda Item 14)* It was agreed that the following items be added to the Board Planner for 26 September 2017: • DTOC Initiatives and Improvements at THH; • Joint Strategic Needs Assessment; • Pharmaceutical Needs Assessment; and • Primary Care Strategy Update. **RESOLVED: That, subject to the above amendments, the Health and Wellbeing Board's Board Planner be agreed.**
14.	**UPDATE ON CURRENT AND EMERGING ISSUES AND ANY OTHER BUSINESS THE CHAIRMAN CONSIDERS TO BE URGENT** *(Agenda Item 15)* The Board discussed a number of issues in relation to the Choosing Wisely consultation, healthcare provision within Yiewsley and Government consultation. **RESOLVED: That the discussion be noted.**
	The meeting, which commenced at 2.30 pm, closed at 3.58 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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HILLINGDON'S JOINT HEALTH AND WELLBEING STRATEGY 2018-2021

Relevant Board Member(s)	Councillor Philip Corthorne Dr Ian Goodman
Organisation	London Borough of Hillingdon Hillingdon CCG
Report author	Kevin Byrne LBH Health Integration Sarah Walker HCCG Transformation
Papers with report	Annex 1: Outline draft Health and Wellbeing Strategy Annex 2: Key performance indicators

1. HEADLINE INFORMATION

Summary	The draft Joint Health and Wellbeing Strategy 2018-2021 incorporates delivery of the Hillingdon Sustainability and Transformation Plan. It is proposed that the draft now be made available for consultation prior to coming back to the Board in December for formal agreement.
Contribution to plans and strategies	Producing a Joint Health and Wellbeing Strategy is a statutory requirement placed on Health and Wellbeing Boards by the Health and Social Care Act 2012. The Hillingdon STP local chapter has been developed as a partnership plan reflecting priorities across health and care services. The Hillingdon STP is also closely aligned to the NWL STP to ensure that delivery meets the needs of local people and supports development of solutions in the best interests of health and care in Hillingdon. The JHWB strategy encompasses activity that is underway including through the Better Care Fund and in taking Hillingdon towards an Accountable Care System.
Financial Cost	There are no costs arising directly from this report.
Ward(s) affected	All

2. RECOMMENDATION

That the Health and Wellbeing Board agrees to the draft Hillingdon Joint Health and Wellbeing Strategy 2018-21 being issued for consultation with findings brought back to the Board for consideration at its meeting on 7th December 2017.

3. INFORMATION

Background Information

The Board has already agreed (at its meetings March 14th and 27th June 2017) that the next iteration of Hillingdon's Joint Health and Wellbeing Strategy should take into account the significant effort across partners that went into developing the Hillingdon Sustainability and Transformation Plan (STP) and that delivery of the STP should be encompassed within delivery of the JHWB Strategy - with the aim of moving towards one strategy and one performance report over time.

It has been recognised that the joint partnership working that has supported, firstly the development of the Hillingdon STP and then establishment of the Hillingdon Care Partners (Accountable Care Partnership) and progress against Better Care Fund Plan all present an opportunity to bring strategic plans across partners together into Hillingdon's 2018-2021 Joint Health and Wellbeing Strategy. This will establish the framework against which the Board can provide strong leadership and oversight over the key issues affecting health and care of people in Hillingdon.

In addition, the June Board asked that officers from all partners should consider:

- How the local plan relates to the overall programme requirements of the North West London footprint STP. Whilst the Hillingdon STP aligns closely to the NWL STP footprint plan, it is also recognised that "double reporting" would be unhelpful.
- Programme management and reporting of outcomes from the implementation actions.
- Agreeing leads for individual workstreams together with timescales and prioritisation
- A greater understanding of risks attached to priorities

STP reporting

We have received confirmation that the STP footprint reporting will be high level and utilise data captured at national level currently. The NWL STP delivery currently anticipates that action at borough level is essential to delivery.

On 21st July, NHS England also published STP progress assessment dashboards setting out a baseline for each of the 44 STPs' progress. Each STP was scored overall against four categories:

1. Outstanding
2. Advanced
3. Making progress
4. Needs most improvement

The North West London STP's overall progress was assessed as "2 - Advanced", one of 20 nationally to receive this score. A further five received "Category 1 - Outstanding".

In addition nine domains are listed covering:

- Hospital performance - emergency, elective and safety
- Patient focused change - at GP, in mental health and in cancer
- Transformation - prevention, leadership and finance.

Programme management

The new Strategy will provide the strategic framework of priority setting among partners in the health and care economy in Hillingdon. Progress against delivery will be reported at future HWB meetings. Reporting will take into account key performance outcome framework data reported nationally through Health profiles.

Project and programme management for Hillingdon's JHWB Strategy will take advantage of existing reporting arrangements and the governance structure established through the Transformation Board to the HWB. The STP footprint progress dashboard reports against the domains listed above (we will explore of this information is available at borough level). Finally the Better Care Fund Plan will also provide granular detail on performance against its six workstreams including the delayed transfer of care targets.

The key performance indicators identified so far to report against are set out at Annex 2. A performance report would come to each Board setting out progress against the five delivery areas. The performance indicators at Annex 2 will also be included, although the Board should not that data on most indicators is only produced annually.

The draft is Strategy is attached at Annex 1, which:

- Sets out the local Health and Wellbeing needs as identified through the Joint Strategic Needs Assessment.
- Sets out the vision and aims, including the nine priorities of the Hillingdon STP and their alignment to the five delivery areas of the NWL STP

Financial Implications

There are no financial implications arising from this report. The financial impact of the Better Care Fund is included in a further report on the Better Care fund 2017/19 elsewhere on the agenda.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

The Strategy once agreed will provide the framework for the Board to drive forwards its leadership of health and wellbeing in Hillingdon.

Consultation Carried Out or Required

Hillingdon's engagement and consultation to date builds on our local approach of continuous dialogue with the public and partners, to serve as a platform for the co-design and co-production of health and wellbeing plans. We have embedded inclusion of patient, public, provider and

other stakeholder input to the initial stages of research, development and testing of system transformation projects in proposals regarding the STP and including the Better Care Fund.

It is envisaged that delivery of priorities in the JHWBS will be subject to similar ongoing co-design principles with residents and service users as proposals come to the fore and are turned into delivery.

NHS England published a guide for Engaging local people within each ST footprint areas (Sept 2016). The NWL STP has been subject extensive consultation based on this guidance and the results published alongside the October STP submission (as its Appendix D). Its Appendix E responds to the feedback from the first draft plan. See :

https://www.healthiernorthwestlondon.nhs.uk/news/2016/11/08/nw-london-october-stp-submission-published

Given that this JHWB Strategy brings all the component parts of the STP and BCF together in one place in relation to Hillingdon it is proposed, therefore, that the draft strategy be made publicly available for eight weeks (from end September to 22nd November 2017) with feedback invited as to :

- Whether the priorities and actions as set out in the five delivery areas and the "I statements " reflect issues of greatest concern to residents and whether anything is missing;
- If there are any areas for improvement/any alternative approaches we could take; and
- Whether the draft strategy has potential to adversely impact any Hillingdon residents.

Policy Overview Committee comments

None at this stage.

5. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

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

Hillingdon Council Legal comments

The Borough Solicitor confirms that there are no specific legal implications arising from this report. Further legal advice will be provided, if necessary, at the Board's meeting in December 2017 when it will agree the final version of the strategy.

Corporate Property and Construction

Not applicable

6. BACKGROUND PAPERS

Previous Board papers.

Hillingdon
Health and Wellbeing Strategy
2018-21

Contents

Foreword

Welcome to our Health and Wellbeing Strategy. This is a strategy for everyone in Hillingdon. It sets out how people, public services, businesses, voluntary and community groups will join together so that everyone can access the best opportunities to be healthy and well.

Hillingdon is a vibrant and healthy borough for people to live in. We have excellent leisure facilities, open green spaces and diverse resilient communities. Our local economy is strong and recent transport developments have already led to further growth with greater connections in the south of the Hillingdon. Health and wellbeing in Hillingdon is good overall, but we are determined to build on our record to date and make it even better for everyone

The NHS and Local Government are, however, facing unprecedented challenges. Our task is to make the best use of our resources to provide high quality health and social care that our growing population needs for more complex, seamless care. A strong partnership in health and care delivery in Hillingdon will help us to rise to meet these challenges.

Signed

Cllr Philip Corthorne

Chairman, Hillingdon Health and Wellbeing Board

Introduction

This Joint Health and Wellbeing Strategy outlines our local priorities and plans for ensuring the health and wellbeing of Hillingdon residents. It sets the agenda and focus for Hillingdon's Health and Wellbeing Board to oversee progress in achieving high quality health and care service outcomes in our borough over the next four years.

In order to enable our residents to live well, we commit to the shared North West London Sustainability and Transformation Partnership aims of improving health and wellbeing, the quality of treatment and care, and the sustainability of our health and care system. As a member of the North West London Sustainability and Transformation Partnership (NWL STP), we are aligned to the five Delivery Areas and associated priorities:

1. We will prioritise **prevention** of disease and ill-health through tackling risk factors, early detection, early intervention and proactive case management in primary care. We will work with parents and carers of babies, and children and young people, in order to give the next generation the best start in life with strong public health and social care engagement and support.

2. We will ensure healthcare services are delivered consistently by incentivising the integration of care services to improve the management of **long term conditions**. We will also address variation in health outcomes, particularly when it comes to caring for people with cancer, cardiovascular disease, respiratory disease, diabetes and dementia. We will reduce early deaths from circulatory diseases (heart disease and stroke) through early detection and prevention; and through improving quality and safety of treatment services.

3. We will achieve better experience and greater choice for **older people** in our communities. We will ensure care is coordinated between social, primary, community and acute care services to manage multiple conditions and frailty. We will reduce isolation and loneliness, especially for people suffering from multiple conditions and for their carers.

4. We will improve outcomes and opportunities to live well in Hillingdon for children and adults with **mental ill health needs and learning disability**.

5. We will ensure we have safe, high quality, **sustainable services**, seven days a week.

When anyone in our community experiences mental or physical ill health, or is living with a physical or mental health disability and requires support, health and care partners will come together to deliver high quality care in a setting that is appropriate and convenient for patients and service users. This strategy unifies and aligns local health partners to delivering the national, regional and local health agenda, including: the London Borough of Hillingdon, Hillingdon Clinical Commissioning Group (CCG), Hillingdon Healthwatch and our local health partners: The Hillingdon Hospital Foundation Trust, Central and North West London Foundation Trust, The Royal Brompton and Harefield Hospital, GP Confederation and primary care services, and third sector partners Hillingdon4All, voluntary organisations, and care homes. Through our shared goals, our strategy is our roadmap to achieving our health and wellbeing goals for Hillingdon, together.

Our people and communities

Hillingdon is a diverse, prosperous borough in West London bordered by Hertfordshire, Buckinghamshire, Hounslow, Ealing, and Harrow. Hillingdon is the second largest by area of London's 32 boroughs. The north of the borough is semi-rural with a large proportion protected by green belt regulation with Ruislip as the major centre of population. The south of Hillingdon is more densely populated, urban in character and contains the administrative centre of Uxbridge and towns of Hayes and West Drayton. There is a great deal on offer in Hillingdon to enable its people to live healthy lives. We have large amounts of green and open space. Hillingdon as a whole has around 800 acres of woodland, country parks, fields and farms, several rivers and the Grand Union Canal. We also have excellent leisure facilities, including the Hillingdon Sports and Leisure complex, Ruislip Lido, with a miniature railway and its own sandy beach. Hillingdon can also boast England's first playground designed specifically for disabled children, and several theatres and arts centres. We are proud to have rebuilt or completely refurbished all of our 17 libraries. Additionally, employment rates are high within the borough, and there are low levels of long-term unemployment.

Hillingdon's population is growing, and in 2018 is estimated to be 314,300 people. Hillingdon has one of the highest levels of projected population growth in England for the period 2014-2024, with a projected increase of 16.1%. Our population continues to grow every year and is expected to increase to around 340,000 by 2024. We are anticipating a 16% rise in those aged 65 or over living in Hillingdon, rising from 40,500 to 47,000. The proportion of people aged 85 or over will increase by an even higher proportion, 24.6%, from 5,700 to 7,100. Additionally, more than 78,000 children and young people aged 0-19 live in Hillingdon, representing 26.3% of the total population, slightly higher than the overall London proportion of 24.6%.

Our increasing population is in part due to the significant increase in the number of new births we have seen in recent years. In 2001, 70% of births in Hillingdon were to mothers born in the UK; by 2014 this had fallen to 44%. The largest increase has been births to mothers born in the Middle East, with Asia being the second most common group. The third most common has remained births to mothers born in Africa, and there has been a significant increase in births to mothers born in EU Accession states, now the fourth most common group. We are home to vibrant and diverse communities: one of most diverse boroughs in England with a high Black, Asian, and Minority Ethnic (BAME) population.

We expect the population will continue to grow as new developments progress, bringing new residents to our borough. Within Hillingdon the areas around the town centres of Hayes, West Drayton and Uxbridge are more densely populated. The Great Western mainline also runs through the south of the borough. The construction of Crossrail, scheduled to start operation in 2019 as the Elizabeth Line, is generating major housing growth along its route, including a dedicated Housing Zone in progress in Hayes which includes the former Nestlé factory site. The development of the former RAF Uxbridge site at St Andrews Park, will all contribute to further population growth. Hillingdon also has Stockley Park, one of Europe's largest business parks and employment centres. Many major companies have their headquarters in Stockley Park, Uxbridge and Hayes. Both RAF Northolt and Brunel University are also located in Hillingdon, with Bucks New University at the edge of Uxbridge. Hillingdon is also home to the UK's largest transport hub – Heathrow Airport. Heathrow Airport lies to the south of the M4, the A40 and the Uxbridge Road, which run East-West through the borough.

Our health and wellbeing needs

Overall, our health outcomes in Hillingdon are varied when compared to the average for England. Hillingdon compares well against the England average in many areas, with some positive indicators being:

- People living in Hillingdon live longer and healthier lives compared to the average for England.
- Levels of breastfeeding, which provides the best start in life for babies are higher in Hillingdon than the England average.
- A lower proportion of pregnant women in Hillingdon smoke, compared to the rest of England.
- Fewer people are admitted to hospitals in Hillingdon with an alcohol-related condition than the England average.
- Early death rates (under age 75) from respiratory diseases are lower than the England average.

However, some of our health outcomes are also worse than the national average:

- Rates of social isolation among social care users and their carers are still too high.
- Accommodation and employment needs of adults with learning disabilities are not being adequately met.
- A higher proportion of children aged 10-11 are overweight / obese compared to the national average.
- The proportion of children with dental decay is significantly worse than the national average.
- Rates of childhood vaccination are lower than the national average.
- Proportion of adults who are physically active is lower than the national average.
- Death rates for men aged 75 or under from cardiovascular diseases are significantly higher than the England average.
- Cancer screening rates are low and the percentage of population being offered an NHS health check is low.

Furthermore, health status is not the same in all parts of Hillingdon, There are health inequalities and differences in life expectancy depending on where people are living in the borough. As a result there is a difference of around 8 years in the life expectancy of people living in Botwell ward compared to people living in Eastcote and East Ruislip ward. Socio-economic circumstances have a complex relationship with unhealthy lifestyle choices which increase the risk of ill-health, including smoking, poor diet, lack of physical activity, higher levels of alcohol consumption and/or binge drinking. Our increasing frailty as we age also affects health and wellbeing. Over half of people aged 65 and over are diagnosed with multiple long term conditions, such as dementia, which increases dependency on care and support. Some of us are born with conditions which might require long term care and management, including physical and/or learning disability, and child and adult mental illness.

Hillingdon's Joint Strategic Needs Assessment (JSNA) identifies key health and wellbeing needs of people in Hillingdon. . It is regularly updated with the latest available information to ensure our programs and priorities are able to respond to the changing needs of our population. Our JSNA is available to read online at http://www.hillingdon.gov.uk/jsna. The JSNA is a key document informing the priorities and outcomes in this strategy.

Our strategy for health in Hillingdon

Hillingdon has a history delivering health and care transformation to meet the needs of our residents. Our strategy is built on the findings in our JSNA and follows national guidance from the NHS Five Year Forward View and the NWL STP strategy.

We will continue to build upon the good work done in existing local plans, from which we have already seen the benefits:

- Hillingdon Joint Strategic Needs Assessment
- NHS Five Year Forward View
- The NWL Shaping a Healthier Future Programme
- Hillingdon 2013-17 Health and Wellbeing Strategy
- NWL Local Services Programme
- NWL Whole Systems Integrated Care
- NWL Local Services Strategy
- The NWL Primary Care Transformation Programme
- The GP Forward View
- The London-wide Strategic Commissioning Framework for Primary Care
- The HCCG 2017/18 Operational Plan
- Better Care Fund 2015/17 Plan
- The Council's Older Peoples Plan
- Digital Strategy
- Strategic Estates Plan
- Long Term Conditions Strategy
- End of Life Strategy
- Prevention Strategy Quality, Improvement, Productivity and Prevention (QIPP) Plans

The National Picture: The NHS Five Year Forward View, and the North West London Sustainability and Transformation Partnership

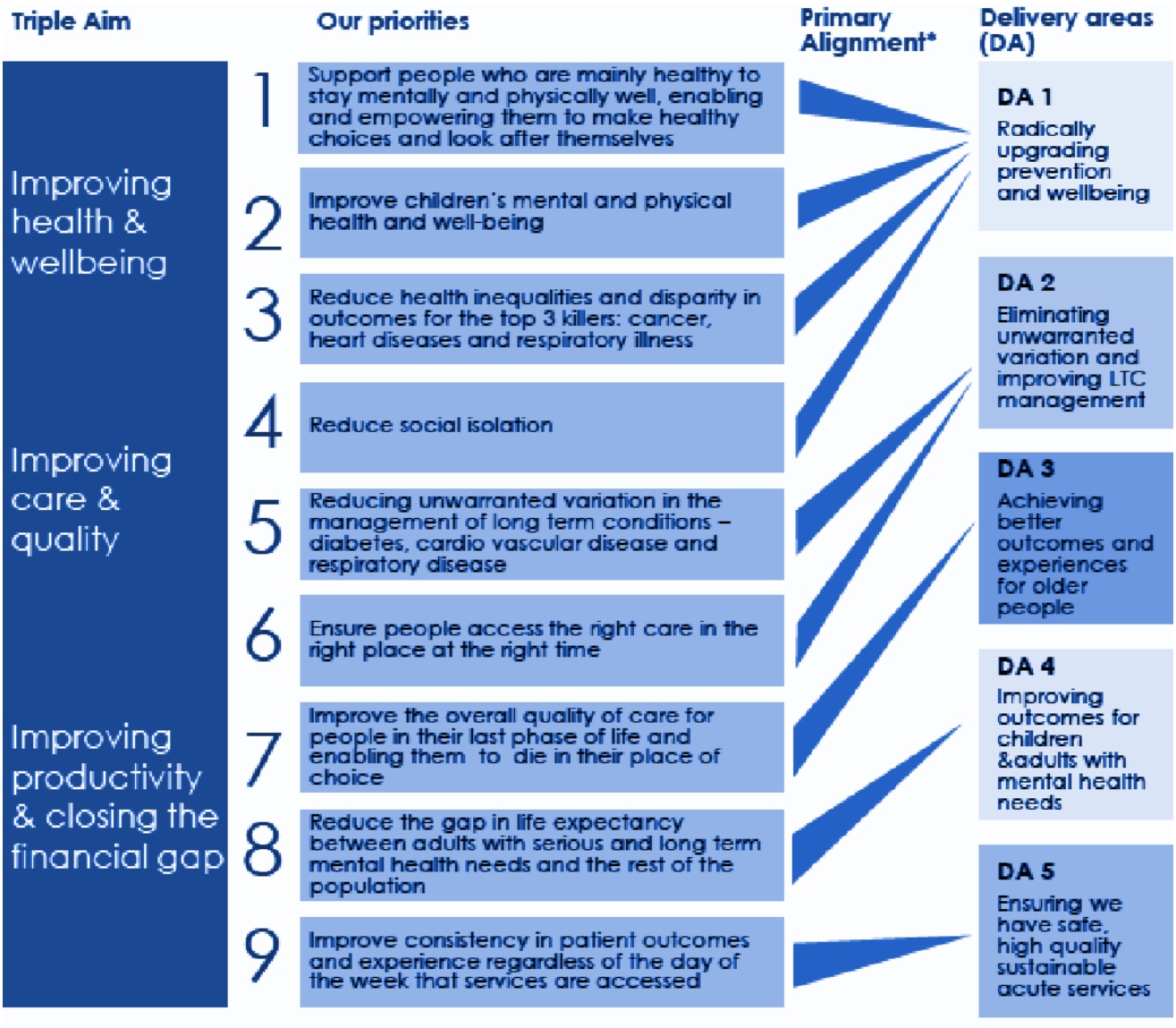
In 2015, the NHS Five Year Forward View articulated a major shift in policy towards place based systems of care through Sustainability and Transformation Partnerships. The approach envisions health and care organisations taking joint responsibility for the health of an entire population, within a particular geographic area. The shift in policy follows a period during which public providers of care services operated with a greater degree of autonomy and competition. The new approach requires organisations to be more strategic and to work to local systems of care.

The Five Year Forward View further sets the Triple Aims of improving people's health and well-being, improving the quality of care that people receive and addressing the financial gap between the cost of expected services and planned budgets. This new approach across health and social care works to ensure that services are planned with a focus on the needs of people living in the area.

As part of this new approach, the NHS recently organised itself into 44 Sustainability and Transformation Partnerships (STP) across England. Hillingdon is a member of the North West London STP (NWL STP). Joined up STP working will address population health and wellbeing needs through new ways of delivering care; better public health and prevention of ill health; joining up services across health and social care; empowering patients and communities; strengthening primary care; and achieving needed efficiencies in health and care services.

In Hillingdon the Health and Wellbeing partners have developed a Sustainability and Transformation Plan that takes as its starting point the priorities locally and aligns them to the approach of the NWL STP. The NWL STP plan is characterised by broad and overarching themes and aims to bring together local organisations to answer the challenge of delivering better health and care services according to the Triple Aims of the Five Year Forward View through nine priorities and five Delivery Areas. The NWL STP priorities and Delivery Areas are set out below.

North West London Priorities and Delivery Areas



The Local Hillingdon Joint Health and Wellbeing STP Strategy Chapter

Hillingdon partners support and promote the high quality, sustainable health and care goals of the Triple Aims, through the NWL STP priorities and alignment of our local transformation programs with the five Delivery Areas. We commit to addressing the unique and specific health and wellbeing needs of Hillingdon, taking advantage of the opportunities that present given the coterminous service provision across the borough. By 2021, we want people living in Hillingdon to be able to say:

- "I am helped to take control of my own health and social care provision"
- "I only have to tell my story once and they pass my details on to others with an appropriate role in my care"
- "If I do need to go to hospital, they start to plan for my social and health care in the community from day one of my stay"
- "Social care and Health Services help me to be proactive. They anticipate my needs before I do and help me to prevent things getting so bad that I need to stay in hospital"
- "I am treated with respect and dignity, according to my individual needs"
- "It doesn't matter what day of the week it is - as I get the support appropriate to my health and social care needs"
- "Systems are sustainable and what once might have been spent on hospital care for me is now spent to support me at home in my community"

Our local approach to achieving these vision statements and implementing the Triple Aims are set out below.

Five Year Forward View Triple Aims – Local Approach

Health and Wellbeing	We will work collaboratively across health, social care and public health to improve outcomes and reduce inequalities for our population with a focus on those with both traditional Long-term Conditions (physical and mental health) and emerging categories of Long-term Conditions such as pain, frailty and social isolation. Our coordinated programme of work will bring together our existing plans for the Better Care Fund (BCF) and seek to engage the whole community to create a resilient population and assist people to remain independent with a better quality of life.
Care & Quality	We will provide care that is safe, effective and provided 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.
Sustainable Services	We are committed to achieving better outcomes for individuals and their families through the integration of services and an increased focus on prevention and supported patient empowerment to manage their condition(s).

Our plans to deliver high quality health and care in Hillingdon

Hillingdon has identified 10 transformation themes and 6 Enabling themes as part of our efforts to focus on local priority areas and address health needs within the borough. These themes align with the 5 Delivery Areas outlined in the NWL STP Strategy.

Transformation Themes	
T1. Transforming Care for Older People (DA3)	**T6. Supporting People with Serious Mental Illness and those with Learning Disabilities (DA4)**
T2. New Primary Care Model of Care (DA1)	**T7. Integrated Care for Children & Young People (DA1)**
T3. Integrating Services for People at the End of their Life (DA3)	**T8. Integration across the Urgent & Emergency Care System (DA5)**
T4. Integrated Support for People with Long Term Condition (LTCs) (DA2)	**T9. Public Health and Prevention of Disease & Ill-Health (DA1)**
T5. Transforming Care for People with Cancer (DA2)	**T10. Transformation in Local Services (DA5)**
Enabling Themes	
E1. Developing the Digital Environment	**E4. Delivering Our Statutory Targets Reliably**
E2. Creating the Workforce for the Future	**E5. Medicines Management**
E3. Delivering Our Strategic Estates Priorities	**E6. Redefining the Provider Market**

Our plans to deliver high quality health and care in Hillingdon are linked to a number of key actions and associated outcomes. We have linked key actions and outcomes in order to track progress against goals as actions are taken and milestones achieved. We intend to evaluate service delivery and success from the perspective of enabling our residents to live healthier lives. We therefore draw heavily from the Public Health Outcomes Framework (PHOF) indicators to measure success.

In addition to outcomes indicators, our plans rely on a number of strategies to inform transformation themes and specific service and population programme developments. As such, some actions outlined in this document will be addressed in significantly more detail within the relevant associated strategy. The aim of this strategy is to highlight these key actions and link these programmes to outcomes indicators. In doing so, we will be able to prioritise and focus our efforts to the areas of most need, and to directly link outcome improvements to action plans.

Our plans for the 10 local Transformation Themes detailed in the following pages, aligned to the 5 Delivery Areas, following by plans for the 6 Enabling Themes:

- DA1. Prevention and Wellbeing
- DA2. Supporting Long Term Conditions
- DA3. Improving Older People's Care
- DA4. Improving outcomes for children and adults with mental health and well-being needs
- DA5. Ensuring we have safe, high quality sustainable health and care services
- Enabling themes

DA1 – Prevention and Wellbeing

Key transformation themes:

- Public health and prevention of disease and ill health
- Integrated care for children and young people
- New primary model of care at scale

"I am helped to take control of my own health and social care provision"

In delivering prevention and wellbeing in Hillingdon, we will focus on developing services that place far greater emphasis on keeping people healthy and well in order to lead longer, more illness-free lives. Our healthcare services will be focused on engaging people in keeping healthy. People in Hillingdon will have the support they need to manage their own health and maintain their independence.

We recognise the importance of public health in preventing disease and ill-health and will work to improve our public health outcomes to address variation in health outcomes and prevent disease. We will proactively engage with residents in developing programmes designed to enhance quality and quantity of life, with particularly focus on enabling people to actively take control of their own health and well-being. We further intend to provide integrated services for children and young people to enhance and ensure service coverage so that every child, parent and carer has access to the right care and information to ensure they have a healthy start in life.

A **healthy start in life** for children and young people begins with their mother's health. Avoiding smoking in pregnancy, breastfeeding, and preventing childhood obesity, and good dental health will give our children the best start in life to become healthy young people and adults. By 2021 we aim to reduce the number of women who smoke during pregnancy, promote and increase the rate of breastfeeding, and reduce dental ill-health and childhood obesity in line with the national ambition to give children a better start in life.

Reducing smoking in pregnancy is important to improve health and pregnancy outcomes for both mother and baby. Smoking during pregnancy is detrimental to the growth and development of the babies and the health of mothers. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy. The proportion of pregnant women who were smokers at the time of delivery in Hillingdon has remained around 8% over the previous 4 years but fell slightly to 7.1% in 2015/16. This is below the national average but above the London average.

Breastfeeding is known to promote the health and attachment of mother and baby and reduce the risk of illness in infancy. Current guidance now advises that ideally babies should be exclusively breastfed for about 6 months. Services in Hillingdon have worked hard to ensure that the proportion of mothers who start to breastfeed their babies is high, at 83%. Around 1 in 5 mothers stop breastfeeding after a few weeks. The proportion of mothers still breastfeeding at 6-8 weeks is 65% (2014/15). These figures are higher than the England average but lower than London as a whole.

Good dental health is a significant factor in supporting children to have a healthy start in life. A survey of dental data for 5 year olds in Hillingdon have been found to have one decayed, missing or filled tooth each, significantly worse than the national average. Access to NHS dentistry for children

is also slightly worse than the London and England average. Dental caries (tooth decay) was the commonest single cause of hospital admission in 1-18 year olds, particularly in those aged 5-9. For children the key elements of improving dental health are healthy eating, breastfeeding, good dental care through regular brushing and the application of fluoride varnish at least twice a year for children aged 3 and over, alongside access to dental care.

Childhood obesity can lead to excess weight in adulthood. Evidence from sample surveys carried out by the Sport England 'Active People' Survey for 2014/15 indicates that 62% of Hillingdon adults are overweight or obese. Children are weighed at school at ages 4-5 and 10-11. The results from 2015-16 show that 78% of children starting school aged 4-5 were a healthy weight. This means that 1 in 5 children aged 4-5 is either overweight or obese, according to their Body Mass index (BMI) measurement – or 800 young children in Hillingdon with excess weight. Around half of these children were obese. By the age of 10-11, (Year 6), only 61% were of healthy weight. More than 1 in 3 (37.2%, or around 1,200 children) were overweight or obese which was significantly worse than the England average (34.2%). Evidence from the Active People survey indicates that 51.5% of our residents said they were physically active which was significantly below the England average (57%). Hillingdon's utilisation of outdoor space (14.9%) was below the national average (17.9%), despite the significant amount of greenspace and opportunities for active lifestyles that exist in the borough. We want to ensure that everyone has the opportunity to live an active lifestyle. By 2021 we aim to see an increase physical activity rates in all age groups.

We want our young people to have the best start in life as children, and to have the opportunities available to them to give their children the best start in life. We want to help our young people succeed and to therefore continue to see teenage conceptions in Hillingdon fall. The rate of **teenage conceptions** has fallen considerably in Hillingdon in recent years; from 43.9 per 1000 females aged 15-17 in 2003, to 18.4 per 1000 in 2015. Most teenage pregnancies are unplanned and around half end in an abortion. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than adult mothers. The children of teenage mothers likewise have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems. Infant mortality rates for babies born to teenage mothers is also sadly around 60% higher than for babies born to adult mothers.

Social isolation and loneliness are growing problems, despite our digitally connected society. Surveys of social care users and carers indicate the problem is significant where Hillingdon is achieving poorly against the national rates for users of social services and their carers Age UK evidence suggests that older people are particularly likely to be socially isolated and suffer from loneliness. By 2021, we will have embedded opportunities to enhance social networks that will see a sustained increase in older people, social care service users and carers who report getting as much social contact as they would like.

Smoking is the greatest risk factor for developing respiratory disease, and a leading cause of preventable death and disability. It is estimated to contribute to more than 300 deaths in Hillingdon annually. 15.2% of Hillingdon residents smoke, which is similar to the England average. A higher proportion of younger adults in Hillingdon smoke in comparison to the London average.

Preventing a large proportion of respiratory diseases is possible by addressing lifestyle factors such as smoking as well as environmental factors such as air pollution and damp housing. Furthermore

earlier detection of respiratory disease provides significant benefit to patients and the health service which should be a priority for Hillingdon.

Alcohol and drug addiction and related admissions to hospital indicate a significant need for strong social care and support for those living with addiction. Hillingdon already has liaison and support services in place, and we aim to continue to improve upon our track record, including a locally commissioned Integrated Community Drug & Alcohol Treatment & Recovery Service. There is also a targeted, confidential support service for children and young adults aged 11-25 who are struggling with a drug or alcohol related problem.

Domestic Abuse remains an area of concern in Hillingdon. Multi-agency partners are committed to acting on the recommendations of the Domestic Homicide Reviews for 'Charlotte' and 'Lottie', including reviewing agencies' procedures as well as training and guidance for all front line staff to give them the skills to support and engage with those at risk, and making every contact count.

Prevention and wellbeing will be further supported by a New Primary Care Model. Hillingdon CCG has recently in 2017 taken on delegated commissioning from NHSE England, with the new approach aiming to deliver locally-led transformation in primary care. Locally led approaches to care will provide opportunities to ensure the sustainability of primary care through at-scale joined up delivery via collaboration and networked working. We will work closely with primary care services to improve service capacity, provide extended hours of operation, and improved pharmacy services. Our plans for primary care will be detailed in our Primary Care Strategy, due for publication for Winter 2017.

Transformation program	Key actions to 2021	Key outcomes by 2021
DA1 Radically upgrading prevention and wellbeing ***I am helped to take control of my own health and social care provision***		
T9. Public Health and Prevention of Disease and ill-health	○ Joint Early Intervention and Prevention Services Plan (currently 2015-2018), with implementation from January 2019 ○ Physical Activity Strategy (due April 2018) ○ Develop Suicide Prevention Strategy ○ Address smoking prevalence in young people and adults ○ Embed Patient Education Programme ○ Review of Air Quality action plan.	○ Integrated approach to addressing the wider determinants of health in the borough ○ Improved rate of adults engaging in physical activity to England average ○ Reduced suicide rate ○ Proportion of adult social carers and care users who have as much social contact as they would like ○ Reduced admissions related to alcohol ○ Improved successful completion of drug and alcohol rehabilitation courses ○ Reduced deaths from drug misuse ○ Reduced domestic abuse related incidents and crimes ○ Reduced smoking prevalence in young people and adults ○ Reduced air pollution levels in Hillingdon
T7. Integrated care for C&YP	○ Implement children's health commissioning strategy 2016-2020 ○ Refreshed Children with Disabilities Strategy ○ Improve vaccination coverage to C&YP against vaccine preventable communicable diseases. ○ Implementation of the recommendations from the audit of neo-natal births & babies screening programmes ○ Implement action plan from EQA visit Sept 2016	○ 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 unplanned care needs for CYP ○ Reduction in the risk of harm to children and young people ○ Increased rates of vaccination in the borough ○ Reduced attendance to hospital due to cold/flu related illness ○ Reduced smoking status at time of delivery ○ Improvement in breastfeeding initiation and prevalence at 6-8 weeks after birth

Transformation program	Key actions to 2021	Key outcomes by 2021
	○ Delivery of wellbeing training programme for schools ○ Improved access to consultant led paediatric services ○ Introduce Single point of Access for CYP	○ Increase 0-4 year olds dental health to England average ○ Reduced childhood excess weight rates ○ Reduced teenage (under 18) conceptions
T2. New Primary Care Model of Care	○ Rollout of Proactive Case Finding in Primary Care to be ready by September 2017 ○ Rationalisation of Primary Care Contracts and investment in enhanced, at scale primary care ○ Implementation of Primary Care Model of Care ○ Develop GP hubs in the North and South of Hillingdon. ○ Extended out of hours working implemented ○ Work with urgent care services to provide integrated urgent and primary care services ○ Expand access to and use of online information and advice ○ Proactive identification and engagement at primary care level with groups at high risk of developing LTCs ○ Explore opportunities for diagnostics in the community	○ Increasing number of patients managed outside of hospital setting with integration across Primary, Community & Secondary Care Services and Social Care ○ Reduction in the mortality gap ○ Reduction in the unplanned care costs associated with supporting vulnerable people and those with an LD ○ Reduction in unplanned care needs arising for people with a known mental health condition ○ Greater access to primary care and GP services, with more appointments available

DA2 – Supporting Long Term Conditions

Key transformation themes:

- Integrated support for people with long term conditions
- Transformation care for people with cancer

"I only have to tell my story one and they pass my details on to others with an appropriate role in my care. If I do need to go to hospital, they start to plan for my social and health care in the community from day one of my stay"

Health and wellbeing needs are growing increasingly complex, with more and more people reporting living with chronic conditions. Long term conditions such as diabetes, respiratory (COPD/asthma), neurological (e.g. epilepsy), and heart disease, with some people managing multiple conditions, are a unique challenge to health and wellbeing today. It is estimated that some 20% of residents in Hillingdon are living with a long term condition. Cardiovascular disease, cancer, diabetes and respiratory ill-health are among the top concerns impacting long and healthy lives lived in Hillingdon.

The biggest cause of death in Hillingdon continues to be **cardio-vascular disease** (heart disease, stroke, diabetes, kidney (renal) disease and peripheral arterial disease). In Hillingdon, deaths as a consequence of circulatory diseases accounted for an annual average of 550 deaths (30% of all deaths) in the five year period 2010-2014.

Diabetes is a lifelong cardiovascular-related condition that causes a person's blood sugar to become too high. Type 2 diabetes (approximately 90% of diagnosed cases) is partially preventable – it can be prevented or delayed by lifestyle changes (exercise, weight loss, healthy eating). Earlier detection of type 2 diabetes followed by effective treatment reduces the risk of developing diabetic complications. Around 16,000 people over 17 years of age are diagnosed with diabetes in Hillingdon, 6.7% of the GP register adult population.

Respiratory disease is the third highest cause of death in Hillingdon. It contributes to at least 15% of hospital admissions and cost approximately £10m to the health service in Hillingdon annually, and costs an estimated £5.7m in working days lost. Poor air quality is thought to contribute to a sizable proportion of acute exacerbations of asthma and Chronic Obstructive Pulmonary Disease as well as up to 90 deaths in Hillingdon annually.

Respiratory disease disproportionately affects people of lower socio-economic status due to lifestyle and environmental factors. In Hillingdon there is a clear link between the rate of hospital attendance for acute respiratory disease and how deprived an area is. 3.5% of adults in Hillingdon are thought to have COPD but only 1.2% of them have been identified. The number of residents with COPD is expected to increase to 10,799 by 2030.

Hillingdon has an additional unique respiratory related health concern due to being home to one of its largest transport and employment hubs in England. Poor air quality around Heathrow Airport and high volumes of traffic presents a real threat to health. Other unique local concerns are asthma, with approximately 5% (or c.16, 000 of Hillingdon residents) having been diagnosed with the condition. This is expected to increase to c.33,000 by 2030. Hillingdon also has the sixth highest incidence of tuberculosis (TB) in London, at 36.5 per 100000 population.

Cancer is also a major cause of early deaths in Hillingdon. Nearly 5000 patients were diagnosed with cancer in Hillingdon in 2014/15, 1.57% of the GP registered population. Deaths from all cancers accounted for an annual average of 540 deaths (30% of the total) in the 5 year period 2010-2014. Increasing early diagnosis of cancer is a priority for Hillingdon.

In order to address these needs, there is significant opportunity for more joined up health and care services in Hillingdon in order to deliver the best possible outcomes for patients. By working better together, we will see a reduction in variation in both quality of and access to care throughout our Borough. Patients will receive more responsive, personalised care delivered out of hospital in a safe and effective way; such as through our existing dermatology and pain management services. People with long term conditions will be supported to help lead a healthier life.

Health and care partners are working to develop a common understanding of long-term conditions to provide better support for people in Hillingdon living with long-term conditions. Hillingdon has recently invested in enhanced cancer screening and survivorship services, and we aim to improve cancer screening and diagnosis to national targets by 2021.

In particular, we will work together to tackle early mortality from cardiovascular diseases. We will promote prevention of hypertension and hypercholesterolemia to reduce heart disease, stroke and impact on dementia. We will also promote prevention of Type 2 diabetes through signposting to weight loss services to adults with excess weight. Our goal is to prevent ill-health, and where ill-health conditions develop, or episodes of ill-health flare up, to have in place care pathways and care plans to better proactively support each individual's needs.

Transformation program	Key actions to 2021	Key outcomes by 2020/21
DA2 Eliminating unwarranted variation and improving LTC management ***I only have to tell my story once and they pass my details on to others with an appropriate role in my care. If I do need to go to hospital, they start to plan for my social and health care in the community from day one of my stay***		
T4. Integrated Support for People with Long Term Conditions	○ Embed approach to tackling co-morbidities and complex needs ○ Determine approach to close the gap between those who have diagnosed and un-diagnosed LTCs and by March 2019 show evidence of the gap closing ○ New AF and stroke pathways and services targeting populations in areas of high need ○ Expand the Empowered Patients Programme, with initial focus around aiding self-management across a wider range of conditions. Evaluate by April 2018 ○ We will expand Personal Health Budgets in Hillingdon, putting patients in charge of their treatment options ○ Expand the usage of Patient Activation Measures to gauge impact of support ○ Mental health and well-being support to people with long-term conditions will be fully embedded within Hillingdon health systems ○ Improve support for patients with MH related LTCs ○ Rollout programme for complex users ○ Expand ICP to wider cohort	○ 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 ○ Reduced mortality from cardiovascular and respiratory diseases ○ 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) ○ Reduction in unplanned events for people with LTCs ○ increase in people with an LTC who self-manage elements of their care ○ Increase in people with an LTC who have an anticipatory care plan

Transformation program	Key actions to 2021	Key outcomes by 2020/21
T5. Transforming Care for People with Cancer	○ Ongoing rollout of actions from our Hillingdon Cancer Improvement Plan leading to earlier diagnosis and improved treatment. ○ By March 2019 we will complete a review and evaluation of our Cancer Improvement Plan ○ Improve awareness in GPs to improve 2 week target for timely diagnosis of cancer ○ We will continue delivery of the National Cancer Vanguard Programme ○ Roll out clinical protocol for the follow ups in community ○ Develop Single Point of Access rehab model ○ Implementation of DA and STT ○ Rollout outstanding actions from Cancer Improvement Plan ○ Evaluation of cancer screening outreach programmes	○ Reduced mortality from cancer ○ Improved screening coverage for breast, cervical and bowel cancer ○ Greater proportion of cancers diagnosed at Stage 1 or 2 ○ Holistic pathways covering both medical and nonmedical care pathways elements ○ Integrated cancer rehabilitation programme ○ SPA survivorship service model ○ Reduction in unplanned events ○ Early identification of Cancer patients in primary care/community settings ○ GP DA and STT community diagnostics

DA3 – Improving Older People's Care

Key transformation themes:

- New model of integrated care for older people
- Integrated service and coordinate support for people at the end of life

"Social care and Health Services help me to be proactive. They anticipate my needs before I do and help me to prevent things getting so bad that I need to stay in hospital"

Our population is ageing, meaning that people are living longer. Many older people will lead healthy lives, but the demand for health and social care services will rise substantially. There are over 38,000 people living in Hillingdon aged over 65 years. This figure is projected to grow by 7.5% to 41,200 by 2020. This is twice the rate of overall population growth.

Not all extra years gained are spent in good health and disability free. Elderly people have complex care needs and it is estimated that over 30% of elderly patients in our hospitals could receive better care closer to home. Additionally, women who live longer spend a higher proportion of years in ill health than men. Tackling major causes of illnesses like diabetes, heart disease, cancers and stroke are essential for improving gains in disability free life years. Evidence based interventions to reduce high blood pressure, high cholesterol, controlling blood sugar, reducing ,smoking, reducing rates of overweight and obesity (estimated to be higher in older people) and increasing physical activity in older people are some of the strategies which can be used to target older people.

Loneliness and isolation is known to increase with age and is associated with higher use of health and care services independent of chronic illness. Levels of isolation for older people in Hillingdon are similar to national average, however social isolation among social care users and their carers is significantly higher.

Cancer and cardiovascular diseases cause majority of deaths in older people. Cardiovascular illnesses are a major cause of deaths from 'treatable' conditions and can be prevented through improving disease management and preventative action. Improving the uptake rates of flu immunisations and cancer screening programmes are other measures for improving quality and length of life.

There were 1,800 patients diagnosed with dementia on GP registers in Hillingdon in 2015/16, 0.6% of the GP register population. However it is believed that the actual numbers of people living with dementia may be higher with an estimated 2,750 people in Hillingdon in 2015 rising to 3,200 in 2020. This is a projected increase of around 16%. For those aged over 85 it is estimated that in 2015 there were 1,200 people in Hillingdon living with dementia a figure expected to rise by 20% to 1,500 by 2020.

In order to address these issues, our health and social care services will work better together to ensure local people receive better coordinated care –especially those with multiple long term conditions. Over the next five years, more intermediate-level care will be provided out of hospitals to meet the needs of elderly residents. This includes more specialist support to frail elderly people in nursing homes and care homes. It also means providing tailored health and care packages which

can be stepped-up in response to escalating needs; and stepped-down care as patients are rehabilitated. The expansion of our community outreach programmes will provide support for nurses and carers working to help their patients stay in the home for longer, rather than being taken into hospital. Mental health professionals and GPs will work better together with care home staff so they can help patients more effectively. We will have community based teams of local specialist clinicians including practice and community nurses, social care workers, allied health professionals, community mental health workers, GPs, and geriatricians.

Transformation program	Key actions to 2021	Key outcomes by 202021
DA3 Achieving better outcomes and experiences for older people ***Social care and Health Services help me to be proactive. They anticipate my needs before I do and help me to prevent things getting so bad that I need to stay in hospital***		
T3. Integrating Services for People at the End of their Life	○ Implementation of EoL Strategy and new integrated service model ○ Increase access and use of the Coordinate My Care record ○ Enhanced social support for those at end of 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
T1. Transforming Care for Older People	○ Improved vaccination access and service coverage to older people in the borough, including care homes ○ Embed the Care Connection Teams across Hillingdon ○ Ongoing implementation of the Hillingdon Carers Strategy ○ Rollout new models of care for care homes integrating Primary, Community and Secondary Care support including embedding the use of frailty tools ○ Evaluation and further development of programmes focussed on the care homes population ○ Implementation of Home to Assess and integrated discharge pathways ○ Full integration of Co-ordinate my Care and Primary Care clinical records systems ○ Supporting those with dementia and their carers in the community	○ Increased rates of vaccination in the borough and reduced attendance to hospital due to cold/flu related illness ○ Estimated dementia diagnosis rate ○ Reduced emergency admissions due to falls ○ Enhanced reablement outcomes with reduced proportion of older persons still at home 91 days after discharge from hospital, and proportion of clients where no further request made for ingoing long term care ○ Reduction in permanent admissions of older persons to residential and nursing care homes, enabling them to live independently and in the family home for longer ○ Increase in use of Connect to Support service ○ Improved PAM scores in older people ○ Improved proportion of those aged 55+ participating in screening programmes ○ Improved number of carers assessments completed and carers receiving respite or other related service following assessment ○ Increased registered carers on Hillingdon Carers Register ○ Reduced delayed transfers of care ○ 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 ○ Reduction in Non-Elective Admissions ○ Reduction in Zero-Length of Stay Admissions ○ Single point of access implemented to simplify referral pathways

DA4 – Improving outcomes for children and adults with mental health and well-being needs

Key transformation theme:

- Effective support for people with mental health and learning disability needs

"I am treated with respect and dignity, according to my individual needs"

Good mental health and well-being is of great importance to ensuring the health and wellbeing of our people and communities. There is some evidence of an increase in numbers of mental health problems in children and young people nationally, although it is not clear if this is because mental health problems are now identified more easily or because the number of problems has risen.

The prevalence of self-reported depression and anxiety in the Hillingdon GP registered population is 9.9%, with hospital admissions for self-harm (10-24 years) 234.7 per 100,000 population. An estimated 4,000 children aged 5-16 in Hillingdon have a mental health disorder, about 60% of whom are boys. Conduct and hyperkinetic disorders are more common among boys and emotional disorders among girls. Some groups are at particular risk including looked after children, young offenders, those with learning difficulties or autism spectrum disorders, and those with long-term physical health problems. There are estimated to be around 2,000 young people aged 16-19 with neurotic disorders, over 350 aged 5-10 with autistic spectrum disorders, and around 480-620 with a learning disability who also have a mental health problem.

Long running concerns about Child and Adolescent Mental Health Services (CAMHS) nationally have been raised in many reports in recent years. Whilst investment has been made into provision of eating disorders and self harm services, more needs to be done to reduce waiting times and intervene early. It is increasingly recognised that the current 'Tier' model of CAMHS should be replaced by a model which places children and young people and their needs at the centre of care.

People in Hillingdon with mental health needs will have a single point of access and their requirements identified early to ensure prevention and improved wellbeing. Those with long term conditions will have psychological support in a community setting through local well-being and prevention services that are provided by primary, community and social care services working together in a coordinated way. Community based services will provide urgent, enhanced crisis and out of hours support giving people the care they need, in the best place and in a timely manner providing better opportunities for healthy active lives.

Community based services will provide urgent, enhanced crisis and out of hours support giving people the care they need, in the best place and in a timely manner providing better opportunities for healthy active lives. Partnership working is critical to improve the co-ordination of care and outcomes, and 'Future in Mind' identifies five priority areas: prevention/early intervention, access to effective support, care for the most vulnerable, accountability and transparency, and workforce development and training. By 2021 we will have improved pathways and response for individuals with mental health needs through our Children and Adults Mental Health Services (CAMHS). We want to ensure those with Serious Mental Illness, Learning Disabilities, and Anxiety have access to the right care, advice, and support.

Transformation program	Key actions to 2021	Key outcomes by 202021
DA4 Improving outcomes for children & adults with mental health needs ***I am treated with respect and dignity, according to my individual needs***		
T6. Effective Support for people with a Mental Health need and those with Learning Disabilities	○ Delivery of the Like Minded Programme ○ Improve support for patients with MH related LTCs ○ Implement MH support for people with a physical LTC ○ Expand integrated care planning to include people with MH needs ○ Rollout new model of Community MH Support ○ Development of psychological support for people with long-term conditions including access to Talking Therapies ○ By January 2019 full operational delivery the strategy for adults and children with autism ○ Implement crisis and out of hours support for CAMHS ○ Commission new CAMHS pathway without tiers by December 2017 ○ Delivery of new model of Community MH Support ○ By March 2019 we will complete evaluation of support programmes for patients with MH related LTCs ○ Delivery of Community LD Services ○ Expand ICP to include people with MH Conditions ○ Rollout new model of Community MH Support ○ Rollout Community LD Service	○ 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 ○ Reduction in the mortality gap ○ Reduction in the unplanned care costs associated with supporting vulnerable people and those with an LD ○ Reduction in unplanned care needs arising for people with a known mental health condition ○ Improved rates of adults with a learning disability living in stable and appropriate accommodation ○ Improved Access to Psychological Therapies (IAPT) recovery rate ○ Improved achievement of two week wait for people with a first episode of psychosis or at risk mental state ○ Reduced waiting time for children waiting for CAMHS treatment

DA5 – Ensuring we have safe, high quality sustainable health and care services

Key transformation themes:

- Transformation in local services
- Integration across urgent and emergency care services

"It doesn't matter what day of the week it is – I get the support appropriate to my health and social care needs. Systems are sustainable and what once might have been spent on hospital care for me is now spent to support me at home in my community

Our NHS is under significant pressure to radically change the approach to care in order to provide personalise, localised, specialised and integrated care to all. The **NWL Local Services Strategy** outlines in detail how we can ensure we have safe, high quality, sustainable health and care services will see the needed transformation in local services and integration in urgent and emergency care.

There are a number of key challenges facing local services. People across demographies are living longer lives, which is a great achievement for healthy living. It has also meant we are living longer and growing frailer with complex and multiple long term conditions often characterising our last decades. Our local services are seeing growing patient demand with a growing population, and within the problematic context of recruiting, training and retaining our clinical workforce, we are seeing demand outstripping service capacity to provide enough appointments. Underlining these issues is the financial challenge the NHS, and all public services, are facing - even a decade after the global financial crisis. Within the NHS, and NWL, there remains inconsistent provision and access to services, opportunities to improve integration along care pathways, and a need to commission care and interventions much earlier to address the risks and indicators of ill-health. Above all, we must engage and empower residents to take control of their health and well-being.

Implementation of key local actions from the NWL Local Services Strategy will help our hospitals respond more effectively to increases in demand and provide more efficient diagnosis, timely triage and consultant services and effective transfer and discharge processes. Patients will have greater access to care in non-acute settings, including specialist primary care outpatient clinics, treatment diagnostics and urgent care for urgent need. Services will be coordinated and people in Hillingdon will receive complete 'joined up' care. We will see the right care provided in the right place, at the right time. Our strategy further acknowledges the role social care can play in putting in place the right reablement, rehabilitation and intermediate care services to support individuals to return home and/or regain their independence.

We aim to address the whole person, and as such our plans will embed mental health and well-being within care pathways to make every contact count. Mental health and well-being care will be integrated into pathways to ensure support is readily available for severe mental illness, learning disabilities, general well-being to address depression and anxiety, as well as support to give patients and their families the confidence to better manage their long term condition, flare-ups of an on-going concern, and general health after a spell in hospital.

Transformation program	Key actions to 2021	Key outcomes by 202021
DA5 Ensuring we have safe, high quality, sustainable acute services ***It doesn't matter what day of the week it is - as I get the support appropriate to my health and social care needs. Systems are sustainable and what once might have been spent on hospital care for me is now spent to support me at home in my community***		
T10. Transformation in Local Services	○ Implement NWL Local Services Strategy ○ Provide medical retina services at Mount Vernon hospital to treat macular degeneration ○ Enhanced progression of BHH RightCare Programme in line with strategic plans developed in October 2016 ○ Full implementation of 7 Day Standards ○ Enhanced progression of BHH RightCare Programme ○ Rollout of Prevention Strategy ○ Rollout of Proactive Case Finding in Primary Care ○ Work to close prevalence gap ○ Explore opportunities for diagnostics in the community	○ Reduction in prevalence gap for key conditions ○ Reduction in the rate of growth in prevalence ○ Reduction in the variation in management of conditions ○ Reduction in the prevalence gap for key conditions ○ Reduction in the rate of growth of prevalence ○ Reduction in the management of people with LTCs
T8. Integration across Urgent & Emergency Care Services	○ Develop Integrated Urgent Care approach, aligning urgent care services across social, primary, community and acute settings ○ Rollout new 111 Service and Primary Care Triage Model aligned to national guidelines ○ Robust monitoring of individuals discharged from hospital to monitor success in avoiding emergency readmissions ○ Develop and enhance ambulatory care pathway services in out of hospital settings	○ Coordination of support across all Urgent & Emergency Care services ○ Reduced emergency attendance, and non-elective admissions that could be treated in the community ○ 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 ○ Reduction in rate of growth for unplanned attendances at hospital ○ Increase in people accessing non-hospital based support for their unplanned care needs ○ Reduction in the costs per capita managing unplanned care needs ○ Reduction in Zero-Length of Stay and Unplanned Admissions ○ Reduction in Length of Stay following an unplanned admission ○ Reduction in the number of emergency readmissions within 30 days of discharge from hospital

Enablers

Key transformation themes:

- Developing the Digital Environment for the Future
- Creating the Workforce for the Future
- Delivery of our Statutory Targets
- Medicines Optimisation
- Redefining the Provider Market

- Better Care Fund

Our six enabling themes will provide the underpinnings for success in ensuring the sustainability of the health and care system, structures and organisations in Hillingdon. The strategies associated with each of these enablers provide enhanced detail as to the key actions and milestones for implementation.

The Better Care Fund is included here as an enabler due to its role as a pooled budget for the NHS and Local Authorities to agree joint social and health programmes to support improved health outcomes.

Transformation program	Key actions to 2021	Key outcomes by 2020/21
Enablers		
E1. Developing the Digital Environment for the Future	○ Improve access to Shared Care Records ○ Develop plans for digitally enabled self-care ○ Develop plans for use of real time data in decision making ○ Additional promotion of assistive technologies eg telecare and telehealth ○ Delivery of a paperless system through the full integration of Co-ordinate my Care and primary care clinical systems ○ 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	○ Relevant information safely and appropriately available when needed to coordinate care for people ○ Clear information available to aid planning of services ○ High utilisation of Shared Care Record across setting ○ Services planned using accurate and timely data ○ Improved outcomes for patients through shared record keeping ○ Reduce reliance on paper records
E2. Creating the Workforce for the Future.	○ Develop recruitment and retention strategy ○ Develop mutli-professional workforce plans ○ Brunel University London (BUL) with THH NHSFT and CNWL NHSFT establishing an Academic Centre for Health Sciences ○ Develop plans with Buckinghamshire New University for workforce development ○ Rollout recruitment and retention strategy and workforce plans	○ A workforce that meets the needs of the evolving health and social care market ○ 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
E3. Delivering our strategic estates priorities	○ Better utilise estates with a view to integration of health and care services	○ Deliver Local Estate Strategy for Hillingdon

Transformation program	Key actions to 2021	Key outcomes by 2020/21
E4. Delivery of our Statutory Targets	○ Robust demand and capacity study undertaken around RTT, Cancer and Diagnostic Targets ○ Continued focus on improvement in A&E Performance ○ Develop resilience plan around core measures ○ Development of diagnostic capacity to meet demands and targets for Cancer pathways ○ Rollout resilience plans	○ Continued, consistent and sustained achievement of our mandatory and statutory targets: A&E RTT Cancer LAS handovers
E5. Medicines optimisation	○ Focus on medicines optimisation and rollout of practice level pharmacy support with medicines reviews and repeat prescriptions ○ Focus on reducing wastage and reducing inappropriate usage of antibiotics ○ Implement Choosing Wisely	○ 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 ○ Reducing spend per capita on medication ○ Reducing incidents of harm ○ Improving outcome for people arising from the effective use of medication
E6. Redefining the Provider Market	○ Rollout and trial ACP model and develop plans for future cohorts ○ Develop Network Development Strategy ○ Implement recommendation of THH master planning exercise ○ Implement the 2016/17 market shaping activities ○	○ A market capable of meeting the health and care needs of the local population within the financial constraints ○ A diverse market of quality providers maximising choice for local people ○ Significant proportion of care delivered through integrated delivery vehicles ○ A high functioning, cost effective Accountable Care Partnership

Better Care Fund

The Better Care Fund was introduced by Government in 2015 to support closer working between health and care sectors, with the ambition of integration of health and social care by 2020. It established a joint pooled budget for services and encouraged joint working. In Hillingdon focus was directed at supporting services for people aged over 65 especially those with long term medical conditions.

The BCF plan is key to the delivery of the aspects of Hillingdon's Sustainability and Transformation Plan that are dependent on integration between health and social care or closer working between the NHS and the Council for delivery. The Better Care Fund proposals for 2017-19 identifies six detailed workstreams:

- Early intervention and prevention
- Integrated support for carers
- Better Care at end of Life
- Integrated Hospital Discharge
- Improving care Market management and development
- Living well with dementia

Key actions and outcomes include:

- Evaluate the impact of BCF schemes for over 65s. Assessment of impact of benefit realisation on the NHS and LA.

- Early intervention and prevention workstream (BCF1) including access to information and advice, use of patient activation measure to gauge impact of support and developing the preventative role of the third sector though the H4All Wellbeing service, Stroke prevention initiatives, promoting physical activity in older people and developing use of assistive technology and disabled facilities grants.

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Appendix 2: Draft performance indicator set

Delivery Areas	Indicator/s	Source
DA1: Radically upgrading prevention and wellbeing		
Smoking	- Smoking prevalence at age 15 - Smoking Prevalence in adults	PHOF 2.09i, 2.09ii 2.09iii, 2.09iv, 2.09v PHOF 2.14 Health improvement
Smoking in pregnancy	- Smoking status at time of delivery	PHOF 2.03 Health improvement
Breastfeeding	- Breastfeeding initiation - Breastfeeding prevalence at 6-8 weeks after birth	PHOF 2.02i & 2.02ii Health improvement
Child dental health	- Proportion of five year old children free from dental decay	PHOF 4.02 Healthcare and premature mortality
Child obesity	- Child excess weight in 4-5 year olds - Child excess weight in 10-11 year	PHOF 2.06i & 2.06ii Health improvement
Teenage conceptions	- Under 18 conceptions	PHOF 2.04 Health improvement
Social isolation/loneliness	- Social Isolation: percentage of adult social care users who have as much social contact as they would like - Social Isolation: percentage of adult carers who have as much social contact as they would like	PHOF 1.18i & 1.18ii Wider determinants of health
Alcohol & drug addiction	- Admission episodes for alcohol-related conditions - Successful completion of alcohol treatment - Deaths from drug misuse - Successful completion of drug treatment - opiate users - Successful completion of drug treatment - non-opiate users	[for review - potential indicators include:] PHOF 2.18, 2.15i, 2.15ii, 2.15iii, 2.15iv Health improvement
Domestic violence	- Domestic abuse-related incidents and crimes	PHOF 1.11 Wider determinants of health
Suicide	- Suicide rate (Persons)	PHOF 4.10 - Healthcare and premature mortality
Air Quality	Air pollution monitoring data	Air Quality Action plan reporting process.
DA2: Supporting people with Long Term Conditions		
Cardiovascular	- Under 75 mortality rate from all cardiovascular diseases (Persons) - Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	PHOF 4.04i & 4.04ii Healthcare and premature mortality
Diabetes	- Recorded diabetes	2.17 Health improvement
Respiratory	- Under 75 mortality rate from respiratory disease	4.07i & 4.07ii Healthcare and

	- Under 75 mortality rate from respiratory disease considered preventable	premature mortality
Cancer	- Under 75 mortality rate from cancer - Under 75 mortality rate from cancer considered preventable - Cancer screening coverage - breast cancer - Cancer screening coverage - cervical cancer - Cancer screening coverage - bowel cancer % of cancers diagnosed at Stage 1 or 2	PHOF 4.05i, 4.05ii Healthcare and premature mortality PHOF 2.20i, 2.20ii & 2.20iii Health improvement PHE published data (STP dashboard)
DA3 - Improving older people's care		
Dementia	- Estimated dementia diagnosis rate (aged 65+)	PHOF 4.16 Healthcare and premature mortality
Falls	- Emergency hospital admissions due to falls in people aged 65 and over - Emergency hospital admissions due to falls in people aged 80+	PHOF 2.24i & 2.24iii Health improvement
Non-elective admissions	Difference between actual number of non-elective admissions of people aged 65+ to general or acute hospital and target reduction	BCF dashboard
Reablement	- % of people aged 65+ still at home 91 days after discharge from hospital to reablement - % of new clients who received reablement, where no further request was made for ongoing long term support.	BCF dashboard
Care	- % reduction in permanent admissions of older people aged 65 or over to residential and nursing care homes per 100,000 population - % increase in utilisation rates for Connect to Support - % of patients with a Patient Activation Measure (PAM) score whose PAM score improved in the previous 12 months - % of people aged 55+ participating in screening programmes	BCF Scheme 4 monitoring BCF Scheme 1 monitoring BCF Scheme 1 monitoring BCF Scheme 1 monitoring
Carers	Number of Carers' assessments completed	

	Number of Carers receiving respite or a carer specific service following assessment Increase in number of carers identified and registered on the Hillingdon Carers Register	
Delayed Transfers of Care	- % reduction in delayed transfers of care (delayed days), including: - % reduction in delays attributed to the NHS - % reduction in delays attributed to Adult Social Care	BCF reporting template
End of Life	- Proportion of people on and End of Life pathway on Coordinate My Care who achieved their preferred place of death	BCF Scheme 3 monitoring
DA4 - Improving outcomes for children and adults with mental health needs and learning disabilities		
IAPT	- Improving Access to Psychological Therapies Recovery Rate	NHS Digital (STP dashboard)
Two week wait	- Two week wait (people with first episode of psychosis or at risk mental state starting treatment within 2 weeks of referral	Unify collection (STP dashboard)
CAMHS	- Difference between actual and target numbers waiting 18 weeks for access to CAMH services - Number of children waiting for CAMH treatment	CAMHS monitoring
DA5 - Ensuring we have safe, high quality, sustainable health and care services		
A&E waiting times	- % of patients admitted, transferred or discharged from A&E within 4 hours	Unify collection (STP dashboard)
Referral To Treatment waiting times	- No. of patients waiting 18 weeks or less from referral to hospital treatment	Unify collection (STP dashboard)

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2017/19 BETTER CARE FUND PLAN

Relevant Board Member(s)	Councillor Philip Corthorne Dr Ian Goodman
Organisation	London Borough of Hillingdon
Report author	Kevin Byrne, Resident Services, LBH Tony Zaman, Adults and Children and Young People's Services Directorate, LBH Caroline Morison, Chief Operating Officer, HCCG
Papers with report	**Appendix 1** - Supporting Narrative Document. **Appendix 2** - Annexes 1 and 1A: DTOC Action Plan (Acute and Mental Health). **Appendix 3** - NHSE Planning Template. **Appendix 4** - Updated Health Impact Assessment. **Appendix 5** - Updated Equality Impact Assessment

HEADLINE INFORMATION

Summary	This report sets out the proposals for the 2017/18 Better Care Fund plan and seeks the Board's approval. The Better Care Fund is a Government initiative intended to improve efficiency and effectiveness in the provision of health and care through increasing integration between health and social care. The focus of Hillingdon's Better Care Fund plan is improving care outcomes for older people.
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	The proposed total amount for the BCF for 2017/18 is **£36,814**k, made up of Council contribution of £19,656k and a CCG contribution of £17,158k. The value for 2018/19 is **£54,049k**, made up of Council contribution of £27,279k and a CCG contribution of £26,770k.
Ward(s) affected	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

1) **approves the 2017/19 Better Care Fund plan for submission to the London Regional Assurance Team by 29th September 2017 as described in this report or with any amendments that it requires;**

2) **delegates authority to make any further amendments to the plan following the assurance process to the Corporate Director of Adult and Children and Young People's Services, LBH, and the Chief Operating Officer, HCCG, in discussion with the Chairman of the Health and Wellbeing Board, the Chairman of HCCG's Governing Body and the Chairman of Healthwatch Hillingdon's Board;**

3) **agrees the delayed transfers of care (DTOC) target for 2017/18, notes the provisional target for 2018/19 but makes approval of any nationally imposed target for 2018/19 subject to consideration by the Board about its deliverability; and**

4) **notes the content of the updated Health and Equality Impact Assessments (Appendices 4 and 5).**

INFORMATION

Strategic Context

1. In accordance with the *2017/19 Integration and Better Care Fund Policy Framework* published in March 2017, Hillingdon is required to develop a Better Care Fund Plan (BCF) for the 2017/19 period. This will be Hillingdon's third BCF plan, the first being for 2015/16. The statutory guidance for the plan was published on 4 July 2017 with the expectation that the draft plan will be submitted to NHSE for evaluation on 11 September 2017.

2. The June 2017 HWB meeting delegated authority to the Chairman of the Board, the Chairman of HCCG's Governing Body and the Chairman of Healthwatch Hillingdon. However, since the June meeting NHSE has set local delayed transfer of care (DTOC) targets for the NHS and adult social care. This new imposed requirement has taken time to be clarified by NHSE and the implications understood locally. Our assessment now is that the targets set are actually achievable even though the way they have been set has been unhelpful. There is also concern that this sets a precedent that will be repeated for 2018/19. In these circumstances it was felt that the full BCF should come back to the Board for discussion at its September meeting.

3. The June Board meeting approved the proposed use of the additional funding announced in the March 2017 Budget under the Improved Better Care Fund Grant (IBCF), which is £4.1m in 2017/18. The proposed use was to stabilise the care market in order to support hospital discharge as well as avoid admission. The BCF planning guidance published in July 2017 states that the Government will review allocations of IBCF for areas that are poor performing. On 6th September NHSE announced the Government's expectation that there will have been significant progress in addressing DTOCs by November as one of the key criteria in determining what constitutes poor performance. There is a commitment stated within the guidance to retain the money within local government but it is not clear whether it is proposed to withhold IBCF funding from areas that are deemed to be poor performers or rather to be more prescriptive in how they should use the IBCF funding.

2017/19 BCF Plan Proposals

4. As with the two previous iterations of the BCF plan, the focus of the proposed plan will continue to be the 65 and over population. The primary purpose of the plan will be to deliver

those aspects of the Sustainability and Transformation Plan (STP) that require integration between health and social care and/or closer working between health and the Council for delivery.

5. The agreed BCF pooled fund for 2016/17 was £22,531k If the Board approves the recommendations in this report the total value of the 2017/18 expenditure plan will be £36,814k and in 2018/19 £54,049k. Table 1 below provides the detailed total planned expenditure by organisation. The narrative plan attached as Appendix 1 provides a detailed financial investment breakdown by proposed scheme, but this is summarised in table 2 below.

Table 1: Council and HCCG Financial Contributions Summary			
Organisation	**2016/17** *£,000s*	**2017/18** *£,000s*	**2018/19** *£,000s*
HCCG	11,965	17,158	26,770
LBH	10,566	19,656	27,279
TOTAL	**22,531**	**36,814**	**54,049**

Table 2 Council and HCCG Financial Contribution by Scheme Summary					
		Funder 2017/18		**Funder 2018/19**	
	SCHEME	**LBH £000's**	**HCCG £000's**	**LBH £000's**	**HCCG £000's**
1	Early intervention and prevention	5,060	2,353	5,426	2,353
2	An integrated approach to supporting Carers	862	18	878	18
3	Better care at end of life	50	992	51	992
4	Integrated hospital discharge	4,607	11,406	4,643	11,406
5	Improving care market management and development	8,695	2,389	15,893	12,001
6	Living well with dementia	300	0	306	0
	Programme Management	82	0	82	0
	Total Partner Contributions	**19,656**	**17,158**	**27,279**	**26,770**
	TOTAL ANNUAL VALUE	**36,814**		**54,049**	

6. Six schemes are proposed under the 2017/19 plan and these and their links to the STP delivery areas are shown in table 3 overleaf.

Table 3: 2017/19 Proposed Schemes and Alignment to STP Delivery Areas		
Scheme	**STP Delivery Area**	**Scheme Title**
1	1	Early intervention and prevention
2	1	An integrated approach to supporting Carers.
3	3	Better care at end of life.
4	3	Integrating hospital discharge.
5	3	Improving care market management and development.
6	3	Living well with dementia.

7. A more detailed description of the above schemes can be found in the supporting narrative plan document attached as **Appendix 1**.

8. The key developments under the proposed plan are:

- ***Developing the Accountable Care Partnership (ACP) and the Council giving full consideration to its involvement*** - Establishing the business case for the Council to decide whether to join the ACP;

- ***Developing a single point of access for older people (scheme 1)*** - Bringing services together into a single service with a single point of access has proved successful for Carers in Hillingdon and the scope for replicating this for older people and building on the work of the H4All Wellbeing Service will be explored;

- ***An integrated approach to supporting Carers (scheme 2)*** - Implementing NHSE's integrated approach to assessing Carer health and wellbeing. The plan looks at identifying 'hidden' and 'young' Carers and the provision of support and break opportunities. It is also covers the development of self-help options such as self-assessment and improving support to Carers of people admitted to hospital;

- ***Getting hospital discharge right (scheme 4)*** - The plan is proposing to bring together the various services involved in facilitating discharge from hospital into the community, e.g. Homesafe, Rapid Response, Reablement, the Night Sitting Service and Prevention of Admission/Readmission to Hospital Service (PATH) into a more integrated model;

- ***Exploring use of Disabled Facilities Grant flexibilities*** - Developing a business case to use flexibilities to address anticipated needs and support hospital discharge, e.g. home/garden clearance, home deep cleaning, home fumigation, furniture removals to set up micro-environment, etc;

- ***Joint market management and development approach (scheme 5)*** - With the objective of ensuring the supply of sufficient quality providers to meet demand, this area represents potential step-change for Hillingdon. It includes:
  - Development of all age, joint brokerage arrangements for homecare, short and long-term nursing home placements and Direct Payments and Personal Health Budgets as a pilot;
  - Commissioning of integrated homecare provision in 2017/18;

- Commissioning of integrated palliative care at home provision in 2017/18;
- Development of an integrated commissioning model for nursing home placements from 2019/20;
- Supporting care homes - This links to the Improving health in care homes programme but also includes converting spot purchase arrangements into block contracts to guarantee capacity.

- ***Closer alignment between Adult Social Care and Care Connection Teams*** - Allocating social care staff to Care Connection Teams supporting extra care schemes.

- ***Development of specialist Dementia Resource Centre (DRC)*** - Maximising benefits from the purpose-built DRC at Grassy Meadow Court extra care scheme.

National Conditions

9. The national conditions from 2015/16 have been rolled forward and two new conditions have been added. Table 4 below summarises the national conditions and the local response.

Table 4: National Conditions and Local Response

Condition	Local Response
1. **A jointly agreed plan** - A plan that has been agreed by the HWB.	This is dependent on the Board's decision.
2. **NHS contribution to social care is maintained in line with inflation** - The Protecting Social Care funding is passported to Social Care with the inflationary uplift.	This is included within HCCG's minimum contribution.
3. **Agreement to invest in NHS-commissioned out of hospital services** - Investing a ring-fenced sum (£7,381k in 2017/18 and in 2018/19) in out of hospital services.	This is already addressed through the funding committed to the CCG's community contract with CNWL and the Care Connection Teams.
4. **Implementation of the High Impact Change Model for managing transfers of care** - This model sets out eight broad changes that will help local systems to improve patient flow and processes for discharge.	This is more fully described in section 6 of **Appendix 1**: *The Plan: Schemes and Spending* and under scheme 4: *Integrated Hospital Discharge*.

Measuring Success

10. The success of the 2017/19 plan will be measured against a combination of nationally determined and some scheme specific metrics.

11. **Performance against national metrics** - The number of reportable national metrics has reduced from six in 2016/17 to four for the duration of the 2017/19 plan and these are:

a) ***Emergency (also known as non-elective) admissions*** - Hillingdon will be reporting on the component of the CCG's emergency admissions target associated with patients aged 65 and over. For 2017/18 a reduction target of 975 emergency admissions is proposed with scheme contributions as shown below:

- Intermediate care (see scheme 4: *Integrated hospital discharge*) - 49 (5%)
- Care of the Elderly Consultant - 78 (8%)
- Wellbeing Gateway (see scheme 1: *Early intervention and prevention*) - 127 (13%)
- Care Connection Teams (see scheme 1: *Early intervention and prevention)* - 517 (53%)
- Homesafe (see scheme 4: *Integrated hospital discharge*) - 205 (21%)

b) ***Permanent admissions to care homes*** - This applies to permanent admissions to care homes by the Council of people aged 65 and over. The proposed target is 150 for 2017/18 and reducing to 145 in 2018/19 to reflect the opening of Grassy Meadow Court and Park View Court extra care sheltered housing in June and September 2018 respectively. The proposed target for 2018/19 reflects a reduction in permanent places into residential care homes but recognises that permanent admissions to residential dementia, nursing and nursing dementia care homes will continue.

c) ***Delayed Transfers of Care 2017/18*** - In July 2017 NHSE issued Health and Wellbeing Board area targets for the NHS and for social care. Final clarification of NHSE requirements was received on 8th September and table 5 below shows the target for 2017/18 and its apportionment across the NHS, Social Care and both.

Table 5: 2017/19 DTOC Targets

Attributed Responsibility	Number of Delayed Days		
	2016/17	2017/18	2018/19
NHS	5,536	6,005	6,095
Social Care	1,866	2,271	2,305
Both	962	1,062	1,078
TOTAL	**8,364**	**9,337**	**9,478**

12. A straightline projection based on Q1 activity would suggest an outturn for 2017/18 of 9,736 delayed days and the difference between this figure and the NHSE set target shown above (9,337 delayed days) is 399 delayed days, which means that the proposed target is achievable but is susceptible to changes in local circumstances, e.g. a bad winter increasing demand at the Hospital and/or capacity issues within the local care market.

13. The range of key initiatives included within the Urgent and Emergency Care Plan and the DTOC action plan that will support the reduction of DTOCs at Hillingdon Hospital include:

- Stronger processes in the Hospital to ensure that delays being reported reflect the correct definition;
- Improved information available for patients and family members to help manage expectations and address the main cause of delays for the Hospital;
- Implementation of the SAFER patient flow bundle;

- Implementation of discharge to assess (D2A);
- Support to care homes, including the action by Adult Social Care to increase capacity by converting spot placements into block arrangements.

14. The key initiatives that will contribute to the reduction in the number of DTOCs attributed to patients of CNWL with mental health needs include:

- Stronger processes to ensure that delays being reported reflect the correct definition;
- Implementation of a discharge planning tool;
- Reviewing the training and guidance provided to staff presenting cases to the joint funding panel for mental health patients that includes membership from Adult Social Care, the CCG and Mental Health; and
- Establishing regular meetings with the Council's Housing Team to address accommodation issues at an early stage.

a) ***Delayed Transfers of Care 2018/19*** **-** The expectation is that a target for 2018/19 will be mandated and the one set in the plan and reflected in the planning template attached as **Appendix 3** meets the BCF planning requirements. It assumes the 2017/18 target as the baseline and applies a 1.5% increase to reflect demographic growth. The DTOC total and apportionment across NHS, Social Care and both is shown in table 5 above.

b) ***Effectiveness of reablement*** - This is seeking to identify the proportion of people aged 65 and over who have been discharged home from hospital into reablement who are still at home 91 days after the discharge. The proposed target for 2017/18 is 88% with the provisional target for 2018/19 also being set at 88%, although this will be subject to the outcome of discussions about Hillingdon's intermediate care service model going forward.

15. **Performance against scheme specific metrics** - The schemes detailed in **Appendix 3** contain a further range of metrics that will not be reported to NHSE but will be reported to the HWB and HCCG's Governing Body as part of the quarterly performance reports. These additional metrics will give a broader understanding of the successful implementation of the plan than the national metrics and will also be supported by specific testing of the service user experience by services. The following are examples of the additional metrics that will be reported:

- Utilisation rates for Connect to Support
- Utilisation of self-assessment facilities on Connect to Support
- % of users of Adult Social Care who have found it easy or difficult to access information and advice about services (tested through annual Adult Social Care Survey)
- Improvement in quality of life score for users of Adult Social Care services (tested through annual Adult Social Care Survey)
- Number of falls-related emergency admissions
- Number of emergency admissions from care homes
- Number of emergency admissions from extra sheltered housing schemes
- Number of emergency admissions with a length of stay of between 0 and 1 days.
- Number of admissions a day avoided following a referral to Rapid Response by Hillingdon Hospital's Emergency Department.
- Number of referrals to Reablement per month.
- % of new users of the Reablement Service where there is no request for long-term support.
- Number of readmissions during a period of reablement.

- % of hospital discharges taking place before midday.
- % of Continuing Healthcare assessments taking place in an acute hospital trust setting
- Number of readmissions within 30 days.
- Number of Disabled Facilities Grants provided and value.
- Number of Carers' assessments completed.
- Number of Carers receiving respite or another Carer's service following an assessment.

Risk Share Arrangements

16. The Council and CCG agreed that for both the 2015/16 and 2016/17 BCF plans both organisations would manage their own risks. It is proposed that a similar approach is taken during 2017/18 except for two specific service areas and these are:

- *Community equipment* - It is proposed that the risks associated with under or over-performance would be shared proportionate to the financial contribution of each organisation. This reflects the practice in 2016/17;

- *Integrated homecare service* - It is proposed that the risks associated with under or over-performance would be shared proportionate to the financial contribution of each organisation.

17. The detail of these arrangements will be reflected in the section 75 (NHS Act, 2006) agreement that Cabinet and HCCG's Governing Body will be asked to consider in November 2017. The CCG is currently in discussion with the ACP regarding risk share arrangements from 2018/19 and the implications for the Council will be subject to a Board decision in due course about the local authority becoming a member.

Governance

18. It is proposed that the delivery of the BCF schemes is overseen by the Transformation Group, which comprises of officers from the Council and the CCG as well as representatives from the GP Confederation and has broader project management responsibilities for the delivery of STP programmes. It is chaired by the chairman of the CCG's Governing Body. The Core Officer Group comprising of the Council's Corporate Director of Finance , the CCG's Deputy Chief Finance Officer, the Corporate Director of Adults and Children and Young People's Services (a statutory member of the HWB), the CCG's Chief Operating Officer and the Council's Head of Health Integration and Voluntary Sector Partnerships that has overseen the delivery of plans over the last two years will continue to have oversight and will also consider opportunities for integrated working and/or joint commissioning for recommendation to the HWB. Any decisions about the use of resources will have to be referred to the Council's Cabinet and the CCG Governing Body in accordance with constitutional arrangements and agreed delegations.

BCF Plan Submission and Assurance Timescales

19. The formal plan submission comprises of the following documents:

- Supporting Narrative Document - see **Appendix 1**.
- Annex 1: DTOC Action Plan - see **Appendix 2**.
- NHSE Planning Template - see **Appendix 3**.

20. In view of the late publication of the guidance there is a single submission process. The scheduled submission date was the 11th September. Officers have liaised with the London Better Care Support Team to advise that the plan is being referred to the Board's scheduled meeting for consideration. However, the documents referred to in paragraph 15 above have been submitted with the caveat that they have not been approved by the Board. Subject to Board approval of the recommendations, officers would seek to formally submit the approved plan by close of business on 28th September or earlier depending on any additional requirements the Board may have.

21. The CCG's Governing Body approved the draft plan at its meeting on the 8th September. An e-governance process has been followed to secure Governing Body approval for the DTOC target, which was resolved after the Governing Body meeting.

22. The following summarises the key milestones that follow submission:

- Letters advising of '*Approved*', *'Approved with conditions*' or *'Not approved'* status issued. - From 6th October
- Escalation panels for plans *'Not Approved'* taking place. - W/c 10th October
- Deadline for areas with plans rated *'Approved with conditions*' to submit updated plans. - 31st October
- All section 75 agreements to be signed and in place. - 30th November

Financial Implications

Improved Better Care Fund Grant 2017/19

23. On 9 March, DCLG published funding allocations for the additional Improved Better Care Fund (IBCF), the Council's share of this increased funding is £4.1m available in 2017/18.

24. The Council has committed the IBCF funding to stabilise the local social care provider market which will have a direct impact on the health and care system's ability to support admission avoidance, e.g. by facilitating more expedient activation of services in liaison with the Care Connection Teams and to support reducing hospital delays, e.g. by supporting the Discharge to Assess model.

25. The Council is required to report quarterly to the DCLG on the use of the impact of this funding in addition to the current requirement for quarterly updates on the progress of the BCF plan to NHSE.

Proposed increased contribution to BCF pooled funds 2017/19.

26. The pooled funding for 2016/17 totalled £22,531k with contributions from both CCG and the Council set out in table 3 below. The minimum level of pooled revenue funding was set by central Government at £16,588k. This was made up of £10,621k to cover CCG expenditure and £5,937k revenue funding to 'Protect Social Care'. The Council also included the Capital funding

for the Disabled Facilities Grant (£3,457k) and in addition contributed further £1,172k revenue funding (which included grants to H4All organisations, the budgets for the Adult Safeguarding service and the Wren centre etc). The HCCG contributed a further £1,346k (which included funding for H4All organisations and community services provided under contract by CNWL, etc).

BCF Pooled Budget 2017/18

27. For 2017/18, the minimum level of HCCG funding contribution is set at £16,854k. The draft pooled budget proposals for 2017/18 set out in Table 1 above and in the detail within the plan total £36,814k. The key funding changes from 2016/17 are set out in table 3 below and include the contribution provided to 'Protecting Social Care', from the minimum HCCG contribution, the additional IBCF section 31 grant to the Council which is explained above, and additional Council and HCCG contributions reflected in the attached detailed plan which includes pooling budgets for expenditure on Homecare provision for both organisations.

BCF Pooled Budget 2018/19

28. For 2018 /19, the minimum level of HCCG funding contribution is set at £17,175k. The draft pooled budget proposals for 2018/19 set out in Table 1 above and in the detail within the plan total £54,049k.. The key movements from 2017/18 are set out in table 3 below and include the contribution provided to 'Protect Social Care', from the minimum HCCG contribution, the IBCF section 31 grant to the Council which is explained above, the Enhanced Better Care Fund funding built into the Local Government Finance Settlement 2017/18 and additional Council and HCCG contributions reflected in the attached detailed plan which includes pooling additional budgets for residential placements expenditure for both organisations.

29. Table 4 below provides a summary of the proposed BCF funding arrangements for 2017/19.

Table 4: BCF Funding Summary 2017/19			
	2016/17	**2017/18**	**2018/19**
	£,000s	**£,000s**	**£,000s**
Protecting Social Care	5,937	6,146	6,263
CCG Share of Minimum Contribution	10,621	10,708	10,912
TOTAL MINIMUM LEVEL OF BCF POOLED FUNDING	**16,558**	**16,854**	**17,175**
Disabled Facilities Grant	3,457	3,815	4,174
Additional Council Contribution	1,172	5,641	11,595
IBCF Section 31 Grant	0	4,054	2,947
Original BCF Grant Contribution	0	0	2,310
Additional CCG Contribution	1,344	6,450	15,858
TOTAL BCF FUNDING 2017/19	**22,531**	**36,814**	**54,049**

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

30. The recommendation will enable a Hillingdon BCF plan to be submitted in accordance with national guidance. The BCF plan will contribute to the development of a sustainable health and care system in Hillingdon that will support residents to regain or maintain their independence.

Consultation Carried Out or Required

31. The 2017/19 BCF plan has been developed with the local acute trust, The Hillingdon Hospitals NHS Foundation Trust, the local community health and community mental health provider, the Central and North West London NHS Foundation Trust (CNWL) and the range of voluntary sector providers that comprise the third sector consortium H4All and these include Age UK Hillingdon, the Disablement Association Hillingdon (DASH), Harlington Hospice, Hillingdon Carers and Hillingdon Mind.

32. Partners have been consulted on the content of the plan through a range of fora. This includes the Clinical Design and Delivery Group, which includes representatives from the local accountable care partnership (ACP), known as Hillingdon Health and Care Partners. The multi-agency Carers' Strategy Group has also been consulted. Proposals contained within the draft plan were also taken to the Older People's Assembly in March 2017.

33. A team comprising of representatives from the Council, CCG and Healthwatch undertook a review of the Health Impact and Equality Impact Assessments, which were updated to reflect the proposals for 2017/19. The outcomes of the updated assessments were then consulted on with a broader range of stakeholders. Both assessments are attached as **Appendices 5 and 6**.

Policy Overview Committee comments

34. None at this stage.

CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

35. Corporate Finance has reviewed this report and notes that the Better Care Fund Plan as described in this report is broadly consistent with budget assumptions included within the 2017/18 budget, which was agreed by Council in February 2017. The Council's contribution to the BCF is £19,656k in 2017/18 and £27,279k in 2018/19, which includes the IBCF Section 31 Grant funding for both years.

Hillingdon Council Legal comments

36. Section 223GA of the NHS Act, 2006, provides the legal basis for the BCF and gives NHSE power to make any conditions it considers reasonable in respect of the release of NHS funding to the BCF. Where it considers that an area has not met these conditions it also has the power, in consultation with the DH and DCLG, to make directions in respect of the use of the funds and/or impose a spending plan and impose the content of any imposed plan.

BACKGROUND PAPERS

2017/19 Integration and Better Care Fund Policy Framework (NHSE Publications Gateway Reference 11120 - March 2017)
Integration and Better Care Fund Planning Requirements for 2017/19 (NHSE Publications Gateway Reference 06945 - July 2017)
BCF Plan 2017/19: A Guide to Assurance of Plans (NHSE Publications Gateway Reference 06945 - August 2017)

Appendix 1

NHS
Hillingdon
Clinical Commissioning Group

Better Care Fund Plan 2017/19

HILLINGDON
LONDON

September 2017

Better Care Fund Plan 2017/19
Contents

2016/17 Better Care Fund Plan

1. INTRODUCTION

1.1 Plan Summary

Local Authority	**London Borough of Hillingdon**
Clinical Commissioning Groups	**Hillingdon Clinical Commissioning Group (NHS Hillingdon)**
Boundary Differences	**Boundaries are co-terminus**
Date agreed at Health and Well-Being Board (HWB):	**26/09/17**
Date submitted:	
Total agreed value of pooled budget:	
2015/16	**£17,991,000**
2016/17	**£22,531,000**
2017/18	**£36,814,000**
2018/19	**£54,049,000**

1.2 Funding Contributions to the Plan

The contributions of the Council and Hillingdon Clinical Commissioning Group (HCCG) to the plan is summarised in table 1 below.

Table 1: Council and HCCG Financial Contributions Summary			
Organisation	**2016/17** *£,000s*	**2017/18** *£,000s*	**2018/19** *£,000s*
HCCG	11,965	17,158	26,770
LBH	10,566	19,656	27,279
TOTAL	**22,531**	**36,814**	**54,049**

1.3 Scheme Summary

Table 2 below shows the financial contribution to each scheme by both the Council and HCCG over the two years of the plan.

Table 2 Council and HCCG Financial Contribution by Scheme Summary					
		Funder 2017/18		**Funder 2018/19**	
	SCHEME	**LBH £000's**	**HCCG £000's**	**LBH £000's**	**HCCG £000's**
1	Early intervention and prevention	5,060	2,353	5,426	2,353
2	An integrated approach to supporting Carers	862	18	878	18

3	Better care at end of life	50	992	51	992
4	Integrated hospital discharge	4,607	11,406	4,643	11,406
5	Improving care market management and development	8,695	2,389	15,893	12,001
6	Living well with dementia	300	0	306	0
	Programme Management	82	0	82	0
	Total Partner Contributions	**19,656**	**17,158**	**27,279**	**26,770**
	TOTAL ANNUAL VALUE	**36,814**		**54,049**	

1.4 Signatories to the Plan, Authorisation and Sign-off

Signed on behalf of the Clinical Commissioning Group	Hillingdon CCG
By	Dr Ian Goodman
Position	Chair of Hillingdon CCG
Date	
Signed on behalf of the Council	London Borough of Hillingdon
By	Cllr Philip Corthorne
Position	Cabinet Member for Social Services, Housing, Health and Wellbeing/ Chairman, Health and Wellbeing Board
Date	
Signed on behalf of the Health and Wellbeing Board	Hillingdon Health and Wellbeing Board
By Chairman of Health and Wellbeing Board	Cllr Philip Corthorne
Date	

Signed on behalf of the Healthwatch Hillingdon	Healthwatch Hillingdon Board
By	Stephen Otter
Position	Chair of Healthwatch Hillingdon Board
Date	

1.5 Wider Partner Involvement

The 2017/19 BCF plan has been developed with the local acute trust, The Hillingdon Hospitals NHS Foundation Trust, the local community health and community mental health provider, the Central and North West London NHS Foundation Trust (CNWL) and the range of voluntary sector providers that comprise the third sector consortium H4All and these include Age UK Hillingdon, the Disablement Association Hillingdon (DASH), Harlington Hospice, Hillingdon Carers and Hillingdon Mind. All of these organisations will have a fundamental role to play in the delivery of the plan.

Partners have been consulted on the content of the plan through a range of fora. This includes the Hillingdon Transformation Board,the Clinical Design and Delivery Group, which includes representatives from the local accountable care partnership (ACP), known as Hillingdon Health and Care Partners. The multi-agency Carers' Strategy Group has also been consulted. Proposals contained within the draft plan were also taken to the Older People's Assembly in March 2017.

2. BACKGROUND AND CONTEXT

2.1 Hillingdon: The Place

Hillingdon is the second largest of London's 32 boroughs covering an area of 42 square miles (11571 hectares), over half of which is a mosaic of countryside including canals, rivers, parks and woodland. As the home of Heathrow Airport, Hillingdon is London's foremost gateway to the world, and is also home to the largest RAF airport at RAF Northolt. Hillingdon shares its borders with Hertfordshire, Buckinghamshire, Hounslow, Ealing, and Harrow.

There are 46 GP practices in Hillingdon with an average of registered patients per practice of 5,605. GP practice with the highest number of registered patients is located in Uxbridge and West Drayton with 14,276 patients. Only 4 GP practices in Hayes and Harlington locality have a registered population size above the Hillingdon average compared to 10 practices in Uxbridge and West Drayton and 8 practices in Ruislip and Northwood. Hillingdon CCG achieved full delegation of primary care commissioning on April 1st 2017.

The borough is divided into three localities that loosely correspond with the parliamentary constituencies. These are: Ruislip and Northwood, Uxbridge and West Drayton and Hayes and Harlington.

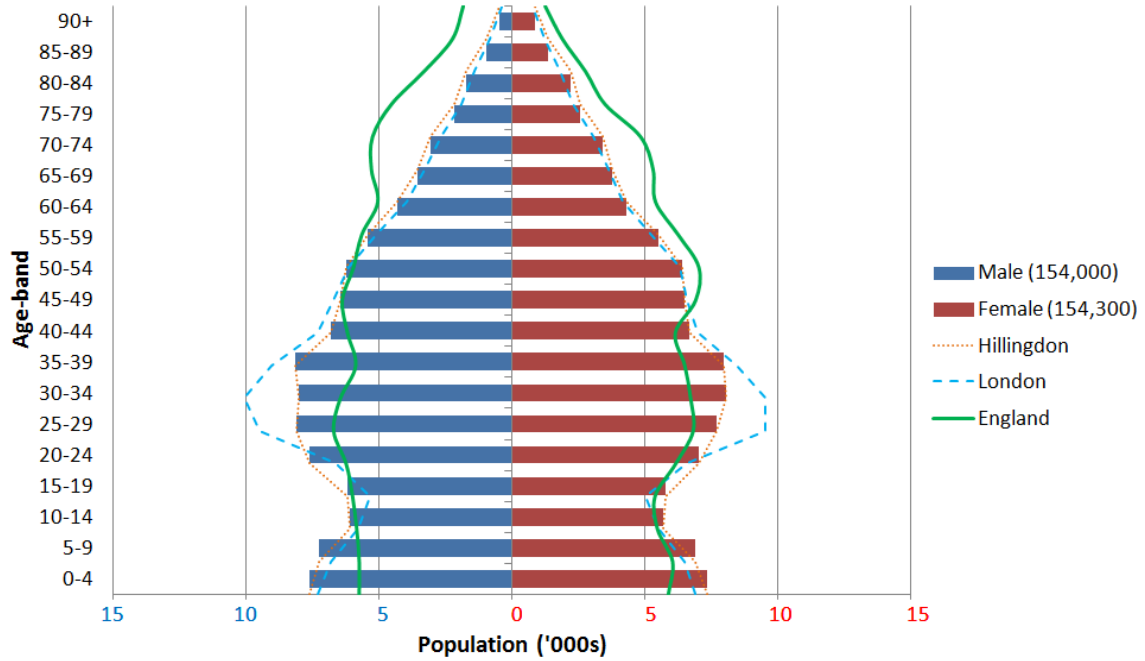
Hillingdon is ranked 153 out of 326 in the English index of multiple deprivation (IMD 2015) where the most deprived is ranked 1. It is ranked 25th most deprived out of London's 33 boroughs, hence it is seen as a relatively affluent area. Social segmentation of Hillingdon's neighbourhoods by dominant Acorn types also shows that a large proportion of Hillingdon's population is stable, home owning and 'fairly comfortable'. There are however major differences in deprivation between wards in the north and south of Hillingdon with small areas in the south the borough falling in the 20% most deprived wards nationally.

Hillingdon is a high employment area and official labour market data from NOMIS shows that 78.3% of the population aged between 16 and 64 are economically active. In June 2016 only 1.4% of the working age population were claiming out of work benefits, which compares to an average of 1.8% in both London and England.

2.2 Local demography, future demographic challenges and long-term health issues.

Hillingdon's Joint Strategic Needs Assessment (JSNA) shows that based on the Census-based sub-national population projections (SNPP) the population of the borough in 2017 is approximately 390,300. The diagram below shows the composition of Hillingdon's population by age and gender.

Chart 1. **Population Pyramid, Hillingdon 2017 (with distribution of other areas)**

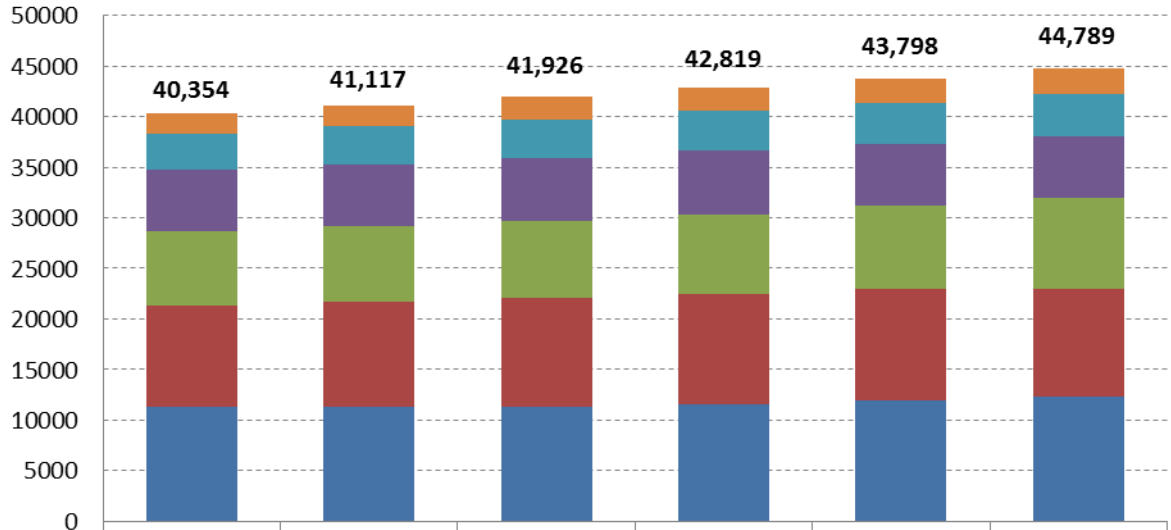


Source: National Statistics, 2014-based SNPP

The proportion of the population aged 0-9 is greater in Hillingdon than in England and also London. The proportion of the population aged 45+ is lower in Hillingdon than in England. The proportion of older people (age 65+ years) in Hillingdon is slightly higher than London, but lower than England. 40,354 people are aged 65 years or more and the table below illustrates the steady increase in the 65 and over population and particularly those people aged 80 and over during the period 2017 to 2022.

The focus of the 2017/19 BCF plan will continue to be on older people as the case for change as to why Hillingdon is focusing on this population group set out in the 2015/16 BCF plan continues to apply, e.g. largest population group with greatest demand on health and social care services. Chart 2 below demonstrates the steady increase in the 65 and over population between 2017 and 2022.

Chart 2



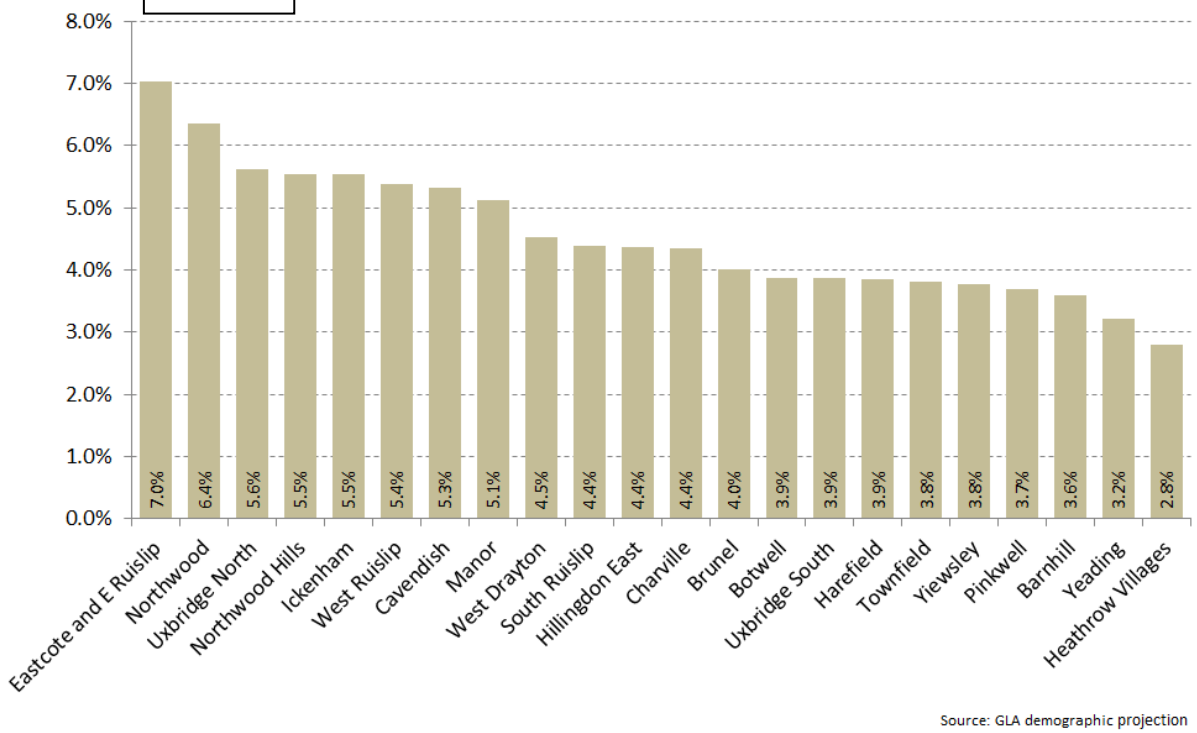
	2017	2018	2019	2020	2021	2022
90+	2063	2111	2182	2296	2396	2509
85-89	3552	3686	3797	3920	4072	4194
80-84	6020	6147	6215	6232	6067	6078
75-79	7353	7454	7652	7852	8303	9061
70-74	9999	10444	10717	10949	10969	10577
65-69	11367	11276	11363	11571	11992	12370

The demographic challenges and related health issues facing Hillingdon in respect of the older people population include:

- 40,354 older people live in Hillingdon in 2017, a figure that is likely to increase by nearly 6% (2,470) by 2020 and 10% (4,440) by 2022.

- The graph below shows the wards with the highest proportion of people aged 65 and over are in wards north of the A40.

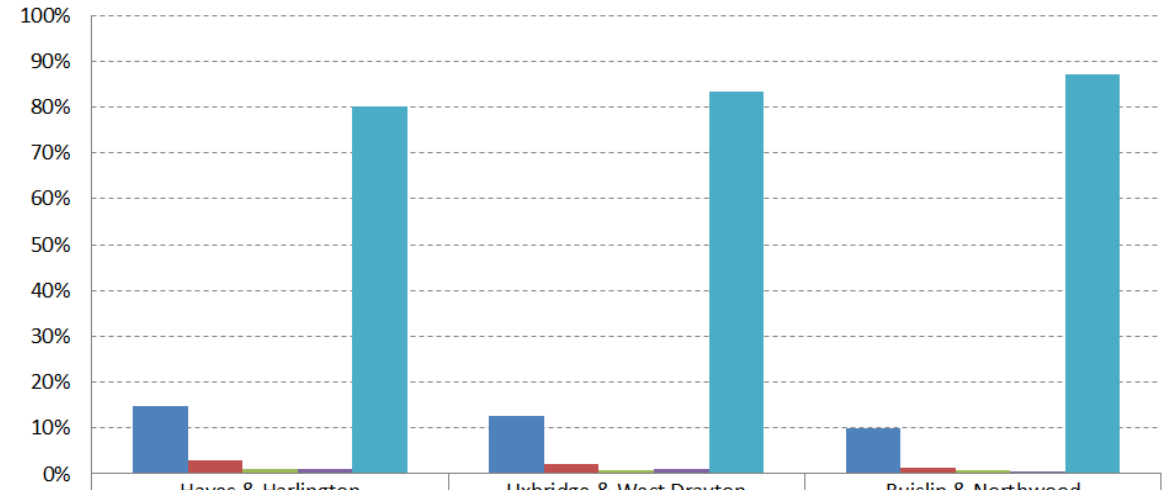
Chart 3. Hillingdon ward population for age 65+, 2016



Source: GLA demographic projection

- In 2016 79% of the 65 and over population was estimated by the GLA 2014 trend-based ethnic projections to be White. Each additional five year age group from 65 is projected to be less diverse. By 2020 the proportion of the 65 and over aged group that are White is projected to reduce to 75%. The highest proportion of Hillingdon's Black, Asian and Minority Ethnic (BAME) population is concentrated south of the A40, as illustrated in chart 4 below.

Chart 4. Census 2011
Over 65s Ethnicity: by locality

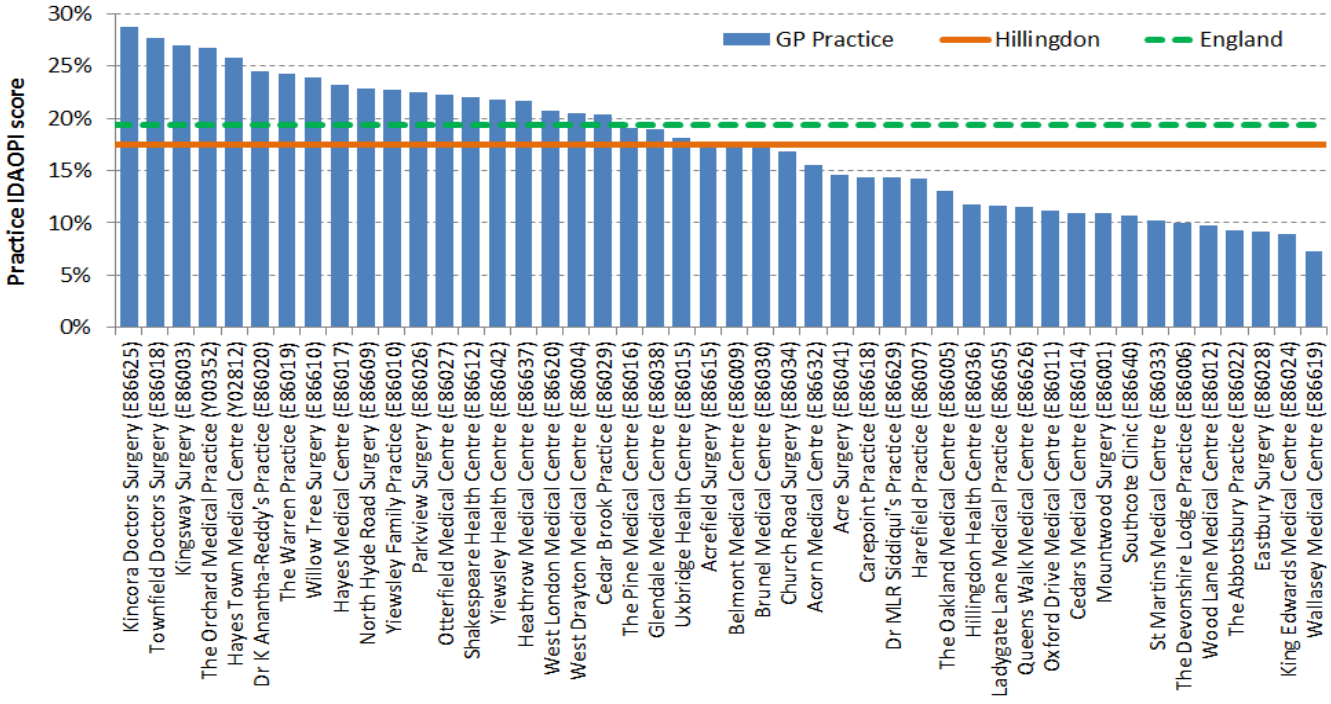


	Hayes & Harlington	Uxbridge & West Drayton	Ruislip & Northwood
Asian	14.8%	12.5%	10.1%
Black	2.9%	2.2%	1.4%
Mixed	1.0%	0.9%	0.8%
Other	1.1%	0.9%	0.5%
White	80.2%	83.5%	87.2%

- Income Deprivation Affecting Older People Index (IDAOPI) 2015 identified that the percentage of older people in Hillingdon experiencing deprivation was in line with the general level of deprivation in the borough and at 15.7% was relatively low in comparison with the average for England of 16.2%. However, the Chart 5 below showing older people deprivation by GP practice demonstrates that this population group is disproportionately concentrated in practices in the south of the borough.

- The Quality Outcomes Framework (QOF) recorded 1,813 people diagnosed with dementia on GP registers in 2015/16, which reflected a diagnosis rate of 54.23%, which was low for London (65.79%) and for England (60.78%). POPPI estimated the population of people living with dementia in 2015 at 2,880 and projected an 8% (240) increase to 3,120 in 2020. For the 85 and over population POPPI estimates suggest that the number living with dementia was 1,250 in 2015 and that this will rise by 17% (250) by 2020. The dementia diagnosis rate increased to 69.3% at the end of 2016/17 compared to 41% in 2014/15.

Chart 5. **Index of deprivation affecting older people index score, Hillingdon GP Practices**



Source: IDAOPI (Index of Deprivation 2015) applied to July 2016 Practice population (NHS Digital)

- The Quality Outcomes Framework (QOF) recorded 1,813 people diagnosed with dementia on GP registers in 2015/16, which reflected a diagnosis rate of 54.23%, which was low for London (65.79%) and for England (60.78%). POPPI estimated the population of people living with dementia in 2015 at 2,880 and projected an 8% (240) increase to 3,120 in 2020. For the 85 and over population POPPI estimates suggest that the number living with dementia was 1,250 in 2015 and that this will rise by 17% (250) by 2020. The dementia diagnosis rate increased to 69.3% at the end of 2016/17 compared to 41% in 2014/15.

- Table 1 below provides prevalence estimates for the number of older people living with long-term conditions. This shows the estimated prevalence of people living with stroke in Hillingdon. Atrial fibrillation is a known risk factor for stroke. The diagnosed prevalence in Hillingdon is 1.1% and the estimated prevalence is 2.0%. There could be an additional 2,500 people with undiagnosed atrial fibrillation in Hillingdon.

Table 3: Prevalence of Long-term Conditions within Older People Population						
Borough Estimate	**Stroke**	**Cardio Vascular Disease**	**Chronic Heart Disease**	**Hypertension**	**Disabetes**	**Mental Health Conditions**
2016	3,067	12,299	6,532	26,616	7,098	4,502
2021	3,312	13,271	7,047	28,688	7,662	4,816

- It is estimated that 2% of the most complex patients (all ages), e.g. people living with two or more long-term conditions, comprise 16.2% of CCG spend. 57% of these complex patients are people aged 65 and over; 35% are aged 75 and over and 14% aged 85 and over. In 2016/17 the local health spend on people aged 65 and over living with multiple health conditions was £9.1m.

- Quality Outcomes Framework (QOF) data shows that 6,741 people aged 65 and over registered with Hillingdon GPs on the 1st April 2017 had a diagnosis of diabetes.

- POPPI data estimates that approximately 4,200 older people are living with frailty. Frailty is a clinically recognised state of increased vulnerability which results from ageing associated with a decline in the body's physical and psychological reserves. Older people with frailty are at risk of unpredictable deterioration in their health resulting from minor stressor events.

- Although nearly 42% (10,049) of our non-elective activity in 2016/17 was attributed to the 65 and over population, this population group accounted for 58% (£27.3m) of the total health emergency admission spend in that year. In 2016/17 34% (£16.1m) of emergency admission spend was on the 80 and over population, which accounted for nearly 23% (5,495) of admissions in 2016/17. We estimate that some 28% (1.553) of emergency admission for the 80 and over population group were avoidable or deferrable, which is based on the proportion of admissions resulting in a length of stay of between 0 and 1 days.

- Nearly 46% of the Council's gross spend on care for older people in 2016/17 was on care homes (residential and nursing). This made Hillingdon the 15th lowest in London (18 boroughs have a higher proportion spend than Hillingdon). However, the desired trajectory would be towards the 40% level, focusing on people who can be better supported in their usual place of residence.

- At the time of the 2011 census 31% of all older people lived on their own and could be at risk of being socially isolated. Projections from the Projecting Older People Population Information System (POPPI) suggest that by 2020 36% (15,580) of the 65 and over population will be living on their own and 64% (9,980) of this number will comprise of people aged 75 and over.

- The 2011 census showed that 18% of unpaid carers were aged 65 and over. POPPI projections suggest that this number is likely to increase by 19% to 5,703 by 2020. The census also showed that approximately 10% of carers were aged under 25, which emphasies the continuing importance of supporting Carers of all ages.

2.3 Current state of the health and adult social care market.

NHS Provider Market

There are 46 GP practices in Hillingdon and 44 of these have formed into a confederation that gained legal staus from 1st April 2017.

Hillingdon has a single acute trust with The Hillingdon Hospitals Foundation Trust, which is based across two sites, with the main hospital being in Hillingdon and Mount Vernon being in Northwood in the north of the borough. Approximately 80% of Hillingdon Hospital's activity comes from residents of the borough.

Hillingdon also benefits from a single community health and community mental health provider, which is the Central and North West London Foundation Trust (CNWL).

The GP confederation, Hillingdon Hospital and CNWL have combined with a third sector consortium through an alliance agreement to form an accountable care partnership, which is called Hillingdon Health and Care Partners.

Harefield Hospital, which specialises in treating heart and lung conditions, is also based in the borough and is part of the Royal Brompton and Harefield Foundation Trust.

Care Homes

59% (4,953 delayed days) of delayed transfers of care in 2016/17 were attributed to issues with securing appropriate care home placements and 65% (3,243 delayed days) of these were nursing home related, primarily in respect of people with more challenging behaviours associated with dementia. This suggests that the current care home market is not suitable to meet current and future needs.

At the end of 2016/17 there were 48 care homes in Hillingdon and 29 of these were for older people. The bed base for older people was 1,247, which represented 91% of Hillingdon's total care home bed base. Table 2 below provides a breakdown of the older people's care homes in Hillingdon. Some homes are dual registered.

Table 4: Summary of Care Home Provision for Older People in Hillingdon

Category	Number of Care Homes	Number of Beds
All care homes for older people	29	1,247
Registered nursing homes	15	729
Residential homes without nursing	14	496
All care homes for people living with dementia	28	789
Registered dementia nursing homes	12	347
Registered dementia residential homes	16	442

Table 3 below shows that in 2016/17 the Council accounted for 35% of all placements of older people in the borough, which is comparable with London. It also demonstrates that 45% of all placements were of self-funders, which is a higher proportion than London. London figures are in brackets.

The CCG is paying Funded Nursing Care (FNC) on 47% (351) of the registered nursing beds in the borough.

Table 5: Placement Share of Older People Care Home Beds	
Placement Source	**Percentage**
LBH	35% (34%)
Other London councils	9% (14%)
London Continuing Healthcare	7% (6%)
Other public sector authorities	5% (5%)
Self-funders	45% (41%)

8 of Hillingdon's 29 care homes for older people are rated as *requires improvement* by CQC and 1 is rated as *outstanding.* The remaining homes are either rated *good* or have no rating because of a recent change of ownership.

Key issues for local providers include:

- **Debt** - The buy and lease financing model, particularly for the larger providers, leaves them with a considerable debt to service and this makes them vulnerable to market fluctuations.

- **National Living Wage** - Introduction of the NLW has increased staffing costs and this has filtered down into increased placement fees.

- **Staff recruitment and retention** - Hillingdon is a high employment area and most homes experience difficulties in recruiting and retaining staff for what continues to be low paid work. The issue is particularly pressing in nursing homes, where the national shortage of nurses is experienced at a local level. Providers are also competing with local NHS organisations that also face challenges with recruiting.

- **Quality** - Staff recruitment and retention issues, including turnover of home managers, and change of ownership arrangements, have resulted in instability in some homes that has contributed to quality issues. At 31st March 2017, 3 older people's care homes in Hillingdon with a combined capacity of 252 beds were identified by the Council's Provider Risk Panel as being *at risk*.

- **Impact of extra care** - The number of permanent placements in residential care homes by the Council is expected to reduce considerably from 2018/19 with the opening of two new extra care sheltered housing scheme comprising of an additional 148 self-contained flats with access to care and support 24/7.

Homecare

Homecare is traditionally low paid, low status work and providers experience a high turnover of staff, an issue particularly evident in areas with plentiful alternative sources of employment such as Hillingdon. There are 25 homecare agencies registered with the Care Quality Commission based in the borough and at least 3 only take referrals from self-funders. There is no legal requirement for homecare agencies operating in the borough to have a base situated within its geographic boundary.

The Council commissions approximately 15,000 hours per week of homecare for adults to support approximately 1,130 people a week. 50% of this activity is supported by three main providers and the other 50% is spread across 20 other providers. A further 1,000 hours a week are commissioned from 5 providers to support 33 children with homecare aweek. In addition, the CCG is commissioning packages of care week for approximately 200 people and this is primarily for people at end of life.

Many of the homecare agencies utilised by the Council also provide outreach support to assist service users to access community based daytime activities (approximately 30 agencies providing 3,850 hrs per week for 390 people).

A key issue for homecare providers is the ability to recruit and retain staff. Providers have also experienced increasing costs attributed to the National Living Wage, new pension requirements and legal judgements regarding travel time payment arrangements. Training requirements have also added to provider costs that fees from the public sector have not addressed. The effect of recruitment and retention issues has impacted on capacity, which has contributed to nearly 6% (468) of delayed days in Hillingdon during 2016/17 being attributed to issues with securing packages of care. These issues have also contributed to a decline in service quality with some providers and the Council's Quality Assurance Team works closely with CQC to support providers to address these when they arise. At 30th June 2017 5 homecare agencies were identified as presenting significant risks that impacted on the number and complexity of referrals they could receive.

Homecare contract financial viability issues contributed to the termination by mutual agreement of one of the Council's main contracts with a private provider in 2016. The agreement by the Council to increase fee rates helped to avoid another provider surrendering their contract. The Improved Better Care Fund (IBCF) grant has been essential to enable this to happen (see sections 5 and 6: *National Conditions* and *The Plan: Schemes and Spending*).

Third Sector

Hillingdon has a vibrant third sector comprising of hundreds of voluntary and community organisations. Five of Hillingdon's larger and established voluntary sector organisations, e.g. Age UK Hillingdon, the Disablement Association Hillingdon, Harlington Hospice, Hillingdon Carers and Hillingdon Mind, have collaborated to form a consortium called H4All that has been legally constituted as a community interest company. H4All is one of the constituent parts of the accountable care partnership known as Hillingdon Health and Care Partners (HHCP).

Workforce

NHS Digital data shows that on 31st March 2017 The Hillingdon Hospitals had a total workforce of 3,172 and this included 1,638 clinically qualified staff and of these 444 were doctors. There are 46 GP practices supported by 140 GPs and associated clinical and support staff. CNWL also has a local workforce of 888 to deliver its community health and community mental health services. It has a vacancy rate of 7.23% in community health and 19.3% in mental health.

The National Minimum Data Set for Social Care held by Skills for Care shows that in 2016 Hillingdon had an adult social care workforce of 5,200 people, 3,900 of which were involved in direct care. The average age of the workforce was 42 and 19% of the workforce was aged 55 and over. The turnover rate was 28%, adult social care workers in Hillingdon had on average 6.0 years experience in the sector and around 59% of the workforce had been working in the sector for at least three years.

2.4 Key financial challenges

Hillingdon's Sustainability and Transformation Plan (STP) submission showed that we know that if we do not transform our health and care system, by 2021 we will be facing a financial gap of around £120m. This is summarised in table 5 below.

Table 6: Hillingdon's Financial Gap 2016/21

Period 2016/2021	Hillingdon £m
CCG	(39)
Primary Care	(2)
Social Care	(34)
Acute and Community Care	(45)
Special Commissioning	0
Total	**(120)**

NHS

Our population segmentation shows that Hillingdon will see larger rises in the populations with increased health needs over the next five years than the wider population. This increased demand means that activity, and the cost of delivering services, will increase faster than our headline population growth would imply. NHS budgets, while increasing more than other public sector budgets, are constrained and significantly below both historical funding growth levels and the increase in demand. The most likely growth assumptions over the next five years in Hillingdon will see approximately 21% more activity that will need to be funded. Addressing this will require a shift in funding and resources in line with agreed STP priority areas, recognising funding pressures across the system and ensuring that human and financial resources shift to focus on delivering the things that will make the biggest difference to closing the funding gaps.

The total improvement resources across all NWL providers and commissioners, including the Academic Health Science Network (AHSN), to realign them around STP delivery areas in order to increase effectiveness and reduce duplication. This includes undertaking extensive system modelling of funding flows and savings through to 2020/21 to inform future funding models and sustain the transformation. The NWL CCG five year financial plan for the STP is currently being refreshed and this information will be added once this work has been completed, which is scheduled for the end of September 2017.

Local Authority

The Council's published Medium Term Financial Forecast to the financial year 2021/22 identifies an overall budget deficit of £70m over the 5 year period. The annual forecast net expenditure for the Council's General Fund Services (includes all services except Housing) is £228m. For 2017/18 savings of £15m have been identified and will be delivered for the current year to balance this year's budget. To date total savings of £107m have been delivered by the Council for the period 2010/11 to 2016/17. On average the Council has had to balance its budget year by year since 2010/11 by delivering savings of around £15m.

The key changes in the Council's budget over the next five years are a continuation in the reduction of government grants estimated to be £28m plus increased expenditure pressures caused by demographic and demand growth for Adult and Children's Social Care £13m, Payroll and Service provider inflation £26m and increased Waste Disposal Costs £4m.

For Adult Social Care the '*do nothing*' funding gap for the five years 2017/22 reflected in the development of the STP included increased demographic growth for services to Older People, People with Disabilities and Mental Health conditions, the impact of the increases of the National Living Wage on homecare and residential and nursing care home accommodation provider costs. As at October 2016, this has been estimated locally as £34m gap over the next 5 financial years. The 'do nothing' forecast funding gap for social care includes a corporate share of the financial savings set out above of £70m over the 5 year period that Adult Social Care Services will need to make to contribute to the Council's statutory requirement to set a balanced budget.

2.5 Key issues and challenges that the plan will aim to address.

The plan seeks to address some of the identified financial pressures associated with the increasing numbers of older people set out in section 2.4 through developing a more integrated model of care where people are supported to remain in their usual place of residence. It aims to embed the shift to planning for anticipated care needs and coordinating care around the person, their family and Carers and supporting self care rather than crisis management and reactive provision of services. Reducing fragmentation of service provision should help to improve patient flow through the Hospital and improve their experience of care, as well as alleviating the need for and cost of escalation beds. Finally, a more integrated approach to managing the private market, including supporting providers, through the development of integrated brokerage and integrated commissioning of homecare and nursing care home placements should help to improve capacity by making the public sector locally easier to do business with and thereby shape the market.

3. PROGRESS SO FAR

3.1 Existing approach to integration and the main points of the 2016/17 BCF plan.

Hillingdon's approach to integration has been to build the level of ambition incrementally, reflecting the developing relationship and appetite to manage risk by both the Council and the CCG. The eight schemes in the 2016/17 plan included some logical extensions of activity undertaken in 2015/16 whilst simultaneously maintaining the cautious and incremental approach to integrated working and the pooling of budgets that minimised the risk to both the Council and HCCG. They included:

- Extending the 2015/16 schemes where benefits could be achieved for other adult client groups, e.g. development and management of the supported living market that included all adults and extending the scheme on supporting Carers to all unpaid Carers;
- Adding funds to the pooled budget where this would have demonstrable benefits for residents/patients, e.g. specialist palliative personal care service for people at end of life;
- Extending the scope of the plan to include new types of activities, e.g. dementia;
- Accelerating benefits through a greater ambition to integrate services across health and social care, building on progress made in 15/16, e.g. intermediate care; and
- Correcting anomalies from the 2015/16 plan, e.g. bringing the Council's budget for the community equipment contract into the pooled budget with that of the CCG so that the whole budget was under the same governance structure.

The eight schemes in the 2016/17 plan were:

Scheme 1: Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.
Scheme 2: Better care for people at end of life
Scheme 3: Rapid Response and Integrated Intermediate Care
Scheme 4: Seven day working
Scheme 5: Integrated community-based care and support
Scheme 6: Care home and supported living market development
Scheme 7: Supporting Carers
Scheme 8: Living well with dementia

3.2 BCF progress to date

2016/17 has been a positional year that has enabled relationships to develop to create the opportunity for greater integration to deliver the objectives within the STP and better outcomes for residents from 2017/18.

Complexities of the local landscape and capacity within the health and care system meant that it was not possible to deliver some of the key actions within the 2016/17 plan in year. However, much of the developmental work has taken place that will facilitate delivery from 2017/18.

2016/17 has also seen significant progress on integrated working across health with voluntary sector partners through the development of the Accountable Care Partnership (ACP). They are working together to deliver integrated person centred care, primarily for people aged 65 and over. Discussions via the Health and Wellbeing Board have contributed to creating an environment that is contributing to a dialogue taking place about the Council joining the ACP.

3.3 Progress against national metrics

The following shows the 2016/17 outturn against the national metrics, including the locally determined user/patient experience indicators:

- *Emergency admissions - Target missed*: During 2016/17 there were 10,252 emergency admissions (also known as non-elective admissions) which exceeded the ceiling for the year of 9,700. However, the performance was similar to the outturn for 2015/16, which was 10,210 emergency admissions.

- *Delayed transfers of care (DTOC) - Target missed*: There were 8,364 delayed days during 2016/17 against a ceiling of 4,117 delayed days. 66% of the delayed days were attributed to the NHS, 22% to social care and 12% to both.

- *Permanent admissions to care homes - Target missed*: There were 161 permanent admissions to care homes in 2016/17 against a ceiling of 150 permanent admissions.

- *Still at home 91 days after discharge from hospital to reablement - Target missed*: The 2016/17 outturn was 86.1% against a target of 93.5%.

- *User experience metric: Social care-related quality of life - Target exceeded:* This metric was tested through the Adult Social Care Survey undertaken each year in Q4. The results are scored out of 24 and the higher the number the better. The target for 2016/17 was 18.6 and the outturn was 19.

- *User experience metric: People who have found it easy to access information and advice - Target missed*: This metric is also tested through the Adult Social Care Survey. The target for 2016/17 was 75.5% and the provisional outturn was 73.3%.

3.4 Successes

The following are examples of key successes deriving from the 2016/17 plan:

- *Joint working across services, e.g. Homesafe, Rapid Response and Reablement* - This has had a significant impact on reducing the number of hospital admissions during a period that has seen a considerable rise in the number of attendances. It has also been possible to achieve shared benefits through more efficient management of the community equipment service;

- *H4All Wellbeing Service* - This innovative service, delivered by a local third sector consortium, is intended to prevent the needs of older people living with long-term conditions escalating which may otherwise result in a loss of independence and lead to an increased demand on health and care services. The service became operational in 2016/17 and is showing positive results;

- *Coordinate My Care (CMC)* - Adult Social Care has gained read and write access to this advanced care planning tool that is used in London to ensure the coordination of care for people at end of life;

- *Hospital discharge* - A new patient information booklet has been produced that should contribute to a reduction in the number of DTOCs attributed to the patient/family choice reason. Increased investment by the CCG has funded an additional consultant geriatrician post that will help to support community health teams to support discharge and prevent readmission. Hillingdon Hospital has established and recruited to nine Patient Flow Coordinator posts intended to help ensure a more consistent discharge process across wards;

- *Discharge to assess* - Partners worked together to establish bed-based discharge to assess arrangements in local care homes in order to relieve pressure on Hillingdon Hospital;

- *Carers' hub contract* - A new contract delivering a single point of access for Carers of all ages started. This is provided by the consortium Hillingdon Carers' Partnership and led by Hillingdon Carers.

4. LOCAL VISION AND APPROACH TO HEALTH AND SOCIAL CARE INTEGRATION

4.1 Vision for 2020

Hillingdon's vision for care and support within the geographical boundary of the borough is set out within our STP submission and this is:

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.

4.2 Model for achieving fuller integration by 2020

The focus of the 2017/19 plan will continue to be on older people. Meeting the needs of 65 and over population represents by far the greatest demand on social care and health services and getting the model of care right for this population group presents an opportunity to then scale up into other areas thereafter, e.g. children and young people. Key beneficiaries of the next iteration of the BCF plan will be:

- All of Hillingdon's residents aged 85 and over
- Frail older people aged 75 and over with one or more long-term conditions
- Older people who are at risk of dementia
- Older people who are at risk of falling for a first time.
- Older people who are socially isolated; and
- Carers of all ages.

The 2017/19 plan will see the delivery of the characteristics of full integration illustrated in table 6 below in respect of older people, e.g. joint commissioning and lead commissioning. Hillingdon CCG's preferred model of delivery for integrated care is through the Accountable Care Partnership, Hillingdon Health and Care Partners (HHCP). Whilst the Council is not formally a member of HHCP at this point, schemes within the 2017/19 plan provide an opportunity for closer alignment that can test the benefits and risks of formal participation, e.g. scheme 1: *Early intervention and prevention* and closer working with the Care Connection Teams and scheme 4: *Integrated hospital discharge* that is intended to see the development of a single intermediate care service.

Table 7: Characteristics of Full Integration

	Joint Commissioning	Lead Commissioning	Accountable Care Organisation (ACO)
Characteristics	Some or all LA/CCG commissioning decisions are made jointly. Budgets (and other resources) are pooled or aligned in line with the extent of joint commissioning.	One body exercises some or all functions of both the CCG and the LA, with relevant resources delegated accordingly.	The CCG and LA pay a set figure (possibly determined by capitation) to an Accountable Care Organisation to deliver an agreed set of outcomes for all health and care activity for a whole population group, using a multi-year contract. The ACO decides what services to purchase to deliver those outcomes.

Source: 2017/19 Integration and Better Care Fund Policy Framework (DH March 2017)

4.3 Links to the Sustainability and Transformation Plan (STP)

Local government has been integral to the development of the North West London sector STP and is represented on the Joint Health and Care Transformation Group, the sector-wide governing group for the delivery of the plan, at both officer and elected member level. Hillingdon's elected member representative is the chairman of the Health and Wellbeing Board (HWB).

The Better Care Fund plan is key to the delivery of the aspects of Hillingdon's STP that are dependent on integration between health and social care or closer working between the NHS and the Council for delivery. The schemes have been devised to contribute to the implementation of relevant STP delivery areas and this is illustrated in section 6: *The Plan: Schemes and Spending*.

4.4 How BCF aligns to wider system transformation, complements the 5-Year Forward View and wider local government transformation

There is a wide range of system transformation programmes in progress in Hillingdon that are linked to the delivery of the Five-year Forward View and these include:

- Urgent and emergency care
- Primary care
- Personalisation
- Mental health
- Long-term conditions
- Children and young people

There are a range of schemes contained within the BCF plan that through their focus on on contributing to supporting timely discharge and preventing hospital admissions that are avoidable will contribute to the implementation of the urgent and emergency care plans. Actions within the Delayed Transfers of Care Action Plan (see Annex 1) will also contribute to the delivery of the Hillingdon Hospital Urgent and Emergency Care Work Plan and are also reflected within that document.

The BCF provides the mechanism through which social care can formally accede to the ACP, subject to the latter demonstrating that this is the most appropriate vehicle for delivering improved health and care outcomes for residents. The ACP is the key delivery vehicle identified by the CCG for the implementation of integrated care in line with the Five-year Forward View. The success of this model over the period of the plan would then enable it to be extended to other population groups from 2019, e.g. children and young people, and therefore see the scope of the BCF (or any successor initiative) extended from that date.

There is alignment with the long-term conditions programme in so far as schemes within the BCF contribute to the identification of older people living with conditions such as frailty, diabetes, obesity, etc. The mental health programme is supported by the BCF through the funding of mental health social workers in A & E, the specific scheme that is focused on addressing the needs of people living with dementia (scheme 6: *Living well with dementia*). The DTOC action plan also includes actions intended to address mental health delays.

There are also three key enablers that are essential to the delivery of integrated care in Hillingdon and these are ICT, estates and workforce. As part of the implementation process of the Five-year Forward View and in accordance with STP guidance, Hillingdon has developed a digital strategy that is aligned with a broader North West London Digital Strategy. This reflects the ambition for integration of Hillingdon's social care data for both direct care and improved commissioning purposes.

An estates strategy was also submitted as part of the broader North West London estates strategy component of the STP submission. A strategic estates group meets locally on a quarterly basis and involves senior representation from all statutory partners, including the Council. A standing item on the agenda of Health and Wellbeing Board meetings considers future developments and provides additional scope to explore best use of partner estates as well as other opportunities for addressing current and future need. A key outcome of this has been the development of the former Woodside Day Centre site to provide a health centre that is scheduled to open in 2019. This will eventually benefit the tenants at the nearby Grassy Meadow Court extra care sheltered housing scheme that is due to open in June 2018.

The scope of Hillingdon's BCF plan includes how the workforce in the independent sector, e.g. care homes, homecare, supported living schemes and voluntary sector providers. This is addressed within the scheme descriptions set out in section 6: *The Plan: Schemes and Spending*.

Local Government Transformation

As part of its devolution agenda the 2015/17 Government made a commitment to see further powers devolved to London. In December 2015, the government agreed the London Health and Care Devolution Agreement, which established five pilots as the first step towards improving health and care in London through integration and devolution. Hillingdon Council was also a signatory to the London Devolution Memorandum of Understanding. Five pilots were established under that agreement and none of these included Hillingdon. The next stage of devolution in London following the General Election remains unclear but the Council remains committed to considering the positive outcomes of the five pilots established under the 2015 agreement to identify scope for replication at a local level.

4.5 What will be different following delivery of the plan and the outcomes it will deliver.

By 2019/20 we expect to have in place a model of care and supporting enablers:

- Where residents have easy access to information and advice about services, including care and support services;

- That has a focus on improving health outcomes for residents with one or more health conditions or care needs, a personalisation of service provision and a collaborative approach between providers;

- Where there is systematic early identification of susceptibility to disease or exacerbation in the population, alongside integrated management of conditions and a consistent approach to care provision;

- Where better coordination of services are configured around Hillingdon's residents, including a much stronger focus on case management and prevention and integration of health and social care;

- Where residents and carers are actively involved in the planning of their care and recognised as expert partners in care;

- Enablement of self-care and preventative services and promotion of independence for as long as possible

- Where people are only admitted to Hillingdon Hospital when they are acutely ill;

- Where a hospital admission is necessary and unavoidable their lengths of stay are reduced;

- That enables people to be treated at or close to their home wherever possible;

- A reduction in the number of people living in residential care;

- The most effective use of health and care resources is made to achieve best value for the Hillingdon £ by allowing for a flexible use of collective resources and reduction in transaction costs; and

- Enablers such as IT interoperability, development of a sustainable workforce and a vibrant market offering residents/patients quality choices.

We will know that the plan has been successful if our older residents are able to say:

- 'I'm helped to take control of my own health and social care provision.'

- 'It doesn't matter what day of the week it is – as I get the support appropriate to my health and social care needs.'

- 'Social care and health services help me to be proactive. They anticipate my needs before I do and help me to prevent things getting so bad that I need a stay in hospital.'

- 'If I do need to go to hospital, they start to plan for my social and health care in the community from day one of my stay.'

- 'I only have to tell my story once and they pass my details on to others with an appropriate role in my care.'

- 'Systems are sustainable and what might once have been spent on hospital care for me is now spent to support me at home in my community.'

The Council, the CCG and other partners do expect that this will be an increasingly common experience as the benefits of closer integration and the roll out of an integrated model of care are experienced by more older people as we get closer to 2020, with the ability to measure residents' experience and the outcome of care across the whole health and care system. By 2019/20 we also expect to be able to roll out a new model of care to a wider population group.

5. NATIONAL CONDITIONS

a) National Condition 1: Jointly Agreed Plan

5.1 Confirmation of use of the Improved BCF Grant

It has been locally agreed that of the 3 conditions for applying the iBCF
- Meeting adult social care needs;
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and
- Ensuring that the local social care provider market is supported

The single biggest impact on maintaining the momentum of Hillingdon's strategies for addressing admission avoidance and timely discharge is having a stable care market. This is in order to ensure quality and capacity of care to address ongoing care needs when patients reach the end of their required interventions.

5.2 Disabled Facilities Grants - how this funding will support a strategic approach to health, care and housing.

The DFG funds will continue to be utilised to support older and disabled residents to remain in their own homes. During 2016/17 170 people were assisted with DFGs and of these 61% (113) were people aged 60 and over. 29% (32) of the older people receiving DFG's were owner occupiers, 66% (74) were social housing tenants, and 5% (5) were private tenants.

Schemes 1:*Early Intervention and Prevention* and 4: *Integrated Hospital Discharge* in section 6: *The Plan: Schemes and Spending* describe how during the lifetime of the plan it is intended to explore the scope for utilisation of the 2003 and 2008 Regulatory Reform Orders to enable DFGs to be used to fund adaptations to meet anticipatory needs, e.g. where a resident has a degenerative long-term condition, as well as establishing a Hospital Discharge Grant to fund house clearances, deep clean and a range of other home-based activities where difficulties in arranging help can lead to delay. Opportunities for using DFG funding to resource equipment for people requiring two or more care workers to transfer will also be explored.

5.3 Have councils with housing responsibility been involved in developing elements of the plan related to housing?

Hillingdon Council is a unitary authority and therefore incorporates housing responsibilities contained within the Housing Act, 1996 (homelessness and housing allocations) and the Housing Grants, Construction and Regeneration Act, 1996 (disabled facilities grants) within its sphere of responsibility. The relevant officers within the Council have been involved in the development of the plan. At elected member level, the chairman of Hillingdon's Health and Wellbeing Board is also the Cabinet Member for Social Care, Housing and Health and Wellbeing.

The development of the extra care sheltered housing programme is a result of the Council utilising its housing and planning responsibilities in an integrated way to deliver key outcomes within the plan. A supported living programme that has seen the delivery of three supported living schemes for people with learning disabilities over the last four years and will see another scheme being delivered in 2018 illustrates the strategic use by the Council of powers and resources available to it to meet the needs of Hillingdon's population. It should be noted that younger adults with learning disabilities are out of the scope of the 2017/19 BCF plan.

***b) National Condition 2*: Social Care Maintenance**

5.4 Expected contributions from the CCG for 2017/18 and 2018/19.

The CCG will be passporting £6,146k for protecting adult social care, including £887k for Care Act implementation in 2017/18 and £6,263k in 2019/20, including a minimum of £887k for Care Act implementation.

5.5 Assurance that contributions to social care from the CCG does not destabilise the local health and care system as a whole.

Contributions from the CCG to social care is helping to stabilise the health and care system. This is achieved by preventing reductions in overall local authority funding resulting in social care spend being limited to meeting statutory requirements.

5.6 Confirmation that the contribution to be spent on social care services that have some health benefit and support overall aims of the plan.

The planning template shows that the main areas of expenditure of the CCG contribution to social care, including Care Act implementation, are:

- *Reablement and hospital assessments* - supports timely discharge and prevents admission
- *Physiotherapy support for Reablement* - supports the effectiveness of the Reablement Team.
- *Packages of care* - supports discharge and prevents increased demand on health services.
- *Supporting Carers* - enables Carers to continuing caring for longer thereby reducing demand on both health and social care.
- *Quality Assurance Team* - supports private providers, e.g. care homes, home care and supported living schemes, which helps to reduce demand on health services.
- *Adult Safeguarding* - ensures effective management of adult safeguarding in Hillingdon, including management of Deprivation of Liberty standards.
- *Wren Centre* - temporary dementia resource centre that will transfer to a purpose-built unit at the Grassy Meadow Court extra care sheltered housing scheme site in 2018.
- *Extra care social work post* - dedicated social work post to support new extra care schemes working closely with Care Connection Teams will help to manage avoidable demand on primary and secondary health care services.

c) ***National Condition 3*: NHS Commissioned Out of Hospital Services**

5.7 Allocation for out of hospital services.

For 2017/18 the BCF plan includes an investment by the CCG of £13,226k in out of hospital services that are included within the BCF. This includes:

- Early supported discharge (Community Homesafe)
- Rapid Response
- Community Rehabilitation
- District Nursing Service
- Community matrons
- Hawthorn Intermediate Care Service
- Franklin House Nursing Home step-down beds
- Community equipment (including pressure mattresses)
- Falls Services (Hillingdon Hospital, CNWL and Age UK)
- Prevention of Admission to Hospital (PATH) Service
- Integrated Care and Support Planning
- Care Connection Teams

The funding for these services is included within the capitated budget for the ACP. The level of investment will not be reduced in 2018/19, although there is an expectation that the ACP will use the opportunities presented by the capitated budget to remodel services to increase efficiency and effectiveness.

5.8 Additional target for non-elective admissions.

The non-elective admissions targets contained within the 2017/19 plan focus on the 65 and over population and will contribute to the overall CCG NEA target. Partners have agreed not to set an additional target over and above what is reflected in the CCG's Operating Plan.

5.9 Contingency funds.

See section 9: *Assessment of Risk and Risk Management*.

***d)* National Condition 4: Transfers of Care**

5.10 Implementation of High Impact Change Model for managing transfers of care.

Implementation Action Plan

Hillingdon's health and care partners are committed to the implementation of the High Impact Change Model (HICM). A detailed action plan (see **Annex 1**) for the delivery of the eight interventions has been developed that will assist in addressing Hillingdon's DTOC issues in acute settings. Nearly 70% of Hillingdon's acute delays are attributed to beds in The Hillingdon Hospitals Foundation Trust.

Many of the actions required to deliver the model are also reflected within BCF scheme 4: *Integrated Hospital Discharge*, unless otherwise stated below. This also includes funding for the relevant services.

- *Change 1: Early discharge planning* - Implementing the SAFER patient flow bundle and 'Red to green' to deliver a consistent approach to discharge planning across Hillingdon Hospitals.

'Red to Green Days' Explained

'Red and Green Bed Days' are a visual management system to assist in the identification of wasted time in a patient's journey.

A ***Red*** day is when a patient receives little or no value adding acute care. The following questions should be considered:

- Could the care or interventions the patient is receiving today be delivered in a non-acute setting?
- If I saw this patient in out-patients, would their current 'physiological status' require emergency admission?

A ***Green*** day is when a patient receives value adding acute care that progresses their progress towards discharge. It's when everything planned gets done.

- *Change 2: Systems to Monitor Patient Flow* - Developing a system-wide demand and capacity dashboard. Modelling system-wide care home requirements. See also BCF scheme 5: *Improving care market management and development*.

- *Change 3. Multi-disciplinary/Multi-agency Discharge teams* - Through the implementation of SAFER to ensure that MDMs are undertaken in a consistent way across all wards at Hillingdon Hospitals and reviewing the role and function of the Integrated Discharge Team within the context of the Home to Assess. See change 4 below.

SAFER Patient Flow Bundle Explained

S – **Senior** Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A – **All** patients will have an Expected Discharge Date and Clinical Criteria for Discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.

F – **Flow of patients** will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.

E – **Early discharge.** 33% of patients will be discharged from base inpatient wards before midday.

R – **Review**. A systematic MDT review of patients with extended lengths of stay (> 7 days – 'stranded patients') with a clear 'home first' mind set.

- *Change 4: Home first/Discharge to assess (D2A)* - Agreeing a D2A model, undertaking a pilot, reviewing the outcomes from the pilot, agreeing the model and implementing it.

- *Change 5: Seven day services* - Services and systems not currently in place to support seven day discharge. Reablement Team contracts to support seven day working in place but Hospital infrastructure not yet in place. This is being addressed through SAFER and implementation of Red to Green. Targets for discharges at weekends and before midday have been set by the Hospital but there has been limited progress so far in 2017/18.

- *Change 6: Trusted assessors* - Reviewing local trusted assessor arrangements in context of D2A model and new guidance.

- *Change 7: Focus on choice* - Producing a new in-patient information booklet. Finalising an agreed D2A model to inform the final version of the discharge policy based on patient choice and adapting a template provided by NHSE. Developing information, advice and advocacy arrangements to enable patients and/or their Carers and/or families to make informed choices.

- *Change 8: Enhancing health in care homes* - Developing business cases to extend the weekend GP care home advice and visiting service and care home pharmacy provision. Establishing a GP with specialist interest pilot to support care homes during the week and developing a 'red bag' scheme pilot. This impact area links into BCF scheme 5: *Improving care market management and development*.

Current Implementation Status

Hillingdon is in the process of implementing all of the eight high impact interventions and implementation is at varying stages. This section should be cross-referenced with section 6.4: *Key milestones associated with the delivery of the 2017/19 plan*. For example, a new patient information booklet about the hospital discharge process as well as a range of letters deriving from the NHSE *Supporting Patient Choice* template are now in operation, which should support a reduction in the number of DTOCs attributed to the patient/family choice reason. 'Red to Green' has been applied in ten wards at The Hillingdon Hospitals and plans are in progress to roll it out to all wards. A Discharge to Assess pilot has been completed and learning from this is being utilised to inform the next stage in its development (see section 6.4).

Trusted assessor arrangements are in place between health partners and between Rapid Response and Reablement. Long standing trusted assessor arrangements are in place between health and social care partners in respect of community equipment. Further extension of trusted assessor arrangements is under development.

Funding

The majority of the funding for implementation of the HICM, which includes services set out in section 5.7 above: *Allocation for out of hospital services*, is mainly split between schemes 4: *Integrated hospital discharge* and 5: *Improving care market management and development*. This includes funding for pathways 1 and 2 of Hillingdon's D2A model. There is a risk that that additional demand of people with greater acuity is placed on the care market that is not funded through the release of funding from closure of escalation beds and that there is insufficient capacity within the market to meet the demand. This is captured within the risk log. See section 9: *Assessment of risk and risk management*.

5.11 Action plan to reduce DTOCs.

Hillingdon's DTOC action plan is appended as **Annex 1** and **Annex 1A**. The focus of **Annex 1** is acute DTOCs at the The Hillingdon Hospitals, which accounts for nearly 70% of Hillingdon's acute DTOCs in 2016/17 and Q1 2017/18. **Annex 1A** utilises an NHSI template to specifically address mental health DTOCs attributed to beds provided by CNWL, which accounted for nearly 90% of Hillingdon's non-acute DTOCs in 2016/17 and nearly 70% in Q1 207/18.

The actions contained within the DTOC action plan are intended to contribute to reducing the numbers of DTOCs in both acute and non-acute settings as well as facilitating the flow of medically optimised patients into the community. For acute care, this is achieved through the implementation of the High Impact Change Model and the Emergency Care Improvement Programme (ECIP) plan agreed at the A & E Delivery Board.

5.12 Relationship between DTOC reduction target and A & E Delivery Plan.

The agreed DTOC reduction targets for 2017/18 and provisional targets for 2018/19 set out in section 10: *National Metrics* reflect the specific targets set by NHSE/I for The Hillingdon Hospitals and the Central and North West London Foundation Trust for 2017/18.

The DTOC action plan that is intended to deliver the DTOC reduction targets is reflected in Hillingdon's whole system Urgent and Emergency Care Work Plan and the direct correlation is identified in the tasks set out in **Annex 1** and **Annex 1A**. Strategic accountability for the delivery of the over-arching plan sits with the A & E Delivery Board, which meets on a monthly basis and is chaired by the chief executive of The Hillingdon Hospitals.

Operational delivery of the Urgent and Emergency Care Work Plan, including the DTOC action plan, sits with five workstream groups of which discharge is one. Each workstream group has an executive sponsor and for the Discharge Workstream Group this is the Director of Adult, Children and Young People's Social Care. This group is chaired by CNWL's Deputy Chief Operating Officer. Delivery blockages that this group is unable to address are escalated directly to the A & E Delivery Board and via that route to HCCG's Governing Body, the HWB and/or the Council's Cabinet where a decision about use of resources is required.

5.13 How progress will be continued with the following former national conditions:

a) Seven day services to support discharge
b) Data sharing
c) Joint assessment and accountable lead professional for high risk populations.

a) <u>Seven day community services to support discharge</u>

Actions to support the development of seven day community services to facilitate discharge from hospital seven days a week are reflected in the DTOC action plan referred to section 5.10 above.

The Hillingdon Hospitals has set targets for increasing the percentage of patients discharged at weekends from its medical wards of 65% in 2017/18 from a baseline of 15.5% in 2016/17 and also 65% from its surgery wards from a baseline of 19% in 2016/17. The Hospital's Urgent and Emergency Care Work Plan includes actions to deliver the four priority seven day standards that will also support the delivery of the out of hospital standard.

b) Data sharing

As at 30th June 2017 just over 94% of all adult social care records had a confirmed NHS number and a robust system is in place with NHS Digital to enable verification to be undertaken. Whilst the NHS number is not used routinely on Adult Social Care correspondence the system functionality to be able to do this is now in place and its application will be explored during 2017/18.

The Council is committed to adopting systems that have APIs and Open Standards. The Council has now signed the North West London Information Sharing Agreement that provides information governance authorisation for participation in the Care Information Exchange (CIE). If successful this will see direct links being established between the Council's case management database, Protocol, and that of the CIE provider. The intention is that Adult Social Care care plans will initially be uploaded which will enable GPs and other healthcare partners to see these plans for the first time.

Work is also in progress to enable electronic transfer of assessment and discharge notices between Hillingdon Hospital and the Council that will improve efficiency as well as contribute towards reducing the demand on paper.

During the period of the 2017/19 plan Hillingdon's health and social care partners will be contributing anonymised data to the North West London data warehouse to assist in mapping spend across health and social care within the borough by condition. This information will help to inform future commissioning decisions.

c) Joint assessment and accountable lead professional for high risk populations.

There is agreement across health and social care that GPs will be the accountable professional for high risk populations. The 15 CCTs being established in the borough are intended to take a more proactive approach to identifying the needs of Hillingdon's older residents who may be at risk of their needs escalating resulting in a loss of independence and increased demand on the local health and care system. Each CCT is comprised of:

a) *Practice GP lead* – They have oversight over the whole care pathway within primary care, with additional time spent with those patients at most risk of becoming unstable;
b) *Guided Care Matron (GCM)* – They are responsible for case management, daily monitoring of patients and referring to other services; in-reach support to care homes and supported housing and linking with Rapid Response for out of hours care and with the Continuing Healthcare Team.
c) *Care Coordinator (CC)* – They assist the Guided Care Matron in proactive care of patients, pulling practice and system intelligence on patients and updating care plans and communicating with other providers and the Continuing Healthcare Team.

The CCTs currently in place are linked to Adult Social Care to ensure appropriate local authority involvement to address eligible social care needs. Further alignment of adult social care staff with the CCTs will be explored further during 2017/18 and allocation of specific Adult Social Care resources to CCTs supporting extra care schemes and high densities of care homes implemented in 2018/19.

There will be further development and definition of the Frailty Pathway across care settings, with the implementation of the Rockwood Frailty score and additional care of the elderly consultant capacity in the community, with recruitment to an existing vacant post underway. Successful recruitment to this post, hopefully by October 2017, will provide additional specialist community based resource to support GPs and community staff.

6. THE PLAN: SCHEMES AND SPENDING

6.1 Schemes, outcomes and spending

Scheme 1: Early Intervention and Prevention

a) Strategic Objectives

This scheme seeks to manage demand arising from demographic pressures by reducing the movement of Hillingdon residents/patients from lower tiers of risk into higher tiers of risk through proactive early identification and facilitating access to preventative pathways, that includes a focus on promoting self-care. It builds on the work undertaken under Hillingdon's 2015/16 and 2016/17 BCF plans and also the broader programme of integration to taking forward the anticipatory model of care and apply a more preventative approach to addressing health and social care need.

b) Scheme Overview

As with previous iterations of the Hillingdon's BCF plan, the focus of this scheme will be people living with dementia, people susceptible to falls and/or who are socially isolated and also people at risk of stroke as these long-term conditions are disproportionately represented in our non-elective admissions and admissions to long term residential care.

Initiatives under this scheme include:

- *Access to information and advice* - Access to good information and advice is fundamental to people being able to self-manage their own health and wellbeing. Over the last two years the Council has developed and promoted the online resident portal called Connect to Support. In 2017/18 platform supplier arrangements will be subject to competitive tender and service specification development will include accessibility through portable technology options. Partners will work on the links between the resident portal and the development of a directory of services to support the hospital discharge process referred to further in scheme 4: *Integrated Hospital Discharge*. A key objective here is to reflect synergies and avoid unnecessary duplication.

- *Risk stratification* - Much work has taken place over the last two years in applying risk stratification tools within primary care, e.g. Qadmissions, PAR30, the Electronic Frailty Index (EFI) and the Patient Activation Measure (PAM), as a means of early identification of people at risk of escalated needs. The development of fifteen Care Connection Teams (CCTs) across the borough comprising of a guided care matron and care coordinator

working alongside GPs, will support more proactive interventions to prevent or delay what might otherwise be an inevitable trajectory towards escalated need. Proactive work between social care and, initially, CCTs in the north of the borough to identify people receiving both social care and health support and explore opportunities for a more efficient and effective means of addressing need will be explored. Involvement of Adult Social Care in multi-disciplinary team (MDT) meetings: the weekly *'huddles'*, where appropriate will ensure a multi-agency approach to addressing the needs of people on the cusp of escalated needs. The allocation of social care resources to support CCTs that have extra care schemes and a concentration of care homes within their catchment area will be explored. See scheme: 5: *Improving care market management and development.*

- *Developing the preventative role of third sector* - 2016/17 has seen the successful implementation of the Wellbeing Service provided by the third sector consortium H4All. People referred to this service have benefitted from an assessment using the Patient Activation Measures (PAM). This assessment is intended to identify people needing support to engage more actively in the management of their own condition(s). During 2017/18 the model of investment in the third sector by both the Council and CCG will be reviewed with voluntary and community sector partners to see how the successes of the H4All Wellbeing Service can be built on to most effectively support Hillingdon's older residents, e.g. by improving access to information, addressing social isolation and keeping people active, through the creation of a single point of access for older people. Any enhancements to the model will be implemented in 2018/19, subject to approval through governance processes.

- *Keeping older people physically active* - Keeping people active is a contributory factor in preventing stroke and preventing or delaying the onset of dementia. During 2017/18 the Council and ACP partners will work together to develop a physical activity strategy, ensuring integration with existing services and the Council's new Sport and Physical Activity Team will continue to deliver a range of activities to keep older people physically active and also prevent social isolation, e.g. tea dances, chair exercise classes and healthy walks.

- *Stroke prevention*: As set out in the 2016/17 plan, the key components of a stroke prevention strategy are: increasing physical activity, addressing excess weight issues and early detection. During 2017/19 the following initiatives will be undertaken:

  - *Increasing physical activity* - Alluded to above, an existing physical activity programme targeted at people aged 55 and over carrying excess weight will continue due to the beneficial outcomes for this group of people.

  - *Early detection* - Atrial fibrillation (AF), a disturbance of heart rhythm, is a major cause of stroke and is not tested as part of the health check programme. In late 2016/17 a pilot started using detection equipment in six community pharmacies in the borough. The results from this will be used to inform possible expansion of screening programmes in 2017/18.

  - *Stroke risk and stroke prevention campaign* - During 2017/18 the Council's Communications Team will develop a proposal for a campaign intended to promote the uptake of the health checks programme for people most at risk of stroke and also signpost residents to physical activities and groups, social engagement activities, and facilities such as leisure centres, green spaces, and libraries.

- *Making best use of assistive technology* - The work of the CCTs referred to above, as well as the integrated approach to hospital discharge described in scheme 4: *Integrated Hospital Discharge,* provide opportunities to identify people who may benefit from assistive technology, e.g. telecare and telehealth, and to make referrals. This technology can help to provide the residents/patients and their families with greater confidence about them remaining in their own home.

- *Flexible use of Disabled Facilities Grants* - A business case will be developed for a six month early intervention pilot to provide a non-means-tested grant to people aged 75 and over for installation of a level-access shower where they have disability/medical condition that significantly restricts their mobility; they have reported difficulty with getting in and out of the bath; and they have no intention of leaving the property for at least 5 years. This is about proactively anticipating needs.

c) Intended Outcomes/Success Measures

This scheme will contribute to the following key BCF metric:
- Reduction in non-elective admissions.

The following measures that link to the Hillingdon outcomes framework for older people will also be used to identify whether the scheme is working:

- Increase in utilisation rates for Connect to Support (new and repeat users);

- Contributing towards a 5% reduction in falls-related non-elective admissions on 2016/17 outturn;

- % of users of Adult Social Care who have found it easy or difficult to access information and advice about services and/or benefits (test through the Adult Social Care Survey);

- Proportion of patients (among all those with a PAM score) whose PAM score has improved in the last 12 months.

- % of people aged 55 and over participating in screening programmes.

d) Scheme Investment Requirements

Service	Provider	Funder 2017/18			Funder 2018/19			
		LBH £000's	HCCG £000's	Total £000's	LBH £000's	HCCG £000's	Total £000's	Total 2017/19 £000's
a) Connect to Support	Shop-4-Support	45	-	45	46	-	46	91
b) Online Service Co-ordinator	LBH	49	-	49	50	-	50	99
c) Wellbeing Service	H4All	543	334	877	543	334	877	1,754

d) Information Advice Welfare and Benefits Service	Age Uk	150	-	150	150	-	150	300
e)Social Wellbeing Service	Age Uk	100	-	100	100	-	100	200
f) Practical Support Service	Age Uk	76	-	76	76	-	76	152
g) Falls Prevention Service	Age Uk	-	143	143	-	143	143	285
h) Older People Wellbeing Initiatives	LBH	20	-	20	20	-	20	40
i) Telecare	LBH	262	-	262	267	-	267	529
j) Disabled Facilities Grant	LBH	3,815	-	3,815	4,174	-	4,174	7,989
k) Integrated Care Programme	CCG	-	1,062	1,062	-	1,062	1,062	2,124
l) Care Connection Team	CCG	-	759	759	-	759	759	1,518
j) Primary Care		-	56	56	-	56	56	112
	Total	**5,060**	**2,353**	**7,413**	**5,426**	**2,353**	**7,779**	**15,193**

Scheme 2: An integrated approach to supporting Carers.

a) Strategic Objectives

The strategic objective of this scheme is to maximise the amount of time that Carers are willing and able to undertake a caring role. This will be contributed to by Carers being able to say:

- "*I am physically and mentally well and treated with dignity*"
- "*I am not forced into financial hardship by my caring role*"
- "*I enjoy a life outside of caring*"
- "*I am recognised, supported and listened to as an experienced carer*"

b) Scheme Overview

This scheme continues the priority given in 2016/17 to support Carers and reflects the implementation of legal duties on local authorities under the Care Act, 2014 and the Children and Familes Act, 2014 respectively to support Adult and Young Carers. It also reflects policy

directives on NHS bodies as directed by NHSE. The health and wellbeing of Carers will be supported through the following actions:

- *Maintaining capacity to deliver Carer's assessments through the Carers in Hillingdon contract that provides a single point of access for Carers in the borough* - Under this contract a triage assessment will continue to be promoted so that Carers can make informed decisions about whether to go through the full assessment process. In addition the online self-assessment facility through Connect to Support will be promoted and supported by Hillingdon Carers.

- *Implementation of NHS England's integrated approach to assessing Carer health and wellbeing* - This will entail the development of a Memorandum of Understanding (MoU) between the Council and Health partners, which will set out how partners will work together to support Carers.

- *Identifying "hidden" and "young" Carers* - This will entail using existing networks and materials e.g. Hillingdon People, social media, local press, street champions newsletter, Public Health initiatives and voluntary sector promotional event, etc, to identify people who do not necessarily consider themselves to be Carers. It will also entail the development of a consistent mechanism for identifying and recording Carers in primary care.

- *Developing the remit of the Young Carers Strategy Group* - This group was launched in 2016/17 to embed Young Carer initiatives at a strategic level, e.g. Healthy Schools Strategy; developing an early intervention and prevention strategy. A key role for the group in 2017/18 will be to develop a Young Carers Plus programme for Young Carers affected by parental drug, alcohol or mental health issues;

- *Health checks and flu prevention* - GP Health Checks and Flu Jab programmes for Carers will be promoted;

- *Hospital admissions and discharge* - Partners will work together to ensure that Carers are supported throughout the hospital admission and discharge care planning processes;
- *Personalisation for Carers* - Awareness of and access to Carer Personal Budgets and the individual's Personal Health Budgets will be maximised;

- *Social activities for Young Carers* - A range of social activities for Young Carers will be developed;

- *Extending availability of services for Adult Carers* - Options to extend services for Adult Carers, particularly working Carers who cannot access weekday provision, will be explored;

- *Social Worker drop-in sessions* - Social Worker drop-in sessions at the Hillingdon Carers Partnership Carers' Centre will be delivered.

c) Intended Outcomes/Success Measures

This scheme will contribute to the following BCF national metrics:
- Reduction in non-elective admissions.
- Reduction in permanent admissions to care homes of 65 + population.

The following measures that link to the Hillingdon outcomes framework for older people will

also be used to identify whether the scheme is working:

- Number of Carers' assessments completed.
- Number of Carers' self-assessment completed.
- Number of Carers receiving respite or a carer specific service following an assessment.
- Through the National Carers' survey in 2018/19:
  Proportion of Carers who have found it easy or difficult to find information and advice about support services or benefits
  Carer quality of life questions about:
  - Getting enough sleep and eating well
  - Having sufficient social contact
  - Receiving encouragement and support.
- Increasing the number of Carers identified and registered on the Hillingdon Carers' Carers' Register.
- Number of Carers in receipt of a Direct Payment or an individual with Personal Health Budget to contribute to the local trajectory by 2021 (303 to 607).

d) Scheme Investment Requirements

Service	Provider	Funder 2017/18			Funder 2018/19			TOTAL 2017/19 £,000
		LBH £,000	HCCG £,000	TOTAL £,000	LBH £,000	CCG £,000	TOTAL £,000	
a) Carers' hub, assessments and review	Hillingdon Carers (lead)	649	0	*649*	661	0	*661*	*1,310*
b) Services to Carers (inc respite)	Various P & V	213	0	*213*	217	0	*217*	*430*
c) Carer Support Worker		0	18	*18*	0	18	*18*	*36*
TOTAL		**862**	**18**	***880***	**878**	**18**	***896***	***1,776***

Scheme 3: Better care at end of life

a) Strategic Objectives

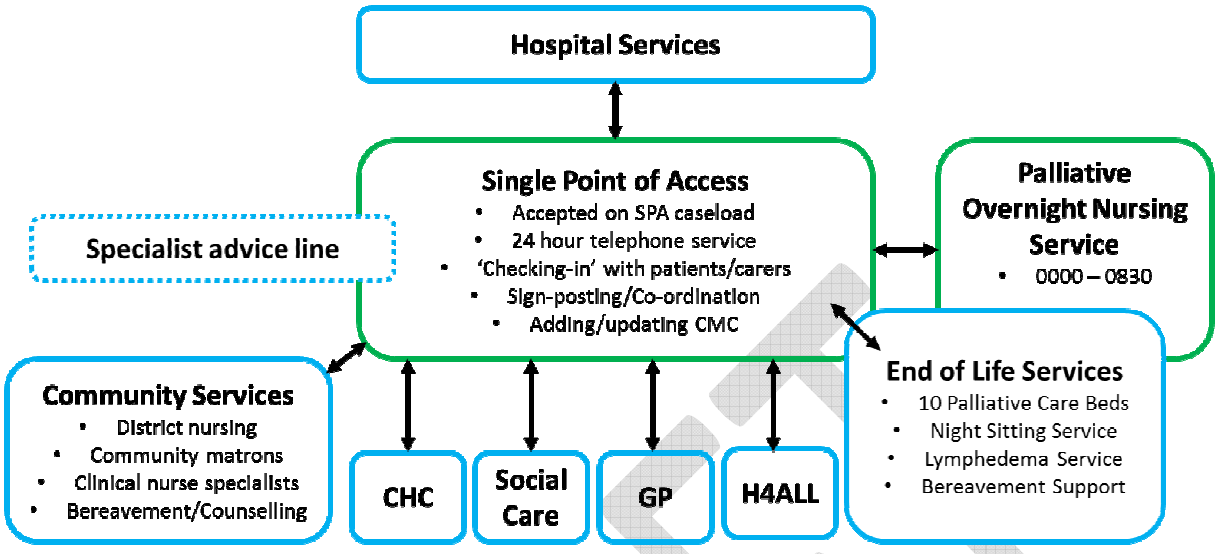
This scheme seeks to realign and better integrate the services provided to support people towards the end of their life in order to deliver the ethos of a 'good death.' The main goals of the scheme are to:

- Ensure that people at end of life are able to be cared for and die in their preferred place of care; and
- To ensure that people at end of life are only admitted to hospital where this is clinically necessary or where a hospital is their preferred place of care or death.

b) <u>Scheme Overview</u>

Building on work undertaken during 2016/17, activity under this scheme will be aligned to the development of a new single point of access for people diagnosed as being within their last year of life. The SPA will act as a central information and advice hub for end of life/palliative care patients and services, whilst providing a co-ordination on behalf of patients, Carers and

staff and giving the wider generalist workforce 24/7 access to specialist palliative advice. This will be supported by the palliative overnight nursing function (PONS) which, in addition to telephone advice will be able to assess and provide hands on care and support at the patient's place of residence if required. The intended model is shown below.



The key initiatives under this scheme intended to deliver better outcomes for people at end of life are:

- *Facilitating seamless care provision between health and social care* - The specialist homecare needs of people at end of life will be reflected in the integrated homecare service model tender referred to in scheme 5: *Improving care market management and development.* The intention behind this and a clear benefit of having the BCF pooled budget in place is to remove the possibility of disruption in care being caused by a transition in funding responsibility between health and social care, except in cases where the existing provider is unable to meet the escalating needs of the person at end of life.

- *Reviewing charges for Council funded services* - The Council will also explore the feasibility of removing the potential charge for people diagnosed as likely to have only six months to live and whose needs are primarily social care. This would help to avoid the complexities and potential disputes that can arise when trying to determine at what point a person's care should be health funded.

- *Utilisation of multi-disciplinary care and support planning* - In 2016/17 Adult Social Care gained read and write access to Coordinate My Care (CMC), an advanced care planning tool used in London primarily to support people at end of life. The intention and expectation is that there will be increased use of this tool by social care staff in line with the expected increase in use by other professionals and service providers across the borough.

- *Reviewing hospice bed provision requirements* - This is linked into the bed-based services requirements review action contained outlined in scheme 5: *Improving care market management and development.* The intention would be to identify future requirements and provision options.

c) Intended Outcomes/Success Measures

This scheme will contribute to the following key BCF metric:

- Reduction in non-elective admissions.

The following measure that links to the Hillingdon outcomes framework for older people will also be used to identify whether the scheme is working:

- Proportion of people on an end of life pathway on CMC who achieved their preferred place of death.

d) Scheme Investment Requirements

Service	Provider	Funder 2017/18			Funder 2018/19			TOTAL 2017/19 £,000
		LBH £,000	HCCG £,000	TOTAL £,000	LBH £,000	CCG £,000	TOTAL £,000	
a) Palliative home care.	Various P & V	50	884	*934*	51	884	*935*	*1,869*
b) Community Palliative Team.	CNWL	0	108	*108*	0	108	*108*	*216*
TOTAL		**50**	**992**	***1,042***	**51**	**992**	***1,043***	***2,085***

Scheme 4: Integrated hospital discharge

a) Strategic Objectives

This scheme seeks to prevent admission and readmission to acute care following an event or a health exacerbation and enabling recovery through intermediate care interventions with the aim of maximising the person's independence, ability to self-care and remain in their usual place of residence for as long as possible.

A further objective of this scheme is to support discharge from mental health community beds in recognition of the impact of these delays on patient flow through Hillingdon Hospital.

b) Scheme Overview

This scheme seeks to consolidate the move to a discharge home to assess model that expedites the flow out of hospital of people whose medical needs no longer require them to be there. This assumes that most people will recover more quickly from the cause of their admission in their usual home environment. The scheme is also seeking to establish an integrated hospital discharge service with a single point of referral to eliminate the existing fragmentation that exists between services and organisations.

Under Hillingdon's Discharge to Assess model there are three pathways:

- *Pathway 0 (Simple Discharges)* - This is for people whose needs can safely be met at home and need no additional assessment. The patient is functionally fit or at functional baseline when they are declared medically optimised. The patient can go directly home either without care or with a care package restart. The patients for this pathway are identified and their discharges managed by ward staff. It is envisaged that the majority of patients will be discharged on this pathway.

- *Pathway 1 (Home to Assess)* - This is for people who are not at their functional baseline when they are declared medically optimised. Following a risk assessment, their needs can be safely met at home (including a residential or nursing care home), where an assessment will be undertaken. Any care, equipment or rehabilitation will be provided at home, including a Continuing Healthcare assessment where appropriate. The discharge will be managed by the Discharge Coordinators or the Integrated Discharge Team (IDT) when required. At present needs are met either by the Council's Reablement Service for up to six weeks or Community Homesafe provided by CNWL for up to 10 days for people who have had a Comprehensive Geriatric Assessment (CGA). The intention is to get to a point where there is a community-based single point of referral and discharge coordinated by community-based staff, including arranging transport and community equipment. The assessment to determine ongoing care needs would then take place in the person's usual place of residence.

- *Pathway 2 (Cannot return home)* - This is for people who are unable to return home as they require a period of further rehabilitation, their care needs are not able to be safely met in their usual place of residence or their home needs preparation or adaptation. It is intended that people will be identified by ward staff and the discharge managed by the Discharge Coordinators or the IDT. The onward route from hospital will either be to the 22 bed Hawthorne Intermediate Care Unit (HICU) for people who require rehabilitation, the 5 step-down beds in a private nursing home commissioned by the CCG for people who require a bed based service on discharge and will be non-weight-bearing for more than 3 weeks or require a full continuing healthcare (CHC) assessment. The Council also has a step-down flat available in an extra care scheme where a person's home is unsuitable to meet their immediate needs.

Improvements to hospital discharge processes, including early identification of people with complex needs likely to impact on timely discharge and transport and medication issues are captured within the Urgent and Emergency Care Work Plan and the Delayed Transfers of Care (DTOC) action plan.

Other actions that will be taking place under this scheme include:

- *Reviewing the Integrated Discharge Team (IDT)* - Within the context of the Discharge to Assess model, the role and function of a multi-agency IDT will be undertaken by the Leadership Centre, an independent organisation that supports the public sector to address complex issues.

- *Emergency Care Improvement Programme (ECIP) undertaking a review of mental health discharges processes and causes of delay* - Delayed discharges of people with mental health needs represent the largest proportion of delayed transfers of care in Hillingdon.

- *Establishing regular liaison meetings between Mental Health and Housing* - Housing-related issues present one of key causes of delays in supporting the discharge from hospital of people with mental health needs. The Council and the community mental health provider, CNWL, will establish more structured referral routes and escalation pathways to ensure early identification of people with complex needs.

- *Developing a business case for establishing a Hospital Discharge Grant* - A business case will be developed to use flexibilities in the use of the Disabled Facilities Grant permitted

under the Regulatory Reform Orders to establish a non-means tested grant of up to £4k to pay for the following in order to expedite a resident's discharge from hospital:
- Home/garden clearance.
- Home deep cleaning.
- Home fumigation.
- Furniture removals to establish a micro-environment.
- Heating repairs, e.g. repairing or replacing boilers.
- Repairs to, or replacement of, essential appliances, e.g. cooker, refrigerator/freezer.

c) Intended Outcomes/Success Measures

This scheme will impact on the following BCF metrics:
- Reduction in the number of non-elective admissions.
- Reduction in permanent admissions of older people aged 65 years and over to residential and nursing care homes, per 100,000 population.
- 88% of older people aged 65 years and over who are still at home 91 days after discharge from hospital into reablement
- % reduction in delayed transfers of care (delayed days), including:
  - % reduction in delays attributed to the NHS
  - % reduction in delays attributed to Adult Social Care

The following measure will also be used:
- 85% of new clients who received reablement where no further request was made for ongoing long term support;
- Less than 15% of Continuing Healthcare assessments completed in a hospital.

d) Scheme Investment Requirements

Service	Provider	Funder 2017/18			Funder 2018/19			
		LBH £000's	HCCG £000's	Total £000's	LBH £000's	HCCG £000's	Total £000's	Total 2017/19 £000's
a) Rapid Response	CNWL	-	1,669	1,669	-	1,669	1,669	3,338
b) Hawthorn Intermediate care Unit	CNWL	-	1,603	1,603	-	1,603	1,603	3,206
c) Community Rehab	CNWL	-	1,198	1,198	-	1,198	1,198	2,396
d) Prevention of Admissions and Readmission (pATh)	Age UK	29	74	103	29	74	103	206
e) Take Home and Settle	Age UK	-	63	63	-	63	63	126
f) Reablement and Hospital Assessments	LBH	2,638	-	2,638	2,689	-	2,689	5,327

g) Reablement Physio	CNWL	51	-	51	51	-	51	102
h) Community Equipment	Medequip	756	715	1,471	761	715	1,476	2,947
i) Community Homesafe	CNWL	0	688	688	0	688	688	1,376
j) Packages of care	Various P&V	1,044	0	1,044	1,064	0	1,064	2,108
k) Step Down beds (Franklin House)	Care UK	0	198	198	0	198	198	396
l) Pressure Mattresses	CCG	0	206	206	0	206	206	412
m) Continence Service	CNWL	0	582	582	0	582	582	1,164
n) Community Matrons	CNWL	0	599	599	0	599	599	1,198
o) District Nursing	CNWL	0	3,346	3,346	0	3,346	3,346	6,692
p)Twilight Service	CNWL	0	124	124	0	124	124	248
q) Tissue Viability	CNWL	0	288	288	0	288	288	576
r) Support to step down Beds	CNWL	0	53	53	0	53	53	106
s) Cottesmore Reablement Flat	Paradigm Housing group	49	0	49	50	0	50	99
t) Mental Health Nurse in rapid response	CNWL	40	0	40	0	0	-0	40
	Total	**4,607**	**11,406**	**16,013**	**4,643**	**11,406**	**16,049**	**32,062**

Scheme 5: Improving care market management and development

a) **Strategic Objectives**

This scheme is intended to contribute to the STP 2020/21 outcomes of achieving:

- A market capable of meeting the health and care needs of the local population within financial constraints; and
- A diverse market of quality providers maximising choice for local people.

b) **Scheme Overview**

The focus of this scheme is the following areas:

- Pilot of an integrated brokerage;
- Integrated homecare for adults and young people;
- Care home market development; and
- Support for extra care sheltered housing.

The scheme represents both a logical progression from work undertaken in 2016/17 and also step-change in the integration between health and social care, which can be seen with the establishing of lead organisation/commissioner arrangements in respect to tendering of homecare and the potential to develop this further for nursing care home provision. By taking the step on the road to integration between health and social care this scheme seeks to address private provider market capacity and service quality issues that have a significant impact on Hillingdon's health and care system. This scheme is therefore also critical to the delivery of the objectives of several other schemes within the BCF plan, e.g. scheme 3: *Better care at end of life*, scheme 4: *Integrated hospital discharge* and scheme 6: *Living well with dementia*.

The key objectives of this scheme will be achieved through the following initiatives:

Integrated Brokerage

- Expanding utilisation of e-brokerage facility in Connect to Support to include nursing care home and homecare placements for Continuing Healthcare patients.

- Trial of co-locating both Council and CCG brokerage teams from September 2017.

- Developing affordable options for Council and CCG approval to expand scope of joint brokerage to include self-funders.

- Expanding take-up of Personal Health Budgets (PHBs) and integrated budgets, e.g. combination of Direct Payments (DPs) and PHBs in order to achieve the defined trajectory by 2021.

- Reviewing the impact of the brokerage pilot and consequent closer alignment of teams to inform a decision about any structural integration in 2018/19.

Integrated homecare for adults, children and young people

- The Council will lead for itself and the CCG in the tendering for an integrated, tiered service model of homecare through a Dynamic Purchasing System (DPS), e.g. a type of framework agreement that allows new providers to the market place to enter at any time if certain specified criteria are met. The DPS will become operational in October 2017 for two years. For the Council the tender will provide coverage for a part of the borough where a contract is currently not in place; it will also provide additional capacity in other parts of the borough. The model is intended to address NHS capacity requirements in all parts of the borough.

- Homecare placements will be made through the piloted integrated brokerage team through an electronic process.

- The integrated homecare model will include specialist palliative provision for people whose final preferred place of care is at home. The investment element for this provision is

reflected in scheme 3: *Better care at end of life*, although delivery will be through work undertaken as part of this scheme 5.

- A review of the impact of the model in 2018/19 will inform the approach taken by both the Council and the CCG to respond to the expiry of the Council's other homecare contracts at the end of 2019.

Care home market development

- Developing and launching a market position statement following a joint health and social care bed based services demand exercise to advise the market of Council and NHS supply requirements over the next 10 years.

- Exploring with providers increasing local capacity for residential dementia and nursing (inc dementia) care home capacity through conversion of spot purchases to block arrangements and seeking approval for other affordable options to meet supply needs.

- Developing an integrated nursing care home specification, e.g. to meet social care and CHC requirements.

- Determining the agreed procurement route for delivery in 2019/20, including the possibility of the Council being included within the NHS Any Qualified Provider (AQP) contract.

- Expanding the existing weekend GP advice and visiting service across the Borough and establish a Monday to Friday GP with specialist interest pilot to provide an emergency response, e.g. advice and/or visits as appropriate, for a defined number of care homes from October 2017 to March 2018.

- Based on the outcomes of the pilot, commission a GP advice and visiting service in an integrated way with existing and planned services in community/primary care through the ACP to support care homes.

- Developing a range of training opportunities for care home staff supported through the ACP and Council, e.g. falls prevention, deprivation of liberty and mental capacity assessments, prevention of pressure ulcers, continence care, palliative care and respiratory conditions.

- Developing a business case for additional community dietician to specifically work with care homes.

- Exploring the development of a career pathway for nursing care home staff through the ACP to contribute to addressing shortage of qualified nurses in this setting.

- Developing a '*Red Bag'* scheme pilot scheme with local care homes. The '*Red Bag*' keeps important information about a care home resident's health in one place, easily accessible to ambulance and hospital staff. contains standardised information about the resident's general health, any existing medical conditions they have, medication they are taking, as well as highlighting the current health concern. This means that ambulance and hospital staff can determine the treatment a resident needs more effectively.

- Developing a care home dashboard to be shared with care home managers that shows

the number of hospital attendances and admissions from care homes and also London Ambulance call outs to care homes and conveyances to hospital.

Support for extra care sheltered housing schemes

- Developing a model of in-reach health and social care support for extra care schemes linked to Care Connection Teams. This will include dedicated social work support and it is proposed will entail the reallocation of Protecting Adult Social funding from contributing to the mental health nurse in Rapid Response to resourcing a dedicated social work post to support extra care.

- Delivering a new care and wellbeing service at Cottesmore House and Triscott House in 2017/18 and at two new schemes called Grassy Meadow Court and Park View Court in 2018.

- Delivering a model of primary care, e.g. GP, support for extra care schemes. This links into the proposed service for care homes referred to above.

c) **Intended Outcomes/Success Measures**

This scheme will contribute to the following national BCF metrics:
- Reduction in non-elective admissions
- Reduction in permanent admissions to care homes of 65 + population.
- Reduction in delayed transfers of care and specifically for those attributed to the lack of care home placement or package of care reasons.

The following measures that link to the Hillingdon outcomes framework for older people will also be used to identify whether the scheme is working:
- Reduction in non-elective admissions from care homes.
- Reduction in inappropriate non-elective admissions from extra care sheltered housing schemes.
- Proportion of people on an end of life pathway on CMC who achieved their preferred place of death.

The following targets will be set for people in receipt of a combination of PHBs, integrated health and social care budgets, e.g. a combination of PHBs and Direct Payments, and people with a managed Personal Health Budget, which is where the actual sum of money allocated is identified but it is managed on behalf of the individual by the CCG:

PHB Target by Quarter 2017/19 (Cumulative)				
	Q1	**Q2**	**Q3**	**Q4**
2017/18	38	58	83	113
2018/19	148	183	223	263

d) **Scheme Investment Requirements**

Service	Provider	Funder 2017/18			Funder 2018/19			Total 2017/19 £000's
		LBH £000's	HCCG £000's	Total £000's	LBH £000's	HCCG £000's	Total £000's	
a) Quality Assurance team	LBH	168	-	168	171	-	171	339
b) Adult Safeguarding	LBH	260	-	260	265	-	265	525
c) Brokerage Team	LBH	315	62	377	315	62	377	754
d) Home Care	Various P&V	7,952	251	8,203	7,952	251	8,203	16,406
e) Care Home Prescriber	HCCG	0	32	32	0	32	32	64
f) Older peoples care Home	Various P&V	0	1,968	1,968	7,149	1,968	9,117	11,085
g) EMI over 65 Residential	Various P&V	0	0	-	0	2,913	2,913	2,913
h) EMI over 65 Domicillary	Various P&V	0	0	-	0	199	199	199
i) Physical Disability (Under65)	Various P&V	0	0	-	0	2,370	2,370	2,370
j) Pallative Care - Residential	Various P&V	0	0	-	0	509	509	509
k) Pallative Care - Domicilliary	Various P&V	0	0	-	0	596	596	596
l)Funded Nursing Care	Various P&V	0	0	-	0	3,025	3,025	3,025
m) Extra Care Social Work Post		0	0	-	41	0	41	41
n) Medication Admin		0	24	24	0	24	24	48
o) Community Matron		0	52	52	0	52	52	103
	Total	**8,695**	**2,389**	**11,084**	**15,893**	**12,001**	**27,893**	**38,977**

Scheme 6: Living well with dementia

a) **Strategic Objective**

The objective of this scheme is that people with dementia and their family carers are enabled to live well with dementia and are able to say:

- *I was diagnosed in a timely way.*
- *I know what I can do to help myself and who else can help me.*
- *Those around me and looking after me are well supported.*
- *I get the treatment and support, best for my dementia, and for my life.*
- *I feel included as part of society.*
- *I understand so I am able to make decisions.*
- *I am treated with dignity and respect.*
- *I am confident my end of life wishes will be respected. I can expect a good death.*

b) **Scheme Overview**

Dementia is primarily a condition associated with old age and as Hillingdon's population ages the numbers of people living with this condition is likely to increase significantly, with a consequential impact on the local health and social care economy. This scheme represents a continuation of work undertaken in 2016/17 and many of the key actions required to support people living with dementia and their families are addressed within other schemes in the plan. These include the following actions:

- *Preventing or delaying the onset of dementia* - This action links in with the work being undertaken under scheme 1: *Early intervention and prevention*, as the actions intended to prevent stroke will also assist in preventing or delaying the onset of dementia, e.g. promoting physical activity, nutrition guidance, smoking cessation and early detection of conditions such as hypertension and high cholesterol.

- *Securing care home provision for people living with dementia with challenging behaviours* – The current limited availability of this provision is the cause of people with dementia staying in inappropriate care settings for longer than is desirable and can contribute to delayed transfers of care. The work being undertaken under scheme 5: *Improving care market management and development is* intended to address this gap in provision.

- *Securing care provision for people living with dementia at end of life* – The work being undertaken under scheme 5: *Improving care market management and development* will ensure that appropriate service provision is available to address need at this particularly sensitive time.

- *Developing dementia-friendly alternatives to care home settings* - Linked to scheme 5: *Improving care market management and development,* two extra care sheltered housing schemes that have been built to the University of Stirling's Gold Standard, an internationally renowned design standard for dementia-friendly environments, will open in 2018. These are Grassy Meadow Court with 88 self-contained flats and Park View Court with 60 flats. Both schemes are intended as a realistic alternative to residential care for older residents and tenants will have access to 24/7 on site care and support provision.

The following action is specific to this scheme:

- *Developing a local dementia resource centre model* - A dementia resource centre will be included in the Grassy Meadow Court extra care scheme referred to above that is due to open in early 2018. This resource is primarily intended to meet the social care needs of people living with dementia in the community with family carers, but during 2017/18 health and social care partners will work together to identify how the maximum benefit can be obtained from this facility.

c) **Intended Outcomes/Success Measures**

This scheme will impact on the following BCF metrics:
- Reduction in permanent admissions to care homes.

d) **Scheme Investment Requirements**

Service	Provider	Funder 2017/18			Funder 2018/19			TOTAL 2017/19 £,000
		LBH £,000	HCCG £,000	TOTAL £,000	LBH £,000	CCG £,000	TOTAL £,000	
Wren Centre (dementia resource centre)	LBH	300	0	300	306	0	306	606
TOTAL		**300**	**0**	**300**	**306**	**0**	**306**	**606**

6.2 How the 2017/19 plan builds on key successes and challenges from 2016/17.

The 2016/17 plan has provided a foundation on which the Council and the CCG are able to work more collaboratively to better manage the care market, thereby supporting primary and secondary care. Work in 2016/17 has also created an environment in which the Council is actively exploring the possible advantages of it joining the ACP.

6.3 Changes from 2016/17 and rationale.

The key changes from the 2016/17 plan:

- *Developing the Accountable Care Partnership (ACP)* and the Council giving full consideration to its involvement - The ACP currently comprises of CNWL, Hillingdon Hospital, the GP Confederation and the local third sector consortium H4All. The Council is not currently part of the ACP but it is proposed that focused work be undertaken between Adult Social Care and the Care Connection Teams (CCTs) in the north of the borough to undertake a retrospective review of people identified during the NHS integrated care pilot who are being supported by both health and social care. The objective would be to explore opportunities for supporting residents more efficiently and more effectively and sharing any resultant benefits that may arise. It is also proposed to allocate social care staff to the CCTs supporting extra care schemes, especially where there are also clusters of care homes, e.g. Grassy Meadow Court. The outcomes from this work will contribute to the development of a business case that will enable the Council to fully evaluate the merits and benefits of formally joining the ACP.

- *Developing a single point of access for older people (scheme 1)* - Bringing services together into a single service with a single point of access has proved successful for

Carers in Hillingdon. It is proposed within the plan to use the opportunities presented by the H4All Wellbeing Service to reduce fragmentation in third sector services provided to older people to replicate the Carers' integrated service model for older people.

- *Getting hospital discharge right* (*scheme 4*) - The plan is proposing to bring together the various services involved in facilitating discharge from hospital into the community, e.g. Homesafe, , Reablement, the Night Carer Service and Prevention of Admission/Readmission to Hospital Service (PATH) into a single, integrated hospital discharge service delivered by a lead provider within the ACP. It is also intended that creating a single hospital discharge service will support the effective implementation of the discharge home to assess model that will reduce the number of older people who are still in hospital when there is no medical reason for them to be there, e.g. people who are referred to as being *'medically optimised*', as well as reducing the number of delayed transfers of care. This will be achieved by ensuring that the right professional is allocated to support a resident in meeting their need first time.

- *Joint market management and development approach* (*scheme 5*) - With the objective of ensuring the supply of sufficient quality providers to meet demand, this area represents potential step-change for Hillingdon. It includes the trial alignment of joint brokerage arrangements for homecare, short and long-term nursing home placements using existing contractual arrangements and Direct Payments and Personal Health Budgets. Also included is the development of integrated homecare via a dynamic purchasing system (DPS) that will meet the homecare needs of adults and children referred by either the Council or the CCG. It is also proposed to explore the Council leading on the procurement for nursing home placements in time for the expiry of current, separate contractual arrangements that the Council and CCG have in place.

Dynamic Purchasing System (DPS) Explained

A DPS is like having an electronic list of approved providers. Procurement of services through a DPS takes place electronically and is subject to certain criteria being met.

New providers can join a DPS at any time as long as they satisfy the membership rules.

6.4 Key milestones associated with the delivery of the 2017/19 plan

This section sets out some of the key milestones for the delivery of the 2017/19 plan.

1. Key milestones 2017/18
Quarter 1 • D2A pilot undertaken. **Quarter 2** • Submission of 2017/19 BCF plan following approval by HWB and CCG Governing Body. • Tender for integrated homecare DPS model.

- Integrated brokerage pilot operational.
- Agreement on D2A model.
- Launch of new discharge letters for patients at The Hillingdon Hospitals.
- Submission of pilot GP with specialist interest support for care homes and 'red bag' pilot business case.
- Introduction of formal monthly liaison meetings between Mental Health and Housing.
- Implementation of new mental health discharge planning tool.
- Agreement on advice, support and advocacy functions within discharge pathways.

Quarter 3

- Approval of 2017/19 BCF plan by NHSE.
- Section 75 agreement approved by Council's Cabinet and CCG Governing Body.
- Launch of new discharge policy to support choice at The Hillingdon Hospitals.
- Integrated homecare model operational.
- Implementation of agreed D2A model.
- Business case on use of DFG flexibilities under Regulatory Reform Order to support anticipatory care needs and early hospital discharge submitted.
- *'Red to Green*' extended to all wards at The Hillingdon Hospitals.
- Start of GP support for care homes pilot.
- Q2 STP delivery update report to HWB and CCG GB.

Quarter 4

- DTOC escalation protocol established between North West London CCGs and Health and Wellbeing Boards.
- Memorandum of understanding supporting an integrated approach to the identification and assessment of Carers' health and wellbeing needs signed by partners.
- Launch of End of Life Single Point of Access.
- Agreement on an integrated commissioning model for nursing care home placements.
- Single point of access in place for out of hospital services operational.
- Development of business case to determine the case for the Council joining the ACP.
- Evaluation of GP in care homes pilot and agreement of model of care and service specification Launch of care home market position statement.
- Launch of 'Red Bag' scheme in all care homes in Hillingdon
- Q3 STP delivery update report to HWB and CCG GB.
- Review outcome of Brokerage pilot.

2. Key milestones 2018/19

Quarter 1

- Grassy Meadow Court extra care scheme opens.
- Q4 STP delivery update report to HWB and CCG GB.

Quarter 2

- Park View Court extra care scheme opens.
- Implementation of GP with specialist interest service to support care homes and extra care housing schemes based on outcomes of pilot.
- Q1 STP delivery update report to HWB and CCG GB.

Quarter 3

- Q2 STP delivery update report to HWB and CCG GB.

Quarter 4

- Single, integrated intermediate care service operational.
- Q3 STP delivery update report to HWB and CCG GB.

6.5 Assessment of impact on patients.

Partners will continue to use the Adult Social Care Survey quality of life measure the percentage of patients scoring 14 or above (out of 24) for self-reported quality of life question. This survey is undertaken in quarter 4 of each financial year. The provisional baseline for 2017/18 is 58%.

The biennial national Carers' Survey will be used to test the quality of life of Carers. The measure will be the percentage of Carers scoring 7 or above (out of 12) for self-reported quality of life. The next survey will be undertaken in 2018/19 and the provisional baseline is 64.6%.

An outcomes framework and scorecard has been developed for the ACP that will test resident experience of integration. The scheme descriptions set out in section 6: *The Plan: Schemes and Spending*, identifies the measures that the BCF plan will make a contribution towards.

6.6 Evidence that plans are deliverable.

Delivery of the 2017/19 plan will be challenging but implementation timescales have been set reflecting priorities and available capacity. The deliverability of the plan has been subject to scrutiny through the governance process set out in section 8: *Programme Governance*.

7. OVERVIEW OF FUNDING CONTRIBUTIONS

7.1 Care Act, 2014 - how funding for implementation is being used.

The Care Act implementation element of the Protecting Social Care funding passported to the Council from the CCG, which is £887k in 2017/18 is being used to fund:

- the online resident portal called Connect to Support;
- capacity to Carers undertake assessments and reviews, including within the Carers in Hillingdon contract; and
- services to Carers, e.g. respite and replacement care services.

7.2 Funding dedicated to Carer-specific support

Hillingdon's plan includes a specific scheme dedicated to supporting Carers. In 2017/18 the total resource dedicated to supporting Carers by the Council is £862k and the amount in 2018/19 will be subject to the allocation of the CCG uplift of £178k. Aligned to this funding is an additional £18k in 2017/19 invested by the CCG for support provided by the

third sector Hillingdon Carers' Partnership, which is led by Hillingdon Carers. Carers of people in receipt of Continuing Healthcare funding will receive funding to provide respite in order to support them in their caring role where required.

7.3 Reablement

The Protecting Adult Social Care funding from the CCG includes £2,302k in 2017/18 for reablement and hospital assessments. The allocation for 2018/19 is subject to the outcome of discussions about the D2A model and its delivery.

7.4 Social care

The CCG has agreed to passport £6,085k to the Council to protect adult social care in 2017/18 and £6,263k in 2018/19. This includes the element for reablement and hospital assessments referred to in section 7.3 above.

7.5 Improved Better Care Fund Grant - How this funding will be used.

The IBCF grant is being used to stabilise the care home, homecare and supported living markets. There are three components to the work that the IBCF will support and these are:

- *Market Stabilisation* - Review of prices for existing providers for which a provision of £4.9m has been set aside. The aim is to agree sustainable prices for providers to enable care workers to receive an increased rate of pay.

- *Dynamic Purchasing System (DPS) for Homecare* - Tendering of Homecare spot provision via a Dynamic Purchasing System in a joint approach with Hillingdon CCG and across Adults and Children's Social Care.

- *Care Home Placements* - Reviewing placement purchasing model and working with providers to block purchase a number of beds thereby securing placements when clients move on from the placements.

The IBCF is intended to contribute to a reduction in delayed transfers of care :

- *Care home providers* - Estimated reduction in care-home related delayed days in 2017/18 3% (31 delayed days) and 5% (51 delayed days) in 2018/19.

- *Home care providers* - Estimated reduction in homecare related delayed days in 2017/18 5% (14 delayed days) and 15% (40 delayed days) in 2018/19.

8. PROGRAMME GOVERNANCE

8.1 Description of Governance Arrangements

The governance arrangements for the 2016/17 plan have evolved to reflect the approach taken by Hillingdon partners that the BCF is a delivery tool for those aspects of the STP that require integration between health and social care or closer working between health and other Council services. This means that there is a single governance structure for the BCF and the STP. This is summarised in Chart 6 on page 56.

The legal agreement between the Council and the CCG established under Section 75 (s.75) of the National Health Service Act, 2006, for the 2016/17 plan will be updated to reflect new financial arrangements and the modified governance arrangements. The terms of the updated agreement will be agreed during October 2017 before formal agreement by the Council's Cabinet and CCG's Governing Body in November 2017.

8.2 Description of how the programme will be delivered.

Each of the six schemes are led by an identified lead who is a senior manager within one of the partner organisations. They are supported by multi-agency task and finish groups created either to deliver service transformation or to deliver the specific requirements of the schemes set out in the plan.

The delivery of STP programmes, including BCF schemes, is overseen by the **Transformation Group**. This group undertakes a programme management office function and therefore monitors the delivery of key milestones within project plans for STP programmes. It is chaired by the chair of the CCG's Governing Body and its membership comprises of key officers across the CCG and Council and representatives from the GP confederation. It also has representation from Healthwatch Hillingdon.

The Tranformation Group is accountable to the **Transformation Board** which has executive level representation from health and care partners across Hillingdon, including elected member representation from the Council in the person of the chairman of the Health and Wellbeing Board. The Board is chaired by the chair of the CCG's Governing Body and meets six weekly . It has responsibility for the delivery of key transformation programmes and alignment of approaches to ensure delivery of the CCG's QIPP and Council's mid-term financial forecast (MTFF) efficiencies:

- Joint Health and Wellbeing Strategy /Sustainability and Transformation Plan
- Shaping a Healthier Future
- Whole System Integrated Care (including the early adopter project)
- Better Care Fund
- Primary Care Transformation
- System-wide Urgent and Emergency Care Transformation
- 7 day working

Partner representatives on the Transformation Board are accountable to the Boards of their respective organisations. The Board reports into the **Hillingdon Health and Wellbeing Board** (HHWBB). The HHWBB provides leadership in developing a strategic approach for health and wellbeing in Hillingdon and is responsible for holding partner agencies to account for performance on agreed priorities. It is also responsible for collaborative working to develop social care and health related commissioning plans to improve the health and wellbeing of residents of the Borough and monitor implementation and performance. The Board therefore takes strategic oversight for health and care systems in the Borough and has been involved from the outset in the planning for 2017/19 BCF plan. It is responsible for final sign off of plans and reports on behalf of partners and is the overarching leadership and governing body but does not, however, have authority to take investment decisions on behalf of its members. Individual partners, therefore, need to be satisfied with the proposals going to the Board and, as necessary, to agree them in advance. This applies to the **HCCG Governing Body** and to **Hillingdon Council's Cabinet**.

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

A **Core Officer Group** comprising of senior officers from the CCG, Adult Social Care, LBH and CCG Finance and the LBH Corporate Policy team was established as part of the governance arrangements for the 2015/16 plan to have operational responsibility for the management of the s.75 pooled budget and it is intended that this group will continue for the duration of the 2017/19 plan. This group meets monthly and is jointly chaired by the Director of Adult Social Care and the CCG's Chief Operating Officer. It provides oversight of the programme and also considers opportunities for integrated working and/or joint commissioning for recommendation to the Transformation Board and the Health and Wellbeing Board. Any decisions about the use of resources that are required are referred to the Council's Cabinet and CCG Governing Body in accordance with constitutional arrangements and agreed delegations.

8.3 Description of how the plan will contribute to reducing health inequalities as per section 4 of the 2012 Health and Social Care Act and reduce inequalities for people with protected characteristics under the 2010 Equality Act.

Health Inequalities

A health impact assessment has been completed that will support the decision by HCCG's Governing Body and the HWB to approve the draft plan.

The BCF Plan seeks to address health inequalities faced by Hillingdon's more vulnerable older population. However, given the disparity in social and economic wellbeing between older people in the north of the borough and those in the relatively more deprived, more culturally diverse wards in the south, particular consideration will have to be given as to how different communities will be engaged. The development of the CCTs with use of risk assessment tools, as referred to in scheme 1: *Early intervention and prevention,* will assist in the identification of residents in need, as will their links with the H4All Wellbeing Service. The Wellbeing Service will be proactively establishing relationships with local faith and other community-based groups to both identify residents in need and to enable them to access existing community-based support arrangements.

The provision of Personal Health Budgets for people meeting Continuing Health Care (CHC) thresholds and Personal Budgets for people meeting the National Adult Social Care eligibility criteria provides opportunities for a more personalised approach to addressing need that would reflect cultural and religious diversity. Promotion of Personal Health Budgets as well as integrated budgets, e.g. a combination of PHBs and Direct Payments, is addressed in *scheme 5: Improving care market management and development* of the plan.

Equality Act Protected Characteristics

An equality impact assessment has been completed that will support the decision by HCCG's Governing Body and the HWB to approve the draft plan. No inequalities were identified as a result of the assessment. The impact of the six schemes was neutral on three of the protected characteristics and these were gender identify, pregnancy and maternity and marriage and civil partnership. The assessment showed that the impact of the schemes was positive for all other characteristics. It should be noted that Hillingdon

includes Carers as a protected characteristic and therefore considers their needs in any impact assessment.

The assessment showed that particular attention will need to be given to how schemes develop to address the greater diversity in the south of the borough. During the lifetime of the plan there are also areas for development that may require specific assessments to support decisions made by either HCCG's Governing Body and/or the Council's Cabinet.

It is recognised that during the 2017/19 period the plan will develop in response to changing circumstances (including new opportunities) and the need for further health and equality impact assessments will be kept under review in light of these.

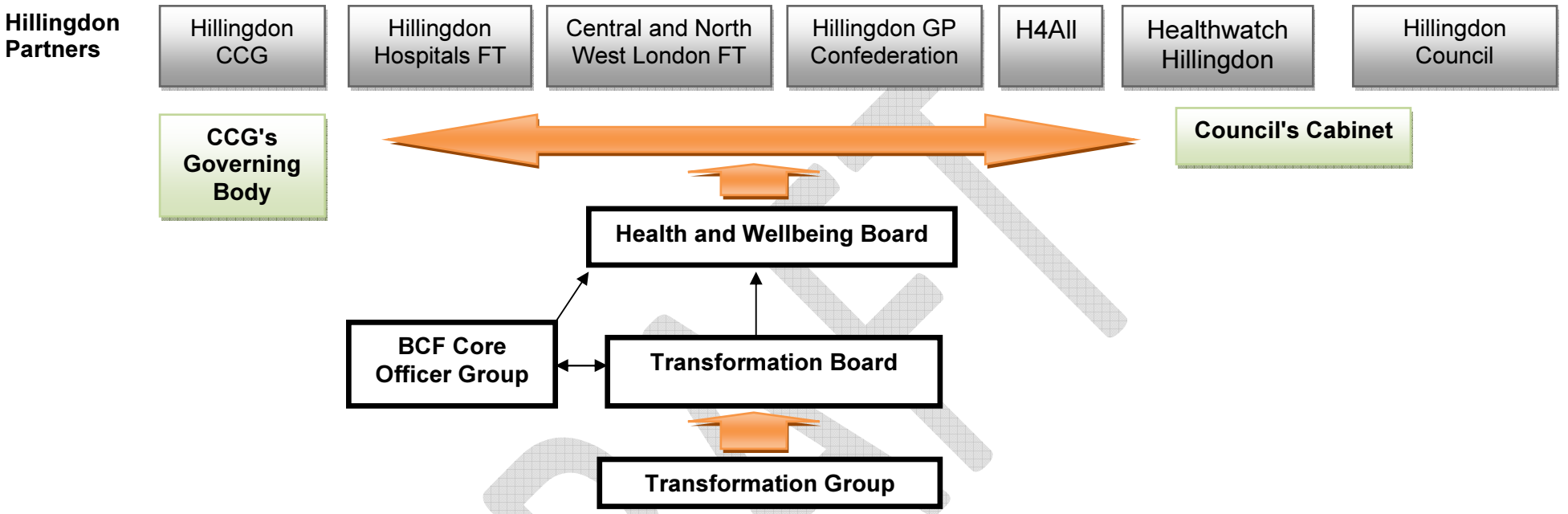
8.4 Description of how learning and insight will be utilised and timely corrective and preventative action taken when needed.

Good practice from vanguard sites as well as other health and care providers across the country and local intelligence about what works and what does not will be fed through the governance structure described above. There are a variety of sources for this intelligence, including the Better Care Exchange and the London Better Care Leads Network.

The BCF schemes are supported by a programme manager who will liaise with scheme leads. The practice during 2016/17 has been to work with key operational leads across partner organisations, e.g. through the ACP Clinical Design and Delivery Group (see chart 6: *Summary of Governance Arrangements*) about proposed changes to the model of care or other operational changes to reflect local learning or good practice elsewhere. This will be replicated in 2017/19.

The governance structure for the STP and BCF described above builds in enough safeguards to ensure that issues can be identified early and appropriate corrective action taken. Quarterly performance reports to the HHWB and CCG's Governing Body also provide opportunities to identify progress blockers that require high level consideration by strategic leaders across the partnership.

Chart 6: Summary of Governance Arrangements



STP Delivery Areas	DA1 Prevention & Wellbeing				DA2 Long-term Conditions		DA3 Older People		DA4 Mental Health	DA5 Sustainable Acute Services		Enablers
Supporting Groups & Scheme Delivery Responsibility (BCF Scheme Number)	Prevention Group (1)	Primary Care	Children & Young People Mothers & Babies	Carers Strategy Group (2)	Long-Term Conditions	Cancer	Clinical Design & Delivery Group	End of Life Forum (3)	Mental Health & Learning Disabilities	Planned Care	A & E Delivery Board	• Digital. • Estates. • Workforce. • Provider market (5). • Medicines. • Statutory targets.
							Dementia Working Group (6)			Integrated Discharge Workstream Group (4)		

Key to Summary of Governance Arrangements	
	*Use of resources decision authority*
	*Line of accountability*
	*Reporting line*

9. ASSESSMENT OF RISK AND RISK MANAGEMENT

9.1 Assessment of main delivery risks and current market position.

The overarching risks for the 2017/19 plan are set out in table 8 below. The risk assessment methodology is described in **Appendix 1**.

Table 8: 2017/19 BCF Plan Risk Log					
Risk No	**Risk Description**	**Likelihood rated on a scale of A-F with A being very likely and F being very unlikely**	**Impact rated on a scale of 1-4 with 1 being a major impact and 4 being a small impact**	**Risk Score**	**Actions in Place**
A. Service Delivery Risks					
R001	Admissions and DTOC targets are not met as a result of schemes failing to deliver system wide solutions.	C	2	C2	Monthly reporting to A & E Delivery Group and quarterly reporting to HWB.
R002	Inability to shift resources from acute into a community setting as a result of acute flows.	D	3	D3	Plans have focused on alignment and integration of investment and service changes with subsequent reduction in demand on secondary care.
R003	Insufficient capacity within partner organisations to deliver scheme actions.	C	3	C3	Capacity to deliver key pieces of work is kept under review by partners through the A & E Delivery and Transformation Boards.
R004	There is insufficient capacity within the private care market to meet demand.	B	1	B1	Embedding strong commissioner-provider relationships and establishing single commissioner arrangements to improve market intelligence. Quarterly updates to HWB/CCG Governing Body on market

					performance issues.
R005	D2A will impact on the local homecare market leading to insufficient capacity to meet demand (links to R004 above).	B	1	B1	Embedding strong commissioner-provider relationships and establishing single commissioner arrangements to improve market intelligence. Developing metrics to enable monitoring of impact on market capacity which will be monitored through Discharge Workstream Group and quarterly updates to HWB/CCG Governing Body on market performance issues.
R006	Lack of engagement from frontline/clinical staff resulting in no changes in frontline service.	D	3	D3	An engagement plan for fontline staff will be developed to share agreed key messages and information during the lifetime of the plan.
R007	Achieving interoperability between health and social care systems cannot proceed for technical reasons or related to excessive supplier charges.	D	3	D3	Participation in IT initiatives as part of the implementation of the local digital strategy. Representations through the LGA to central government about supplier costs is on going.
R008	Confusion amongst staff and the public about services available to support residents and access points.	D	3	D3	fontline staff will be developed to share agreed key messages and information during the lifetime of the plan.
B. Financial Risks					
R009	There is insufficient capacity within community services (including mental health), which means that the Hospital is unable to decommission escalation beds.	C	3	C3	A hospital discharge dashboard will enable the Transformation Group to monitor on a monthly basis. Escalation route will be through A & E Delivery Board, HWB and CCG Governing Body as appropriate.
R010	Financial challenges faced by the constituent organisations within the ACP could conflict with the overall objectives of the ACP and inhibit its ability to deliver system changes.	D	3	D3	There is a joint protocol in place to manage this. Regular meetings between the ACP Board and CCG Governing Body will help to manage this.
R011	Increased costs arising related to issues faced by private providers in recruiting staff and/or statutory requirements.	C	2	C2	See R004.

9.2 Financial risks, including deficits or risks relating to provider or care market financial positions.

Financial risks, including those experienced as well as posed to the whole system by the care market are identified in the risk log in table 8 above. More detail is provided about the current state of the health and social care market in section 2.3.

9.3 Approach to mitigation of risks, including risk shares and contingency arrangements.

Risk Sharing

The CCG is currently in discussion with the ACP regarding risk share arrangements from 2018/19. For 2017/18 any risk share arrangements between the CCG and the Council will be linked to specific services, e.g. community equipment and homecare, and both organisations with otherwise manage their own risks. This reflects the practice in 2016/17.

Contingency Arrangements

As the partners have not agreed an NEA target over and above that in the CCG's Operating Plan no specific contingency arrangements have been put in place. Risk management arrangements are as described above.

10. NATIONAL METRICS

10.1 Non-elective admissions (General and Acute)

a) Explanation for how the target has been reached.

An all age non-elective (also known as emergency) admissions ceiling for Hillingdon has been set by NHSE at 24,494 admissions. Section 2 of this document (*Background and Context)* shows that nearly 42% (10,049) of non-elective admissions in 2016/17 were attributed to the 65 and over population and Hillingdon's BCF is seeking to reduce the number of admissions by 9% (975) in 2017/18.

b) Analysis of previous performance and assessment of impact of 2017/19 plan.

The activity in 2016/17 exceeded the ceiling for the year of 9,700 but was similar to the activity in 2015/16. In 2017/18 the contribution to delivering the 975 target is intended to be as follows:

- Intermediate care (see scheme 4: *Integrated hospital discharge*) - 49 (5%)
- Care of the Elderly Consultant - 78 (8%)
- Health and Wellbeing Gateway (see scheme 1: *Early intervention and prevention*) - 127 (13%)
- Care Connection Teams (see scheme 1: *Early intervention and prevention)* - 517 (53%)
- Homesafe (see scheme 4: *Integrated* - 205 (21%)

hospital discharge)

10.2 Permanent admissions to residential and nursing care homes.

a) Explanation for how the target has been reached.

The target of 150 permanent admissions in 2017/18 reflects the demographics of the borough and the lack of realistic alternatives to residential care pending the delivery of two extra care schemes comprising of 148 self-contained flats in 2018. The target of 145 permanent admissions for 2018/19 reflects the fact that Grassy Meadow Court extra care scheme will open in June 2018 and Park View Court scheme in September and that both schemes will take up to a year to achieve full occupancy due to the complexity of the needs of the population group. It is assumed that there will be no change in the number of permanent placements into residential dementia, nursing and nursing dementia care homes during 2018/19. Any reduction in the number of placements will be attributed to lower numbers of permanent placements into residential care homes and also a lower number of short-term residential care placements converting into permanent placements. This can happen where people admitted to care homes as a temporary measure may experience an escalation of need leading to their temporary placement being converted to permanent. Built into the target assumptions for 2018/19 is 1.5% demographic growth. This reflects the increase in the 65 and over population as illustrated in section 2.2 of this document: *Local demography, future demographic challenges and long-term health issues.*

b) Analysis of previous performance and assessment of impact of 2017/19 plan.

161 permanent placements were made during 2016/17 against a ceiling of 150. Nearly 56% (90) of placements were to nursing homes and 44% (71) into residential and of these 92% (65) were residential dementia. The key impact of the 2017/19 plan will be the opening of the two new extra care sheltered housing schemes in 2018/19 as well as improvements in the capacity and quality of provision of homecare.

10.3 Effectiveness of reablement

a) Explanation for how the target has been reached.

The review period is people being discharged from hospitals in Q3. The target referrals into the Reablement Service in 2017/18 is 70 a month and 71% (50) of these are expected to be from hospitals, primarily from Hillingdon Hospital. This would mean a total of 150 discharges from hospitals in Q3 being supported by Reablement. The target assumes that 88% (132) of patients will still be at home after the 91 day period. The key reasons during 2016/17 why people were not home were deaths, readmissions and new reablement plans arising from changes of circumstances, e.g. escalation of need. Of the people readmitted approximately 50% were related to the original cause of admission and the proposed target is predicated on joint working between partners being able to reduce the number of readmissions relating to the original cause of admission by at least 3 people. The number of deaths could only really be affected by restricting the levels of acuity of people accepted into the service, which would be contrary to the purpose of the service.

The provisional target for 2018/19 is dependent on the outcome of discussions about the D2A model, including the development of an integrated intermediate care service.

b) Analysis of previous performance and assessment of impact of 2017/19 plan.

The focus of the Reablement Service is to support people with reablement potential rather than accepting all new referrals from hospitals and the community. This ensures that the service is able to assist in maximising the independence of residents and reduce on going demands on the local health and care system. Recruitment issues during 2016/17 impacted on the number and complexity of referrals that the service was able to accept but this has been addressed for 2017/18. It is not intended to reduce the level of community referrals accepted into the service as this has a major benefit for Hillingdon Hospital in helping to avoid admissions.

The following additional measures will be used to assess the impact of Reablement during 2017/18:

- 85% of new people referred to the Reablement Service require no further long-term support.
- <30% of people supported by the Reablement Service from hospitals are readmitted during the 91 day period following hospital discharge.

10.4 Delayed transfers of care

a) Explanation for how the target has been reached.

The information contained in table 9 below summarises the 2017/18 target outturn position for Hillingdon in accordance with targets set by NHSE. The trajectory for 2017/18 and that for the provisional 2018/19 target is set out in tab 4: *HWB Metrics* of the planning template supporting this narrative document.

Table 9: 2017/19 DTOC Targets

Attributed Responsibility	Number of Delayed Days	
	2017/18	2018/19
NHS	6,005	6,095
Social Care	2,271	2,305
Both	1,062	1,078
TOTAL	**9,337**	**9,478**

Quarter 1 2017/18 activity would, on a straightline projection, suggest an outturn for the year of 9,736 delayed days, reducing the number of DTOCs by 399 delayed days (9,736 - 9,337) is achievable. Taking into consideration that in 2016/17 67% (Q1 2017/18 position was 69%) of acute delayed days were attributed to Hillingdon Hospital patients and 86% (Q1 2017/18 position was 67%) of non-acute delays to CNWL patients, addressing issues with and for these two trusts will have a significant impact on Hillingdon's position.

The range of key initiatives included within the Urgent and Emergency Care Plan and the DTOC action plan that will support the reduction of DTOCs at Hillingdon Hospital include:

- Stronger processes to ensure that delays being reported reflect the correct definition;
- Improved information available for patients and family members to help manage; expectations and address the main cause of delays for the Hospital;
- Implementation of the SAFER patient flow bundle;
- Implementation of discharge to assess.

- Support to care homes, including the action by Adult Social Care to increase capacity by converting spot placements into block arrangements.

The key initiatives that will contribute to the reduction in the number of DTOCs attributed to patients of CNWL with mental health needs include:

- Stronger processes to ensure that delays being reported reflect the correct definition;
- Implementation of a discharge planning tool;
- Reviewing the training and guidance provided to staff presenting cases to the joint funding panel for mental health patients that includes membership from Adult Social Care, the CCG and Mental Health; and
- Establishing regular meetings with the Council's Housing Team to address accommodation issues at an early stage.

The provisional target for 2018/19 uses the projected 2017/18 outturn as the baseline and applies a 1.5% increase to it to reflect demographic growth as identified in the JSNA.

94% of people registered with a Hillingdon GP are residents of the borough and nearly 90% of inpatient activity comes from people registered with a GP in the borough. To address issues with delays involving people either with GPs out of the area and/or who are resident in another part of the region, a joint protocol with clear escalation routes is in the process of development between CCGs and local authorities in North West London. The intention is to have this in place by December 2017.

b) Assessment of impact of 2017/19 plan.

Delivery against plan DTOC targets will be monitored via the Hospital Discharge Workstream Group, the A & E Delivery Board, the HWB and the CCG's Governing Body as described in section 5.12: *Relationship between DTOC reduction target and A & E Delivery Plan.*

Appendix 1

Risk Scoring Methodology

Attributes:

				Risk rating	Risk rating	Risk rating	Risk rating
Greater than 90%	This week	LIKELIHOOD	**Very High (A)**	**A4**	**A3**	**A2**	**A1**
70% to 90%	Next week / this month		**High (B)**	**B4**	**B3**	**B2**	**B1**
50% to 70%	This year		**Significant (C)**	**C4**	**C3**	**C2**	**C1**
30% to 50%	Next year		**Medium (D)**	**D4**	**D3**	**D2**	**D1**
10% to 30%	Next year to five years		**Low (E)**	**E4**	**E3**	**E2**	**E1**
Less than 10%	Next ten years		**Very Low (F)**	**F4**	**F3**	**F2**	**F1**

THREATS:

Attributes	**Small (4)**	**Medium (3)**	**Large (2)**	**Very Large (1)**
	IMPACT			
Financial	up to £250K	£250k - £1million	£1million - £5million	Over £5million
Service Provision	Slightly reduced	Service suspended short term/ reduced	Service suspended long term/ statutory duties not delivered	
Health & Safety	Sticking plaster/ first aider	Broken bones/ Illness	Loss of life/ major illness	Major loss of life/ large scale major illness
Objectives	Objectives of several teams not met	Group objectives not met	Corporate objectives not met	

	Morale	Negative attitude	Some hostility/ minor non co-operation	Industrial action	Mass staff leaving/ unable to attract staff
	Reputation	No media attention/ minor letters	Adverse local media	Adverse national publicity	Remembered for years
	Government Relations		Poor assessment(s)	Service taken over temporarily	Service taken over permanently
	Attributes:	**Minor (4)**	**Moderate (3)**	**Major (2)**	**Outstanding (1)**
OPPORTUNITIES:	Financial	Some financial gain	High financial gain	Major financial gain	Huge financial gain
	Reputation	Minor improvements to image	Some enhancement to reputation	Enhanced reputation	Significantly enhanced reputation

Appendix 2 - Annex 1A Mental Health DTOC Action Plan

The plan is in addition to the statement that your trust must complete to provide assurance on implementation of the 8 Improving and Sustaining Performance Priorities for the 62 Day Cancer Standard.

Submission Details	
Name	Hillingdon Mental Health
Submission Date	06-Sep-17

Section 1 - Expected date of achievement of the DTOC action plan:

	Specific recovery date	Comments
DTOC <2.5% (regional expectation)	Trajectory in place to achieve 4.5% by	

Section 2 – week by week trajectory for achievement of the national standard (<2.5% DTOCs):
Please complete the table detailing the week by week trajectory for achievement of the DTOC targets.

WEEK:		Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17				
Number of patients with DTOC		9.6%	20.0%	20.6%	20.4%	17.3%	22.2%	19.2%	14.0%	13.4%	10.5%	7.1%				
Total bed base		66	66	66	66	66	66	66	66	66	66	66				
Percentage (%) of bed day delays due to DTOCs as a proportion of available beds	Trajectory as per January Submission															

Are all DToCs agreed by the MDT	Decisions regarding DTOC are agreed at ward level patient reviews attended by the Consultant and other	If not, when will this be in place?
Are DToCs monitored on a daily basis via bed management processes	Yes	If not, when will this be in place?
Do you have weekly meetings between partner organisations to validate DToCs	Detailed review of DTOC takes place at local weekly bed management meetings, attended by members of the MDT Team.	If not, when will this be in place?
Is there weekly multi-agency escalation for complex DToCs?	1. Central Bed Management Business Support emails Borough Social Care Leads DTOC report from clinical system on weekly basis. 2. Social Care Leads check Clinical System (JADE) to review all identified patients in their area where the attributed reason for the delay is Social Care or Both. 3.Social Care Lead to report any challenges/queries to Inpatient Service Manager/Discharge Co-ordinator and arrange to meet to discuss if required. Inpatient Service Manager to involve MDT clinical team to review decision.	If not, when will this be in place?
Do you have an agreed escalation process for when you do not meet your agreed DTOC trajectory?	Yes - weekly bed local bed management meetings escalate, agree and plan for discharges	
Please provide details of your DTOC escalation process?	N/A	

Please use the table below to detail the key actions you are taking to address delays.

Recovery actions aligned to specific challenges (prioritised list)	Action linked to DTOC trajectory	Owner (Trust, CCG, LA etc)	Key milestones	How will you measure progress/delivery? (KPIs)	completion date (week and month	Quantifiable impact of actions
1.Work ongoing with CCGs and LAs to develop s117 policies outlining funding splits. There is not one approach across all 5 Local Authority/CCGs. Updating s117 CNWL Policy	Increased understanding of s117 and agreed policy will reduce delays due to Awaiting Public Funding	CCG/LA - funding split decision Trust - internal s117 Policy	Reconfirm national mandates around S117 as per guidance. Ensure full processes are in place. Escalate all delays over 7 days. s75 between LA and CCG by Policy signed off . Recirculate S117 funding pathway agree programme of workshop training on S117 matrices and funding splits	Submission of funding pathway and training programme	01-Mar-18	Reduction in DTOC. Reduced spend on activity and increasing numbers returning from out of area. No unwarranted delays in agreeing joint placements, clear framework for agreeing funding decisions for all placements.

2. Mapping of all Panel Pathways and improved and more consistent decision making on improving discharge care pathway, including planing for discharge on admission	Improved clarity of an individual's discharge pathway will ensure presentation to the right panel with the right information to avoid delays	Trust, CCG, LA	In first quarter 2017 agree and confirm all pathways, Develop forward planner of all panel pathways which support hospital discharges	Monitor Care Coordinator Vacancy Rates, Caseload and timeliness of Placement Papers and Reviews to Panel, jointly with LA in s75, at local Monthly Performance Meeting with Trust. Submission of the Forward planner Failure to agree pathways will incur sanctions (5% of performane)	Dec-18	Improved quality and timeliness of placement reports and reviews to panel. Reduction in DTOC.
3. Establish single, clear and understood definition of DTOCs	Shared understanding of DTOC definiiton	Trust, CCG, LA	Develop definition of mental health DTOC and agree with CCG & LA	Agreed and DTOC definition	31-Mar-17	Reduction in DTOC. Reduced spend on activity and increasing numbers returning from out of area
4. Institute clear reporting tool which includes both DTOCs and early warming for clients likely to become DTOCs to be reviewed at regular DTOC conference calls involving key stakeholders and commissisoners	Regular joint work and visability to promote timely discharges.	Trust, CCG, LA	Trust has developed tool, full insitgation during 2017/18	Pilot of an operational DTOC tool commencing on 1st April 2017 The trust will have an early detection and escalation process with all aprties meeting as needed (at least weekly when more than 5 indivduals identified)		Reduced DTOC, reduced LOS, increased shared/system understanding of issues and joint working.
5. Review training and guidanve provided to staff presenting cases to the Joint (LBH/CCG/CNWL) Funding Panel for mental health patients.	Improved process and understanding of the information required to access approriate placements	CCG/LA	Training sessions planned and commenced	reported improvement in quality of presentations to panel and reduction in delay caused by inadequate information	On-going	streamlined and efficient panel process'
6. Regular liaison meetings to be established between MH team and Housing.	Shared understanding of current need and provision	Trust/LA housing authority	Regular attendance of the housing named representative at the weekly discharge plannign meetings	Shorter delays attributable to housing need	Sep-17	Fewer delays due to housing need and clear understanding of the provisions available
7 Discharge planning should commence at the point of the admission including early identification of potential DTOCs and early allocation of Care Co-ordinator. Project to be developed to identify key action and timescales to address these issues.	Consistent approach to discharge planning across the Borough	Trust	Definition of project actions reporting tool identified in 5 above.	Achievement of project milestones	Aug-17	Reduction of DTOCs

Section 5 – Governance and programme management arrangements Please use this space to describe the governance and programme management arrangements in place to ensure this improvement plan will be implemented and achieve the standard by the date provided in Section 1 above.
Governance: There will be daily bed management meetings to discuss DTOC and weekly bed management meeting attended by CCG and LA. Routine reporting of all metrics monthly and escalation as needed
Programme Management: There will be daily bed management meetings to discuss DTOC and weekly bed management meeting attended by CCG and LA.

Planning Template for BCF: due on 11/09/2017

Better Care Fund 2017-19 Planning Template

Sheet: Checklist

[<< Link to the Guidance tab]

Complete Template

1. Cover

	Cell Reference	Checker
Health and Well Being Board	C10	Yes
Completed by:	C13	Yes
E-mail:	C15	Yes
Contact number:	C17	Yes
Who has signed off the report on behalf of the Health and Well Being Board:	C19	Yes
Area Assurance Contact Details	C22 : G31	Yes

Sheet Completed:	Yes

2. HWB Funding Sources

	Cell Reference	Checker
Are any additional LA Contributions being made on 2017/18? If yes please detail below	C35	Yes
Are any additional LA Contributions being made on 2018/19? If yes please detail below	D35	Yes
Local authority additional contribution:	B38 : B40	Yes
Gross Contribution (2017/18)	C41	Yes
Gross Contribution (2018/19)	D41	Yes
Comments (if required)	F38	N/A
Are any additional CCG Contributions being made on 2017/18? If yes please detail below;	C62	Yes
Are any additional CCG Contributions being made on 2018/19? If yes please detail below;	D62	Yes
Additional CCG Contribution:	B65	Yes
Gross Contribution (2017/18)	C65	Yes
Gross Contribution (2018/19)	D65	Yes
Comments (if required)	F65	N/A
Funding Sources Narrative	B83	N/A
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority? (2017/18)	C91	Yes
2. i) In areas with two tiers of local government, can you confirm that the full amount of Disabled Facilities Grant will be passed to local housing authorities? (2017/18)	C93	Yes
2. ii) In areas with two tiers of local government, can you confirm that relevant district councils have agreed how Disabled Facilities Grant will be spent in line with ambitions in the BCF to support integrated approaches to health, social care and housing? (2017/18)	C94	Yes
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified? (2017/18)	C95	Yes
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? (2017/18)	C96	Yes
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? (2017/18)	C97	Yes
6. Is the iBCF grant included in the pooled BCF fund? (2017/18)	C98	Yes
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority? (2018/19)	D91	Yes
2. i) In areas with two tiers of local government, can you confirm that the full amount of Disabled Facilities Grant will be passed to local housing authorities? (2018/19)	D93	Yes
2. ii) In areas with two tiers of local government, can you confirm that relevant district councils have agreed how Disabled Facilities Grant will be spent in line with ambitions in the BCF to support integrated approaches to health, social care and housing? (2018/19)	D94	Yes
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified? (2018/19)	D95	Yes
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? (2018/19)	D96	Yes
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? (2018/19)	D97	Yes
6. Is the iBCF grant included in the pooled BCF fund? (2018/19)	D98	Yes
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority? Comments	E91	Yes
2. i) In areas with two tiers of local government, can you confirm that the full amount of Disabled Facilities Grant will be passed to local housing authorities? Comments	E93	Yes
2. ii) In areas with two tiers of local government, can you confirm that relevant district councils have agreed how Disabled Facilities Grant will be spent in line with ambitions in the BCF to support integrated approaches to health, social care and housing? Comments	E94	Yes
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified? Comments	E95	Yes
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? Comments	E96	Yes
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? Comments	E97	Yes
6. Is the iBCF grant included in the pooled BCF fund? Comments	E98	Yes

Sheet Completed:	Yes

3. HWB Expenditure Plan

	Cell Reference	Checker
Scheme ID	B18 : B267	Yes
Scheme Name	C18 : C267	Yes
Scheme Type (see table below for descriptions)	D18 : D267	Yes
Sub Types	E18 : E267	Yes
Please specify if 'Scheme Type' or 'Sub Type' is 'other'	F18 : F267	Yes
Area of Spend	G18 : G267	Yes
Please specify if 'Area of Spend' is 'other'	H18 : H267	Yes
Commissioner	I18 : I267	Yes
if Joint Commissioner % NHS	J18 : J267	Yes
if Joint Commissioner % LA	K18 : K267	Yes
Provider	L18 : L267	Yes
Source of Funding	M18 : M267	Yes
Scheme Duration	N18 : N267	Yes
2017/18 Expenditure (£000's)	O18 : O267	Yes
2018/19 Expenditure (£000's)	P18 : P267	Yes
New or Existing Scheme	Q18 : Q267	Yes

Sheet Completed:	Yes

4. HWB Metrics

	Cell Reference	Checker
4.1 - Are you planning on any additional quarterly reductions?	E18	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q1 (2017/18)	F20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q2 (2017/18)	G20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q3 (2017/18)	H20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q4 (2017/18)	I20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q1 (2018/19)	J20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q2 (2018/19)	K20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q3 (2018/19)	L20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q4 (2018/19)	M20	Yes
4.1 - Are you putting in place a local contingency fund agreement on NEA?	E24	Yes
4.1 - Cost of NEA (2017/18)	E30	Yes
4.1 - Cost of NEA (2018/19)	E31	Yes
4.1 - Comments (2017/18) (if required)	F30	N/A
4.1 - Comments (2018/19) (if required)	F31	N/A
4.2 - Residential Admissions : Numerator : Planned 17/18	H48	Yes
4.2 - Residential Admissions : Numerator : Planned 18/19	I48	Yes
4.2 - Comments (if required)	J47	N/A
4.3 - Reablement : Numerator : Planned 17/18	H57	Yes
4.3 - Reablement : Denominator : Planned 17/18	H58	Yes
4.3 - Reablement : Numerator : Planned 18/19	I57	Yes
4.3 - Reablement : Denominator : Planned 18/19	I58	Yes
4.3 - Comments (if required)	J56	N/A
4.4 - Delayed Transfers of Care : Planned Q1 17/18	I65	Yes
4.4 - Delayed Transfers of Care : Planned Q2 17/18	J65	Yes
4.4 - Delayed Transfers of Care : Planned Q3 17/18	K65	Yes
4.4 - Delayed Transfers of Care : Planned Q4 17/18	L65	Yes
4.4 - Delayed Transfers of Care : Planned Q1 18/19	M65	Yes
4.4 - Delayed Transfers of Care : Planned Q2 18/19	N65	Yes
4.4 - Delayed Transfers of Care : Planned Q3 18/19	O65	Yes
4.4 - Delayed Transfers of Care : Planned Q4 18/19	P65	Yes
4.4 - Comments (if required)	Q64	N/A

Sheet Completed:	Yes

5. National Conditions

	Cell Reference	Checker
1) Plans to be jointly agreed (2017/18)	C14	Yes
2) NHS contribution to adult social care is maintained in line with inflation (2017/18)	C15	Yes
3) Agreement to invest in NHS commissioned out of hospital services (2017/18)	C16	Yes
4) Managing transfers of care	C17	Yes
1) Plans to be jointly agreed (2018/19)	D14	Yes
2) NHS contribution to adult social care is maintained in line with inflation (2018/19)	D15	Yes
3) Agreement to invest in NHS commissioned out of hospital services (2018/19)	D16	Yes

4) Managing transfers of care	D17	Yes
1) Plans to be jointly agreed, Comments	E14	Yes
2) NHS contribution to adult social care is maintained in line with inflation, Comments	E15	Yes
3) Agreement to invest in NHS commissioned out of hospital services, Comments	E16	Yes
4) Managing transfers of care	E17	Yes

Sheet Completed:	Yes

2. HWB Funding Sources

	2017/18 Gross Contribution	2018/19 Gross Contribution
Total Local Authority Contribution exc iBCF	£9,284,000	£15,588,000
Total iBCF Contribution	£4,054,178	£5,257,796
Total Minimum CCG Contribution	£16,854,388	£17,174,622
Total Additional CCG Contribution	£6,622,711	£16,031,378
Total BCF pooled budget	**£36,815,278**	**£54,051,796**

Specific Funding Requirements for 2017-19	2017/18 Response	2018/19 Response
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority?	Yes	Yes
2. In areas with two tiers of local government:		
i) Are there plans to pass down the full amount of Disabled Facilities Grant from the county to each of the district authorities?		
ii) If a portion of the DFG funding has been retained by the county, have the relevant district councils agreed to this approach? If applicable, please detail in the comments box how the retained portion of DFG will be spent to support integrated approaches to health, social care and housing.		
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes	Yes
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes	Yes
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	Yes
6. Is the iBCF grant included in the pooled BCF fund?	Yes	Yes

3. HWB Expenditure Plan

Summary of BCF Expenditure (*)	2017/18 Expenditure	2018/19 Expenditure
Acute	£0	£0
Mental Health	£0	£0
Community Health	£11,131,000	£11,131,000
Continuing Care	£3,121,000	£12,733,000
Primary Care	£1,317,000	£1,317,000
Social Care	£18,595,278	£26,219,796
Other	£2,651,000	£2,651,000
Total	**£36,815,278**	**£54,051,796**

Summary of BCF Expenditure from Minimum CCG Contribution (***)	2017/18 Expenditure	2018/19 Expenditure
Acute	£0	£0
Mental Health	£0	£0
Community Health	£8,968,000	£8,968,000

Summary of NHS Commissioned Out of Hospital Services Spend from MINIMUM BCF Pool (**)	2017/18 Expenditure	2018/19 Expenditure
Mental Health	£0	£0
Community Health	£8,968,000	£8,968,000
Continuing Care	£0	£0
Primary Care	£323,000	£323,000
Social Care	£0	£0
Other	£1,245,289	£1,448,622
Total	**£10,536,289**	**£10,739,622**
NHS Commissioned OOH Ringfence	£4,789,539	£4,880,540

Additional NEA Reduction linked Contingency Fund	2017/18 Fund	2018/19 Fund
NEA metric linked contingency fund held from the ringfenced local allocation for NHS OOH spend	£0	£0

BCF Expenditure on Social Care from

Continuing Care	£0	£0
Primary Care	£323,000	£323,000
Social Care	£6,146,100	£6,263,000
Other	£1,417,289	£1,620,622
Total	**£16,854,389**	**£17,174,622**

→

Minimum CCG Contribution	2016/17	2017/18	2018/19
Minimum Mandated Expenditure on Social Care from the CCG minimum		£6,146,080	£6,262,856
Planned Social Care expenditure from the CCG minimum	£6,038,000	£6,146,100	£6,263,000
Annual % Uplift Planned		**1.8%**	**1.9%**
Minimum mandated uplift % (Based on inflation)		**1.79%**	**1.90%**

4. HWB Metrics

4.1 HWB NEA Activity Plan

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 17/18	Total 18/19
Total HWB Planned Non-Elective Admissions	6,694	6,328	6,513	6,408	6,077	5,981	6,263	6,173	**25,943**	**24,494**
HWB Quarterly Additional Reduction Figure	0	0	0	0	0	0	0	0	**0**	**0**
HWB NEA Plan (after reduction)	6,694	6,328	6,513	6,408	6,077	5,981	6,263	6,173	**25,943**	**24,494**
Additional NEA reduction delivered through the BCF									**£0**	**£0**

Planning Template for BCF: due on 11/09/2017

Better Care Fund 2017-19 Planning Template

Sheet: 1. Cover Sheet

<< Link to the Guidance tab

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Health and Well Being Board	**Hillingdon**
Completed by:	GARY COLLIER
E-Mail:	gcollier@hillingdon.gov.uk
Contact Number:	01895 250730
Who signed off the report on behalf of the Health and Well Being Board:	Councillor Philip Corthorne

	Role:	Title and Name:	E-mail:
Area Assurance Contact Details*	Health and Wellbeing Board Chair	Cllr Philip Corthorne	pcorthorne@hillingdon.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)	Rob Larkman	r.larkman@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	N/A	N/A
	Local Authority Chief Executive	Fran Beasley	fbeasely@hillingdon.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Tony Zaman	tzaman@hillingdon.gov.uk
	Better Care Fund Lead Official	Gary Collier	gcollier@hillingdon.gov.uk
	LA Section 151 officer	Paul Whaymand	pwhaymand@hillingdon.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->	Clinical Commissioning Group	Caroline Morison	caroline.morison@nhs.net
	N/A	N/A	N/A
	N/A	N/A	N/A

***Only those identified will be addressed in official correspondence**

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete Template

	No. of questions answered
1. Cover	**6**
2. HWB Funding Sources	**31**
3. HWB Expenditure Plan	**16**
4. HWB Metrics	**31**
5. National Conditions	**12**

Planning Template for BCF: due on 11/09/2017

Sheet: 2. Health and Well-Being Board Funding Sources

Selected Health and Well Being Board:

Hillingdon

Data Submission Period:

2017-19

2. HWB Funding Sources

<< Link to the Guidance tab

Local Authority Contributions exc iBCF		
Disabled Facilities Grant (DFG)	2017/18 Gross Contribution	2018/19 Gross Contribution
Hillingdon	£3,815,535	£4,174,477
Lower Tier DFG Breakdown (for applicable two tier authorities)		
Total Minimum LA Contribution exc iBCF	**£3,815,535**	**£4,174,477**

Are any additional LA Contributions being made in 2017/18 or 2018/19? If yes please detail below	Yes	Yes

Local Authority Additional Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Hillingdon	£5,468,465	£11,413,523
Total Local Authority Contribution	**£9,284,000**	**£15,588,000**

Comments - please use this box clarify any specific uses or sources of funding

iBCF Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Hillingdon	£4,054,178	£5,257,796
Total iBCF Contribution	**£4,054,178**	**£5,257,796**

CCG Minimum Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
NHS Hillingdon CCG	£16,854,388	£17,174,622
Total Minimum CCG Contribution	**£16,854,388**	**£17,174,622**

Are any additional CCG Contributions being made in 2017/18 or 2018/19? If yes please detail below	Yes	Yes

Additional CCG Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
NHS Hillingdon CCG	£6,622,711	£16,031,378	
Total Additional CCG Contribution	**£6,622,711**	**£16,031,378**	

	2017/18	2018/19
Total BCF pooled budget	**£36,815,278**	**£54,051,796**

Funding Contributions Narrative
No comments.

Specific funding requirements for 2017-19	Response	Response	If the selected response for either year is 'No', please detail in the comments box
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority?	Yes	Yes	
2. In areas with two tiers of local government:			
i) Are there plans to pass down the full amount of Disabled Facilities Grant from the county to each of the district authorities?			

ii) If a portion of the DFG funding has been retained by the county, have the relevant district councils agreed to this approach? If applicable, please detail in the comments box how the retained portion of DFG will be spent to support integrated approaches to health, social care and housing.			
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes	Yes	
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes	Yes	
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	Yes	
6. Is the iBCF grant included in the pooled BCF fund?	Yes	Yes	

Planning Template for BCF: due on 11/09/2017

Sheet: 3. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:
Hillingdon

Data Submission Period:
2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to Summary sheet

Running Balances	2017/18	2018/19
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc iBCF	£0	£0
CCG Minimum Contribution balance	£0	£0
Additional CCG Contribution balance	£0	£0
iBCF	£0	£0
Running Totals	**2017/18**	**2018/19**
Planned Social Care spend from the CCG minimum	£6,146,100	£6,263,000
Ringfenced NHS Commissioned OOH spend	£10,536,289	£10,739,622

		Expenditure													
		Scheme Descriptions Link >>													
Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
1	Early intervention and prevention	13. Primary prevention / Early Intervention	4. Other	Early intervention and prevention	Social Care		Local Authority			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£45,000	£46,000	Existing
1	Early intervention and prevention	13. Primary prevention / Early Intervention	4. Other	Early intervention and prevention	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£49,000	£50,000	Existing
1	Early intervention and prevention	15. Wellbeing centres			Other	Third sector	Local Authority			Charity / Voluntary Sector	Local Authority Contribution	Both 2017/18 and 2018/19	£543,000	£543,000	Existing
1	Early intervention and prevention	15. Wellbeing centres			Other	Third sector	CCG			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£195,000	£195,000	Existing
1	Early intervention and prevention	13. Primary prevention / Early Intervention	4. Other	Early intervention and prevention	Other	Third sector	Local Authority			Charity / Voluntary Sector	Local Authority Contribution	Both 2017/18 and 2018/19	£150,000	£150,000	Existing
1	Early intervention and prevention	13. Primary prevention / Early Intervention	2. Other - Mental health /wellbeing		Other	Third sector	Local Authority			Charity / Voluntary Sector	Local Authority Contribution	Both 2017/18 and 2018/19	£100,000	£100,000	Existing
1	Early intervention and prevention	13. Primary prevention / Early Intervention	4. Other	Early intervention and prevention	Other	Third sector	Local Authority			Charity / Voluntary Sector	Local Authority Contribution	Both 2017/18 and 2018/19	£76,000	£76,000	Existing
1	Early intervention and prevention	13. Primary prevention / Early Intervention	3. Other - Physical health/wellbeing		Other	Local Authority	Local Authority			Local Authority	Local Authority Contribution	Both 2017/18 and 2018/19	£20,000	£20,000	Existing
1	Early intervention and prevention	1. Assistive Technologies	1. Telecare		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£262,000	£267,000	Existing
1	Early intervention and prevention	4. DFG - Adaptations			Social Care		Local Authority			Private Sector	Local Authority Contribution	Both 2017/18 and 2018/19	£3,815,000	£4,174,000	New
1	Early intervention and prevention	10. Integrated care planning	4. Other	Care Connection Team	Community Health		CCG			NHS Community Provider	Additional CCG Contribution	Both 2017/18 and 2018/19	£759,000	£759,000	Existing
1	Early intervention and prevention	10. Integrated care planning	1. Care planning		Primary Care		CCG			NHS Community Provider	Additional CCG Contribution	Both 2017/18 and 2018/19	£994,000	£994,000	Existing
2	An integrated approach to supporting Carers	3. Carers services	1. Carer advice and support		Social Care		Local Authority			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£649,000	£661,000	Existing
2	An integrated approach to supporting Carers	3. Carers services	3. Respite services		Social Care		Local Authority			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£213,000	£217,000	Existing
2	An integrated approach to supporting Carers	3. Carers services	1. Carer advice and support		Continuing Care		CCG			Charity / Voluntary Sector	Additional CCG Contribution	Both 2017/18 and 2018/19	£18,000	£18,000	Existing
3	Better care at end of life	16. Other		End of life care	Continuing Care		CCG			NHS Community Provider	Additional CCG Contribution	Both 2017/18 and 2018/19	£884,000	£884,000	New
3	Better care at end of life	16. Other		End of life care	Social Care		Local Authority			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£50,000	£51,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	3. Rapid/Crisis Response		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,669,000	£1,669,000	Existing

Selected Health and Well Being Board:

Hillingdon

Data Submission Period:

2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to Summary sheet

Running Balances	**2017/18**	**2018/19**
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc iBCF	£0	£0
CCG Minimum Contribution balance	£0	£0
Additional CCG Contribution balance	£0	£0
iBCF	£0	£0
Running Totals	**2017/18**	**2018/19**
Planned Social Care spend from the CCG minimum	£6,146,100	£6,263,000
Ringfenced NHS Commissioned OOH spend	£10,536,289	£10,739,622

		Expenditure													
		Scheme Descriptions Link >>													
Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
4	Integrated hospital discharge	11. Intermediate care services	1. Step down		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,603,000	£1,603,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	4. Reablement/Rehabilitation services		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,198,000	£1,198,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	4. Reablement/Rehabilitation services		Other	Third sector	Local Authority			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£29,000	£29,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	4. Reablement/Rehabilitation services		Other	Third sector	CCG			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£74,000	£74,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	4. Reablement/Rehabilitation services		Other	Third sector	CCG			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£63,000	£63,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	4. Reablement/Rehabilitation services		Other	Third sector	Local Authority			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£143,000	£143,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£2,638,000	£2,689,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£51,000	£51,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£246,000	£251,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care		Local Authority			Private Sector	Local Authority Contribution	Both 2017/18 and 2018/19	£510,000	£510,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	4. Reablement/Rehabilitation services		Other	Third sector	CCG			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£715,000	£715,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	3. Rapid/Crisis Response		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£688,000	£688,000	Existing
4	Integrated hospital discharge	6. Domiciliary care at home	1. Dom care packages		Social Care		Local Authority			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,044,000	£1,064,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	1. Step down		Other	Third sector	CCG			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£198,000	£198,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	1. Step down		Community Health		CCG			NHS Community Provider	Additional CCG Contribution	Both 2017/18 and 2018/19	£53,000	£53,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	1. Step down		Social Care		Local Authority			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£49,000	£50,000	Existing

Selected Health and Well Being Board:

Hillingdon

Data Submission Period:

2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to Summary sheet

Running Balances	**2017/18**	**2018/19**
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc iBCF	£0	£0
CCG Minimum Contribution balance	£0	£0
Additional CCG Contribution balance	£0	£0
iBCF	£0	£0
Running Totals	**2017/18**	**2018/19**
Planned Social Care spend from the CCG minimum	£6,146,100	£6,263,000
Ringfenced NHS Commissioned OOH spend	£10,536,289	£10,739,622

		Expenditure													
		Scheme Descriptions Link >>													
Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
4	Integrated hospital discharge	11. Intermediate care services	4. Reablement/Rehabilitation services		Other	Third sector	CCG			Private Sector	Additional CCG Contribution	Both 2017/18 and 2018/19	£205,711	£2,378	Existing
4	Integrated hospital discharge	11. Intermediate care services	5. Other	Continence Services	Community Health		CCG			NHS Community Provider	Additional CCG Contribution	Both 2017/18 and 2018/19	£582,000	£582,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	3. Rapid/Crisis Response		Community Health		CCG			NHS Community Provider	Additional CCG Contribution	Both 2017/18 and 2018/19	£599,000	£599,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	3. Rapid/Crisis Response		Social Care		Local Authority			NHS Mental Health	CCG Minimum Contribution	2017/18 Only	£40,000		Existing
3	Better care at end of life	16. Other		End of life care	Community Health		CCG			NHS Community Provider	Additional CCG Contribution	Both 2017/18 and 2018/19	£108,000	£108,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	4. Reablement/Rehabilitation		Other	Third sector	CCG			Private Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£289	£203,622	Existing
5	Improving care market management and development	16. Other		Care market quality support	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£168,000	£171,000	Existing
5	Improving care market management and development	16. Other		Adult Safeguarding	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£260,000	£265,000	Existing
5	Improving care market management and development	16. Other		Integrated Brokerage	Social Care		Local Authority			Local Authority	Local Authority Contribution	Both 2017/18 and 2018/19	£315,000	£315,000	New
5	Improving care market management and development	6. Domiciliary care at home	1. Dom care packages		Social Care		Local Authority			Private Sector	Local Authority Contribution	Both 2017/18 and 2018/19	£3,755,000	£3,755,000	New
5	Improving care market management and development	6. Domiciliary care at home	1. Dom care packages		Continuing Care		CCG			Private Sector	Additional CCG Contribution	Both 2017/18 and 2018/19	£251,000	£251,000	Existing
5	Improving care market management and development	8. Healthcare services to Care Homes	3. Other	Pharmacy support	Primary Care		CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£32,000	£32,000	Existing
5	Improving care market management and development	14. Residential placements	5. Nursing home		Continuing Care		CCG			Private Sector	Additional CCG Contribution	Both 2017/18 and 2018/19	£1,968,000	£1,968,000	Existing
5	Improving care market management and development	14. Residential placements	4. Care home		Social Care		Local Authority			Private Sector	Local Authority Contribution	2018/19 Only		£5,945,000	New
5	Improving care market management and development	14. Residential placements	3. Extra care		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	2018/19 Only		£41,000	Existing
5	Improving care market management and development	16. Other		Sustaining care market	Social Care		Local Authority			Private Sector	Improved Better Care Fund	Both 2017/18 and 2018/19	£4,054,178	£5,257,796	Existing
5	Improving care market management and development	8. Healthcare services to Care Homes	3. Other	Medication Administration	Primary Care		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£24,000	£24,000	Existing
5	Improving care market management and development	11. Intermediate care services	3. Rapid/Crisis Response		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£52,000	£52,000	Existing

Selected Health and Well Being Board:

Hillingdon

Data Submission Period:

2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to Summary sheet

Running Balances	**2017/18**	**2018/19**
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc iBCF	£0	£0
CCG Minimum Contribution balance	£0	£0
Additional CCG Contribution balance	£0	£0
iBCF	£0	£0
Running Totals	**2017/18**	**2018/19**
Planned Social Care spend from the CCG minimum	£6,146,100	£6,263,000
Ringfenced NHS Commissioned OOH spend	£10,536,289	£10,739,622

		Expenditure													
		Scheme Descriptions Link >>													
Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
6	Living well with dementia	16. Other		Dementia care	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£300,000	£305,000	Existing
5	Improving care market management and development	16. Other		Integrated Brokerage	Community Health		CCG			CCG	Additional CCG Contribution	Both 2017/18 and 2018/19	£62,000	£62,000	Existing
5	Improving care market management and development	14. Residential placements	6. Other	EMI Over 65 Residential	Continuing Care		CCG			Private Sector	Additional CCG Contribution	2018/19 Only		£2,913,000	Existing
7	Programme Management	7. Enablers for integration	3. Programme management		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£82,100	£84,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	1. Step down		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£3,346,000	£3,346,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	1. Step down		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£124,000	£124,000	Existing
4	Integrated hospital discharge	11. Intermediate care services	1. Step down		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£288,000	£288,000	Existing
5	Improving care market management and development	6. Domiciliary care at home	1. Dom care packages		Continuing Care		CCG			Private Sector	Additional CCG Contribution	2018/19 Only		£199,000	Existing
1	Early intervention and prevention	13. Primary prevention / Early Intervention	4. Other		Primary Care		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£56,000	£56,000	Existing
1	Early intervention and prevention	1. Assistive Technologies	5. Other		Primary Care		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£143,000	£143,000	Existing
1	Early intervention and prevention	15. Wellbeing centres			Other	Third sector	CCG			Charity / Voluntary Sector	Additional CCG Contribution	Both 2017/18 and 2018/19	£139,000	£139,000	Existing
1	Early intervention and prevention	10. Integrated care planning	1. Care planning		Primary Care		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£68,000	£68,000	Existing
5	Improving care market management and development	14. Residential placements	6. Other	Physical Disab (Under 65)	Continuing Care		CCG			Private Sector	Additional CCG Contribution	2018/19 Only		£2,370,000	Existing
5	Improving care market management and development	14. Residential placements	6. Other	Pallative Care - Residential	Continuing Care		CCG			Private Sector	Additional CCG Contribution	2018/19 Only		£509,000	Existing
5	Improving care market management and development	6. Domiciliary care at home	1. Dom care packages		Continuing Care		CCG			Private Sector	Additional CCG Contribution	2018/19 Only		£596,000	Existing
5	Improving care market management and development	14. Residential placements	6. Other	Funded Nursing Care	Continuing Care		CCG			Private Sector	Additional CCG Contribution	2018/19 Only		£3,025,000	Existing

Planning Template for BCF: due on 11/09/2017

Sheet: 4. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board:

Hillingdon

Data Submission Period:

2017-19

4. HWB Metrics

<< Link to the Guidance tab

4.1 HWB NEA Activity Plan

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 17/18	Total 18/19
HWB Non-Elective Admission Plan* Totals	**6,694**	**6,328**	**6,513**	**6,408**	**6,077**	**5,981**	**6,263**	**6,173**	**25,943**	**24,494**

Are you planning on any additional quarterly reductions?	No

If yes, please complete HWB Quarterly Additional Reduction Figures

HWB Quarterly Additional Reduction										
HWB NEA Plan (after reduction)										
HWB Quarterly Plan Reduction %										

Are you putting in place a local contingency fund agreement on NEA?	No

	2017/18	2018/19
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/contingency fund **	£4,789,539	£4,880,540

Cost of NEA as used during 16/17***	£1,490	Please add the reason, for any adjustments to the cost of NEA for 17/18 or 18/19 in the cells below
Cost of NEA for 17/18 ***		
Cost of NEA for 18/19 ***		

		Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Total 17/18
Additional NEA reduction delivered through BCF (2017/18)						
		Q1 18/19	**Q2 18/19**	**Q3 18/19**	**Q4 18/19**	**Total 18/19**
Additional NEA reduction delivered through BCF (2018/19)						
HWB Plan Reduction % (2017/18)						
HWB Plan Reduction % (2018/19)						

The CCG Total Non-Elective Admission Plans are taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level, extracted on 10/07/2017

* This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)

** Within the sum subject to the condition on NHS out of hospital commissioned services/contingency fund, for any local area putting in place a contingency fund for 2017/18 or 2018/19 as part of its BCF

*** Please use the following document and amend the cost if necessary: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577083/Reference_Costs_2015-16.pdf

4.2 Residential Admissions

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	341.6	377.8	371.7	352.7	Plan targets reflect that two new extra care sheltered housing schemes are due to open in 2018/19 comprising of 148 additional self-contained flats. Assumes no change in residential dementia, nursing and nursing dementia placements. Lower target linked to reduced number of permanent placements into long-term residential care and a reduction in the conversion of short-term residential care placements into permanent placements.
	Numerator	133	150	150	145	
	Denominator	38,930	39,705	40,354	41,117	

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2014 based Sub-National Population Projections for Local Authorities in England;
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a Residential Admissions rate for these two Health and Well-Being Boards.

4.3 Reablement

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	88.0%	93.8%	88.0%	88.0%	Denominator for 2015/16 and 2016/17 actually included all referrals to Reablement during the sample period. Target in 2017/18 reflects that out of the 70 referrals received by Reablement a month 50 will come from hospitals. The key reasons during 2016/17 why people were not home were deaths, readmissions and new reablement plans arising from changes of circumstances, e.g. escalation of need. Target assumes that joint work between
	Numerator	176	225	132	132	
	Denominator	200	240	150	150	

4.4 Delayed Transfers of Care

		16-17 Actuals				17-18 plans				18-19 plans				
		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Comments
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	625.3	1041.4	913.9	1008.1	1032.0	1013.5	966.3	934.3	1032.0	1013.7	966.0	936.0	2017/18 target reflects NHSE imposed trajectory with the additional of Q1 actual data. Provisional 2018/19 target reflects a baseline based on the 2017/18 target with the addition of 1.5% for demographic growth.
	Numerator (total)	1,452	2,418	2,122	2,377	2,433	2,390	2,278	2,236	2,470	2,426	2,312	2,269	
	Denominator	232,191	232,191	232,191	235,788	235,788	235,788	235,788	239,333	239,333	239,333	239,333	242,413	

Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+) population projections are based on a calendar year using the 2014 based Sub-National Population Projections for Local Authorities in England;
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a DTOC rate for these two Health and Well-Being Boards.

Planning Template for BCF: due on 11/09/2017

Sheet: 5. National Conditions

Selected Health and Well Being Board:

Hillingdon

Data Submission Period:

2017-19

5. National Conditions

<< Link to the Guidance tab

National Conditions For The Better Care Fund 2017-19	Does your BCF plan for 2017/18 set out a clear plan to meet this condition?	Does your BCF plan for 2018/19 set out a clear plan to meet this condition?	If the selected response for either year is 'No', please detail in the comments box issues and/or actions that are being taken to meet the condition.
1) Plans to be jointly agreed	Yes	Yes	
2) NHS contribution to adult social care is maintained in line with inflation	Yes	Yes	
3) Agreement to invest in NHS commissioned out of hospital services	Yes	Yes	
4) Managing transfers of care	Yes	Yes	

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Appendix 4

Health Impact Assessment Update

STEP A) Description of what is to be assessed and its relevance to health

What is being assessed? Please tick ✓

Review of a service ☐ Staff restructure ☐ Decommissioning a service ☐

Changing a policy ☐ Tendering for a new service ☐ A strategy or plan ✓

The Better Care Fund (BCF) Plan is a mechanism for providing better outcomes for residents and patients through closer integration between health and social care. This assessment updates that undertaken for the 2016/17 BCF plan, which was itself an update of the assessment undertaken for the original 2015/16 plan.

The focus of the 2017/19 BCF plan, as for the last two years, is the 65 and over population and there is a specific focus on:

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

The HIA that was undertaken for the 2016/17 plan still applies to the new plan and this assessment focuses on the changes for 2017/19. There are six schemes within the 2017/19 BCF plan and these are:

- ***Scheme 1*** - Early intervention and prevention.
- ***Scheme 2*** - An integrated approach to supporting Carers.
- ***Scheme 3*** - Better care at end of life.
- ***Scheme 4*** - Integrated hospital discharge.
- ***Scheme 5*** - Improving care market management and development.
- ***Scheme 6*** - Living well with dementia

Appendix 1 provides a summary of each of the schemes, but the key developments under the proposed plan are:

- ***The Council giving full consideration to its involvement in the Accountable Care Partnership (ACP)*** - Establishing the business case for the Council joining the ACP.

- ***Developing a single point of access for older people (scheme 1)*** - Bringing services together into a single service with a single point of access has proved successful for Carers in Hillingdon.

- ***An integrated approach to supporting Carers (scheme 2)*** - Implementing NHSE's integrated approach to assessing Carer health and wellbeing. The plan looks at identifying 'hidden' and 'young' Carers and the provision of support and break opportunities. It is also covers the development of self-help options such as self-assessment and improving support to Carers of people admitted to hospital.

- ***Getting hospital discharge right (scheme 4)*** - The plan is proposing to bring together the various services involved in facilitating discharge from hospital into the community, e.g. Homesafe, Rapid Response, Reablement, the Night Sitting Service and Prevention of Admission/Readmission to Hospital Service (PATH) into a single, integrated hospital discharge service delivered by a lead provider within the ACP.

- ***Exploring use of Disabled Facilities Grant flexibilities*** - Developing a business case to use flexibilities to address anticipated needs and support hospital discharge, e.g. home/garden clearance, home deep cleaning, home fumigation, furniture removals to set up micro-environment, etc;

- ***Joint market management and development approach (scheme 5)*** - With the objective of ensuring the supply of sufficient quality providers to meet demand, this area represents potential step-change for Hillingdon. It includes:
  - Development of all age, joint brokerage arrangements for homecare, short and long-term nursing home placements and Direct Payments and Personal Health Budgets as a pilot;
  - Commissioning of integrated homecare provision in 2017/18;
  - Commissioning of integrated palliative care at home provision in 2017/18;
  - Development of an integrated commissioning model for nursing home placements from 2019/20;
  - Supporting care homes - This links to the Improving health in care homes programme but also includes converting spot purchase arrangements into block contracts to guarantee capacity for local authority placements.

- ***Closer alignment between Adult Social Care and Care Connection Teams*** - Allocating social care staff to Care Connection Teams supporting extra care schemes.

- ***Development of specialist Dementia Resource Centre (DRC)*** - Maximising benefits from purpose-built DRC at Grassy Meadow Court extra care scheme.

What is the lead organisation for the service to be assessed? EG Hillingdon CCG or London Borough of Hillingdon

The plan is jointly led by HCCG and Hillingdon Council (LBH)

Who is accountable for the service? E.g. Head of Service or Corporate Director

Chief Operating Officer, HCCG
Corporate Director of Adults and Children and Young People's Services, LBH

Date assessment completed and approved by accountable person

Date assessment completed: 25th August 2017
Date assessment approved:

Names and job titles of people carrying out the assessment

Gary Collier - Health and Social Care Integration Manager, LBH/HCCG
Graham Hawkes - CEO, Hillingdon Healthwatch
Jane Walsh - Older People's Commissioner, HCCG

A.1) What are the main aims and intended benefits of what you are assessing?

By 2019/20 we expect to have in place a model of care and supporting enablers:

- Where residents have easy access to information and advice about services, including care and support services;
- That has a focus on improving health outcomes for residents with one or more health conditions or care needs, a personalisation of service provision and a collaborative approach between providers;
- Where there is systematic early identification of susceptibility to disease or exacerbation in the population, alongside integrated management of conditions and a consistent approach to care provision;
- Where better coordination of services are configured around Hillingdon's residents, including a much stronger focus on case management and prevention and integration of health and social care;
- Where residents and carers are actively involved in the planning of their care and recognised as expert partners in care;
- Enablement of self-care and preventative services and promotion of independence for as long as possible
- Where people are only admitted to Hillingdon Hospital when they are acutely ill;
- Where a hospital admission is necessary and unavoidable their lengths of stay are reduced;
- That enables people to be treated at or close to their home wherever possible;
- A reduction in the number of people living in residential care;
- The most effective use of health and care resources is made to achieve best

value for the Hillingdon £ by allowing for a flexible use of collective resources and reduction in transaction costs; and
- Enablers such as IT interoperability, development of a sustainable workforce and a vibrant market offering residents/patients quality choices.

The key benefits of the plan are:

a. A reduction in the number of non-elective admissions (NELs) attributed to the 65 and over population by 975 during 2017/18. This is a contribution to the overall CCG target for 2017/18;
b. A reduction in the number of permanent admissions of older people (65 + and over) to care homes, per 100,000 population;
c. Increase in the proportion of older people (65 + and over) who were still at home 91 days after discharge from hospital into reablement services;
d. Reduction in delayed transfers of care (delayed days) from hospital per 100,000 population (18 +).

A.2) Who are the service users or staff affected by what you are assessing?

The service users, residents and patients affected by the BCF Plan are Hillingdon's 65 and over population and their Carers. People affected would also include adults with learning disabilities and adults living with mental health conditions who are living in a supported living environment or who could benefit from this model.

There are some services included within the plan that are intended to address need irrespective of age, e.g. community equipment and homecare.

A.3) Who are the stakeholders in this assessment and what is their interest in it?

Stakeholders	Interest
Residents and patients	People directly affected by the Plan
Carers	People directly affected by the Plan
Hillingdon Health and Care Partners	Involved in delivery of the schemes
Third sector (voluntary and community)	Involved in delivery of the schemes

A.4) Which health-related issues are relevant to the assessment? ✓ in the box.

Employment or financial well-being	✓	Self-care	✓
Access to healthcare (primary, secondary, specialised)	✓	Social inclusion	✓
Environmental exposures (e.g. noise, air quality, green space)		Mental wellness	✓

Lifestyle (e.g. diet, physical activity, smoking, alcohol)	✓	Health inequalities	✓
Infectious disease	✓	Community Safety (eg crime, road safety, defensible space)	
Scope of health care services	✓	Other – please state	

STEP B) Consideration of information; data, research, consultation, engagement

B.1) Consideration of information and data - what have you got and what is it telling you?

Overview

The 65 + population accounted for 42% of all non-elective admissions in 2016/17 and 58% of the non-elective health spend. In 2016/17 34% of emergency admission spend was on the 80 and over population, which accounted for nearly 23% of admissions. It is estimated that 28% of admissions for the 80 and over population group were avoidable or deferrable, which is based on the proportion of admissions resulting in a length of stay of between 0 and 1 days.

Population 65 +

Hillingdon's Joint Strategic Needs Assessment (JSNA) shows that in 2017 there are a total of 40,355 people over the age of 65 in Hillingdon, out of which 40,355 (46%) are men, and 21,881 (54 %) are women. Older People's (65+) population is predicted to increase by 6% (2,470) by 2020 and 10% (4,440) by 2022.

Population 85 +

The projected overall increase in the population of persons aged 85+ is 8% in the next five years compared with 5% in Hillingdon's total population. Currently, the total number of people aged 85+ is 5,616, out of which 2,172 (39%) are men and 3,444 (61%) are women.

Population 65 + and Ethnicity

A key feature of Hillingdon's demography is that ethnic diversity is concentrated in the younger age groups. For each of the five year age bands for people aged 65 and over there is an increasing proportion of White British. It is expected that the lack of diversity within these older age groups will change over the coming decades as the younger age groups grow older.

Long-term Conditions

It is estimated that 2% of the most complex patients (all ages), e.g. people living with two or more long-term conditions, comprise 16.2% of CCG spend. 57% of these

complex patients are people aged 65 and over; 35% are aged 75 and over and 14% aged 85 and over. In 2016/17 the local health spend on people aged 65 and over living with multiple health conditions was £9.1m.

Within the next 5 years, there is a projected increase of 9% in the number of people aged 65 and over with a limiting long-term illness. This figure is slightly higher than the projections for Ealing and the London region, but close to the percentage increases projected for Hounslow and Harrow. Overall Hillingdon has the highest projected increase in relation to the London region and the forenamed neighbours.

The latest official data on dementia prevalence data (Joint Commissioning Panel for Mental Health, 2013) suggests that at mid-year 2014 there were 2,574 people in the borough living with dementia. This is projected to grow by 13.5% to 2,975 by 2021. The Projecting Older People's Population Information (POPPI) service developed by the Institute of Public Care (IPC) in partnership with Oxford Brookes University suggests that there are currently 2,670 people living with dementia and predicts an increase of 12% to 3,037 by 2020. The dementia diagnosis rate increased to 69.3% in Hillingdon at the end of 2016/17 compared to 41% in 2014/15.

The Royal Society of Psychiatrists' 2009 study *Dementia and People with Learning Disabilities: Guidance on the assessment, diagnosis, treatment and support of people learning disabilities who develop dementia* shows that there is an increased susceptibility amongst this population group to develop dementia once they reach the age of 50. The following figures suggest that the risk is up to four times greater than the general population:

- 1 in 10 of those aged 50 to 64
- 1 in 7 of those aged 65 to 74
- 1 in 4 of those aged 75 to 84
- Nearly three-quarters of those aged 85 or over.

Research undertaken in partnership with the Alzheimers' Society estimates that 1 in 10 people with a learning disability will go on to develop dementia between the ages of 50 and 65 and approximately 50% of those aged 85 and over. For people living with Down's syndrome 1 in 50 are estimated to develop dementia in their 30s and 50% of those aged 60 and over will develop it. The Projecting Adult Needs and Service Information (PANSI) suggests that there are currently 5,393 adults in Hillingdon with a learning disability and that this will increase by 6% to 5,749 in the period up to 2020. There are approximately 117 people who have Down's syndrome in Hillingdon.

POPPI projections suggest that the number of people aged 65 and over with a body mass index of 30 + was 10,094 in 2015 and that this will increase by 8% to 10,943 by 2020. The numbers of older people living with types 1 & 2 diabetes are projected to increase by nearly 10% from 4,805 in 2015 to 5,307 in 2020.

Stroke

In 2013/14 there were 3,246 people who had been diagnosed with a stroke in Hillingdon. In the same period there were 310 admissions recorded on the Sentinel Stroke National Audit Programme. Atrial fibrillation is a known risk factor for stroke.

The diagnosed prevalence in Hillingdon is 1.1% and the estimated prevalence is 2.0%. There could be an additional 2,500 people with undiagnosed atrial fibrillation in Hillingdon.

Falls and Fractures

The consequences of falls have a significant impact on both NHS and social care services. Falling can precipitate loss of confidence, the need for regular social care support at home, or even admission to a care home. Fractures of the hip require major surgery and inpatient care in acute and often rehabilitation settings, on-going recuperation and support at home from NHS community health and social care teams. In addition, hip fractures are the event that prompts entry to a care home in up to 10% of cases. Indeed, fractures of any kind frequently require a care package for older people to support them at home.

In the UK, 35% of over-65s experience one or more falls each year. About 45% of people aged over 80 who live in the community fall each year. Between 10% and 25% of such fallers will sustain a serious injury.

In 2016/17 there were 816 falls-related admissions to Hillingdon Hospital at a cost of £2.8m.

Life Expectancy

The latest data (2013-15) shows that a male child born in Hillingdon can expect to live for 80.4 years and females for 83.7 years, which is higher than the England average (79.5 years for males and 83.1 for females). Life expectancy in Hillingdon is estimated at 79.4 years for males and 83.5 years for females (data from 2008-12). This is similar to the averages for London and England & Wales. Men in Hillingdon aged 65 now can expect to live to the age of 84.3 years and females 86.4 years.

There are inequalities within the Borough at ward level. The gap in male life expectancy between Eastcote and East Ruislip and Botwell is 6.7 years and the gap in female life expectancy between Eastcote & East Ruislip and Botwell is 8.5 years.

Sedentary Lifestyle

Health Survey for England 2008 Volume 1 Physical activity and fitness shows that approximately 50% of Hillingdon's population aged 65 - 74 year olds spend 6 or more hours sedentary time per day during the week and over 50% at weekends. For the over 75s it is 62% for both week days and at weekends.

Older People Living Alone

The 2011 census identified that 31% of older people lived alone. Projections from the Projecting Older People Population Information System (POPPI) suggest that by 2020 36% (15,580) of the 65 and over population will be living on their own and 64% (9,980) of this number will comprise of people aged 75 and over.

The study *Preventing Suicide in England - a cross-governmental outcomes strategy*

to save lives (DH 2012) shows that living alone and becoming socially isolated and experiencing bereavement are contributory factors that can lead to suicide. Available figures show that the number of suicides amongst the 65 + age group in Hillingdon is small, e.g. 5 in 2010, 4 in 2011 and 3 in 2012, but they predominantly occur amongst men.

Extra Care Sheltered Housing

Two extra care sheltered housing schemes for the 55 and over population comprising of 95 self-contained flats for rent were opened in 2011 and 2012 respectively. These are Cottesmore House and Triscott House. Two further schemes comprising of a total of 148 self-contained flats are due to open in 2018. Two new schemes totalling an additional 148 self-contained flats, Grassy Meadow Court and Park View Court, are due to open in June and September 2018 respectively.

Consultation

B.2) Did you carry out any consultation or engagement as part of this assessment?

Please tick ✓ NO ☐ YES ✓

If Yes, what did you do or are planning to do? What were the outcomes?

The timescale for delivering the HIA did not permit consultation with a wide group of patients, residents and other stakeholders. However, the following stakeholders were invited to comment on the draft assessment:

- Kevin Byrne - *Head of Health Integration and Voluntary Sector Partnerships*
- Sally Chandler - *CEO, Hillingdon Carers*
- Claire Eves - *Operational Head of Hillingdon Health Care Partnership*
- Julian Lloyd - *CEO, Age UK Hillingdon*
- Jo Manley - *Hillingdon ACP Programme Director*
- Kam Rai - *Deputy Borough Director, CNWL*
- Shikha Sharma - *Consultant in Public Health*

B.3) Provide any other information to consider as part of the assessment

MTFF/QIPP context

The Council is required to find £15m of savings in 2017/18 and an equivalent amount in 2018/19.

HCCG's two year financial plan for 2017/19 identified a requirement to generate gross savings of £16.8m in 2017/18 with a further £11.2m in 2018/19.

National Policy Context

The Better Care Fund has been introduced as part of national policy as a tool to

implement the new general duty under the 2014 Care Act to integrate services between health and social care. The intention behind integration is to achieve efficiencies through better coordination and provide patients and residents with an improved experience of care and support. In the 2015 Autumn Statement the Government announced its intention that the BCF would be the mechanism to deliver full integration between health and social care by 2020.

A further objective is that there are timely and appropriate interventions by the statutory agencies working with primary care and the third sector to prevent non-elective attendances at A & E that are avoidable as well as avoidable hospital admissions. Integration through the BCF is also intended to be used as a mechanism for preventing escalation in the needs of older people that result in a loss of independence and the need for more expensive forms of intervention by health and social care.

Hillingdon's plan has been drafted in accordance with the requirements of the *Integration and Better Care Fund Policy Framework 2017/19* (DH March 2017) and the *Integration and Better Care Fund Planning Requirements for 2017/19* (NHSE July 2017)

Local Policy Context

The Better Care Fund plan is key to the delivery of the aspects of Hillingdon's Sustainability and Transformation Plan that are dependent on integration between health and social care or closer working between the NHS and the Council for delivery. It also contributes to the delivery of the statutory Joint Health and Wellbeing Strategy. It enables HCCG and the Council, as well as other statutory partners to meet integration requirements contained within the 2012 Health and Social Care Act.

C) Assessment

What did you find in B1? Who is affected? Is there, or likely to be, an impact on certain groups?

C.1) Describe any **NEGATIVE** impacts (actual or potential):

Health-related issues	Impact on this issue and actions you need to take
Employment or financial wellbeing	The 2017 assessment review confirmed that there were no negative impacts on this health-related issue arising from the proposed 2017/19 plan. The potential negative impact on staff as a result of the development of further integration options (structural as well as functional) that apply under proposals contained within scheme 4: *Integrated hospital discharge* will be mitigated through the application of good employment practice procedures.

	The seven day working requirements under national condition 4: *Transfers of care* could also result in staff coming under pressure, real or perceived, to work extended hours to ensure that services are available. This issue was identified in the assessment of the 2016/17 plan and will continue to be mitigated, once again, through the application of good employment practice procedures.
Access to healthcare	Assessments of earlier iterations of the BCF plan considered whether the BCF Plan would lead to resources being diverted from other user groups. There has been no evidence of this in 2015/16 or 2016/17. In 2017/19, as in previous years, much of the investment going into the pooled budget is committed to existing contracts and this militates against this eventuality. Additional demands on health services could arise from the pro-active early identification work proposed to be undertaken as part of *scheme 1: Early intervention and prevention*. The compensation for this is the potential for avoiding or delaying increased costs as a result of a more anticipatory model of care. The assessment team identified a potential concern about clinical treatment decisions being influenced negatively by the early identification of a person as being within the last year of life. This is again militated by the benefits of early identification for enabling advanced planning to take place and therefore reducing the likelihood of crisis situations occurring that will inevitably be distressing for everyone involved. *Scheme 5: Improving care market management and development* - This includes the development of wrap-around services to support the independence of residents in supported living schemes, such as extra care sheltered for older people, could result in initial cost pressures. The scheme also includes a similar approach with care homes. It is expected that any financial outlay will be matched by reductions in A & E attendances and emergency admissions. The outcomes of the scheme both in terms of resource outlay and reductions in avoidable demand on hospital resources will be monitored and reported to Governing Body and the Health and Wellbeing Board. The Plan is aligned with the key integration enablers such as care and support planning being delivered by the GP Confederation, shifting to planning for anticipated needs with GPs as lead professional. This will result in more services being delivered from local GP practices and may create access issues for some people who might otherwise have gone to Hillingdon Hospital. However, the compensation is the probable increased access and convenience that there will be for others as a result of health services being delivered closer to home. For

	those for whom transport may be an issue this is being addressed through amendments to provider contracts to ensure that patient transport is provided where needed. The current issue with access to transport for people attending medical appointments should be addressed once the new contract starts.
Self-care	The assessment team acknowledged a point made during the assessment for the 2016/17 plan that people with capacity had the right to make 'bad' decisions and that a continuing objective of the plan was to ensure that people had access to information and support to enable them to make informed decisions. The assessment team did identify services provided to people as under discharge to assess (D2A) arrangements could create unrealistic expectations. This would be mitigated by the provision of improvements in the information made available post-admission to patients and their families. Addressing this issue is included in the Delayed Transfers of Care Action Plan (see **Annex 1** of the submission documents).
Social inclusion **Mental wellness** **Lifestyle** **Infectious disease**	No negative impacts were identified from the six schemes within the 2017/19 plan on these health-related issues by the assessing team. However, the importance of H4All Wellbeing Service and third sector consortium partners managing flow through services, including managing dependency and associated service capacity was acknowledged. This will be kept under review through the Wellbeing Service contract monitoring process.
Health inequalities	The assessment team noted that the basis for establishing the CCTs was on GP registered population rather than disease/condition prevalence, which could consequently lead to variable impact on the capacity of the teams dependent on geographical location. However, it was recognised that the CCTs were a new concept for Hillingdon and that their composition would be reviewed once data was available following full implementation in 2017/18 and into 2018/19.
Scope of healthcare services	The proactive approach to identification of need required under *schemes 1 and 2 - An integrated approach to supporting Carers,* may lead to the identification of health needs for which the appropriate services may not currently be in place and which may therefore have additional resource implications. 2016/17 has seen additional service requirements of a preventative nature being identified and both the H4All Wellbeing Service and Hillingdon Carers' Partnership have pursued innovative ways of addressing these both with the support of other H4All consortium members and through attracting external funding.

	The individual benefits of the schemes versus additional resource requirements will be kept under review as part of the BCF monitoring process.

C.2) Describe any **POSITIVE** impacts

The assessing team felt that the comments raised as part of the 2015/16 plan assessment were still valid. Additions have been made to those comments where the team felt that this was appropriate in view of the content of the 2016/17 proposed plan.

Health-related issues	**Impact on this issue and actions you need to take**
Employment or financial well-being.	Scheme 5 - The use of the Improved Better Care Fund Grant (IBCF) to fund a requirement that agencies on the homecare Dynamic Purchasing System (DPS) pay their workforce the equivalent of the London Living Wage will help to sustain the financial wellbeing of care workers. This will assist in ensuring market capacity and service quality that will have implications for admission avoidance as well as preventing delayed transfers of care attributed to the absence of a package of care reason. Most of all, it should improve the resident's experience of care. *Scheme 1* - Should lead to early identification of Carers who may be in employment and provision of timely support following a Carer's assessment may enable them to continue in employment for longer with the benefits as described above. *Schemes 1 and 6*: Living well with dementia - Early identification of people living with dementia and their Carers may help to ensure early access to appropriate treatments that may enable them to retain employment longer.
Access to healthcare	*Scheme 1* - As with the 2016/17 plan the early identification of people at risk of falls, dementia and/or social isolation will ensure timely access to appropriate healthcare as well as other care and support services. This will allow for more effective care planning where required and prevent deterioration in need that can lead to a loss of independence and more expensive healthcare interventions. The Care Connection Teams (CCTs) will have a critical role in delivering this at a GP surgery level. *Scheme 3: Better care at end of life* - This will support people to die in their preferred place of care, which is generally at home. As well as being a more comforting

	environment for the person in the last days of their life (as well as their family). The scheme will lead to a more effective coordination of the required services. *Scheme 1* - This should result in the health needs of residents being addressed at a more local level. Taken in conjunction with the other schemes within the BCF Plan and other integrated care system enablers such as improved care planning, care navigation and multi-disciplinary team working, the result should be a more efficient use of resources. *Scheme 5*: *Improving care market management and development* - The creation of a dedicated social care resource to support extra care and link in with the CCTs will help to ensure timely access to appropriate healthcare services. The wrap-around primary care service proposals also support this.
Self-care	*Schemes 1, 2, 3* and 4 promote self-care as a means of putting individuals more in control of managing their own health and care needs, thus preventing or delaying a escalation in their needs and the loss of independence that can arise from this. The H4All Wellbeing Service should have an increasingly significant impact in empowering people to take more control and navigate the health and care system in a better way.
Social inclusion	*Scheme 1* - The implementation of the CCTs across the borough creates an opportunity to identify people who are either socially isolated or at risk of social isolation and through the H4All Wellbeing Service present them with options to engage with their local communities. This could include opportunities to volunteer with third sector organisations.
Mental wellness	*Scheme 1* - Early identification of those living with dementia can help to ensure timely access to treatment that may arrest the progress of the condition. Access to advice about changes in lifestyle habits that may contribute to and/or accelerate progress of the condition could also have the same effect. Engaging with people who are socially isolated can help prevent adverse health impacts, such as depression, that can also lead to other physical health problems. *Scheme 2*: Better management of the end of life pathway should relieve some of the stress experienced both by the

	person at the end of their life and also their family. The study *Preventing Suicide in England - a cross-governmental outcomes strategy to save lives* (DH 2012) shows that living alone and becoming socially isolated and also bereavement are contributory factors in leading to suicides. Living with a long-term condition is also a contributory risk factor. Available figures show that the number of suicides amongst the 65 + age group is small, e.g. 5 in 2010, 4 in 2011 and 3 in 2012, and these predominantly occur amongst men. *Schemes 1, 2* and *8* in particular would seek to address some of the issues that can lead to suicide.
Lifestyle	*Schemes 1, 2 and 4* will identify particular lifestyle issues, e.g. diet, smoking, alcohol abuse, through visits to patients' homes. The result will be referrals to appropriate professionals and/or third sector organisations to provide advice and support.
Infectious disease	Key objectives of the BCF Plan are to prevent non-elective admissions and to reduce Length of Stay (LOS) in the event of an admission. Achieving this will help to prevent the risk of hospital acquired infections. *Scheme 5* - Support provided to care homes should help to improve standards and reduce the number of care home acquired infections acquired by residents that can lead to hospital admission and a rapid deterioration in mental wellbeing as well as physical health. It was also noted that the DPS homecare specification jointly developed between health and social care and contained much more explicit provisions concerning infection control that reflected the content of the pan-London NHS any qualified provider (AQP) domiciliary care specification.
Health inequalities	The BCF Plan seeks to address health inequalities faced by Hillingdon's more vulnerable older population. However, given the disparity in social and economic wellbeing between older people in the north of the borough and those in the relatively more deprived, more culturally diverse wards in the south, particular consideration will have to be given as to how communities will be accessed. It is envisaged that this will be accomplished by close working with faith and other community-based groups. The provision of Personal Health budgets for people meeting Continuing Health Care (CHC) thresholds and Personal Budgets for people meeting the National Adult

	Social Care eligibility criteria provides opportunities for a more personalised approach to addressing need that would reflect cultural and religious diversity. Promotion of Personal Health Budgets is addressed within *scheme 5* of the plan. Proposals within *scheme 6* of the plan to provide wrap-around support for supported living schemes will also help to address health inequalities experienced by people with learning disabilities and people living with mental health conditions as well as maximising their independence within the least restrictive care setting.

D) Conclusions

The assessment has shown that the health implications of the 2017/19 BCF Plan are overwhelmingly positive for the residents of Hillingdon, which should consequently result in financial benefits for the local health and social care economy.

The assessment also identified that there may be access issues for some residents, as more health services are delivered locally from GP practices. The conclusion was that more people were likely to benefit from local provision and that individual solutions would need to be identified to address the needs of those who are disadvantaged. Transport-related access issues identified as part of the 2016/17 assessment are still current but should be addressed once the new NHS transport contract is implemented.

Key areas that need further consideration are:

- The impact of any functional or structural changes arising from the integrated hospital discharge proposals on staff, including seven day working, will be managed through the application of good employment practices.
- The suitability of existing services to meet the needs of people identified from the more proactive case finding approach set out in *scheme 1*.
- Patient expectations regarding service provision as a result of the D2A model, which can be managed through appropriate information provision.
- Impact of the CCTs being established on the basis of registered population rather than disease/condition prevalence, which will be reviewed when data becomes available as the teams become more established.

The impact of all of the schemes will be monitored as part of the governance process for the BCF Plan.

Signed and dated:……..

Name and position:……

Appendix 1

BCF Scheme Summaries

Scheme Number	Scheme Title	Scheme Aim(s)
1.	Early intervention and prevention.	To manage demand arising from demographic pressures by reducing the movement of Hillingdon residents/patients from lower tiers of risk into higher tiers of risk through proactive early identification and facilitating access to preventative pathways.
2.	An integrated approach to supporting Carers.	To maximise the amount of time that Carers are willing and able to undertake a caring role.
3.	Better care at end of life.	To realign and better integrate the services provided to support people towards the end of their life in order to deliver the ethos of a 'good death.' The main goals of the scheme are to: • Ensure that people at end of life are able to be cared for and die in their preferred place of care; and • To ensure that people at end of life are only admitted to hospital where this is clinically necessary or where a hospital is their preferred place of care or death.
4.	Integrated hospital discharge.	This scheme seeks to prevent admission and readmission to acute care following an event or a health exacerbation and enabling recovery through intermediate care interventions with the aim of maximising the person's independence, ability to self-care and remain in their usual place of residence for as long as possible. A further objective of this scheme is to support discharge from mental health community beds in recognition of the impact of these delays on patient flow through Hillingdon Hospital.
5.	Improving care market management and development.	This scheme is intended to contribute to the STP 2020/21 outcomes of achieving:

		• A market capable of meeting the health and care needs of the local population within financial constraints; and • A diverse market of quality providers maximising choice for local people.
6.	Living well with dementia	The objective of this scheme is that people with dementia and their family carers are enabled to live well with dementia and are able to say: • *I was diagnosed in a timely way.* • *I know what I can do to help myself and who else can help me.* • *Those around me and looking after me are well supported.* • *I get the treatment and support, best for my dementia, and for my life.* • *I feel included as part of society.* • *I understand so I am able to make decisions.* • *I am treated with dignity and respect.* • *I am confident my end of life wishes will be respected. I can expect a good death.*

Appendix 5

Equality Impact Analysis Update: Better Care Fund Plan 2017/19

Equality Impact Analysis is the method used by the Hillingdon Clinical Commissioning Group (HCCG) and Hillingdon Council (LBH) to demonstrate that it is giving due regard to equality when developing and implementing changes to services, strategy, policy and/or practice.

The purpose of this equality analysis is to:

1. Identify unintended consequences and mitigate them as far as is possible,
2. To actively consider how the CCG and LBH can support the advancement of equality and fostering of good relations
3. Reduce health inequalities across the Borough of Hillingdon

Section 1: General information
Background: The Better Care Fund (BCF) Plan is a mechanism for providing better outcomes for residents and patients through closer integration between health and social care. This assessment updates the one undertaken for the 2016/17 BCF plan, which updated the assessment undertaken in respect of the first plan for 2015/16. The focus of the 2017/19 BCF plan, as for the last two years, is the 65 and over population and there is a specific focus on: • All of Hillingdon's residents aged 85 and over • Frail older people aged 75 and over with two or more conditions • Older people who are at risk of dementia • Older people who are at risk of falling for a first time. The HIA that was undertaken for the 2016/17 plan still applies to the new plan and this assessment focuses on the changes for 2017/19. There are six schemes within the 2017/19 BCF plan and these are: • ***Scheme 1*** - Early intervention and prevention. • ***Scheme 2*** - An integrated approach to supporting Carers. • ***Scheme 3*** - Better care at end of life. • ***Scheme 4*** - Integrated hospital discharge. • ***Scheme 5*** - Improving care market management and development. • ***Scheme 6*** - Living well with dementia

Appendix 1 provides a summary of each of the schemes.

Responsible officer completing this assessment:

Gary Collier - Health and Social Care Integration Manager

Date completed:

25th August 2017

Relevant documents:

Name of document	Year	Owner(s)	Public document
Better Care Fund Plan Narrative	2017	CCG/LBH	Yes
Better Care Fund Planning Template	2017	CCG/LBH	Yes
Better Care Fund Annex 1: Delayed Transfers of Care (DTOC) Action Plan	2017	CCG/LBH	Yes

Responsible Clinical Lead

Dr Kuldhir Johal HCCG Governing Body and Older People's Model of Care Delivery Group co-chair

Supporting team

Kevin Byrne - *Head of Health Integration and Voluntary Sector Partnerships, LBH*
Nina Durnford - *Assistant Director, Older People & Physical Disabilities, LBH*
Joan Veysey - *Deputy Chief Operating Officer, HCCG*
Jane Walsh - *Older People Commissioner, HCCG*

Section 2: Data gathering

What are the aims of the policy?

By 2019/20 we expect to have in place a model of care and supporting enablers:

- Where residents have easy access to information and advice about services, including care and support services;
- That has a focus on improving health outcomes for residents with one or more health conditions or care needs, a personalisation of service provision and a collaborative approach between providers;
- Where there is systematic early identification of susceptibility to disease or exacerbation in the population, alongside integrated management of conditions and a consistent approach to care provision;
- Where better coordination of services are configured around Hillingdon's residents, including a much stronger focus on case management and prevention and integration of health and social

care;

- Where residents and carers are actively involved in the planning of their care and recognised as expert partners in care;
- Enablement of self-care and preventative services and promotion of independence for as long as possible
- Where people are only admitted to Hillingdon Hospital when they are acutely ill;
- Where a hospital admission is necessary and unavoidable their lengths of stay are reduced;
- That enables people to be treated at or close to their home wherever possible;
- A reduction in the number of people living in residential care;
- The most effective use of health and care resources is made to achieve best value for the Hillingdon £ by allowing for a flexible use of collective resources and reduction in transaction costs; and
- Enablers such as IT interoperability, development of a sustainable workforce and a vibrant market offering residents/patients quality choices.

What health and social care outcomes do HCCG and the Council hope to achieve?

a. A reduction in the number of non-elective admissions (NELs) attributed to the 65 and over population by 975 during 2017/18. This is a contribution to the overall CCG target for 2017/18;
b. A reduction in the number of permanent admissions of older people (65 + and over) to care homes, per 100,000 population;
c. Increase in the proportion of older people (65 + and over) who were still at home 91 days after discharge from hospital into reablement services;
d. Reduction in delayed transfers of care (delayed days) from hospital per 100,000 population (18 +).

Are there any factors that might prevent these outcomes being achieved?

The following are factors that could impact on these outcomes being achieved:
a. Continuing increase in the level of NEL activity;
b. Impact of severe weather;
c. Lack of suitably qualified staff;
d. Private care provider business failure.
e. Lack of available providers who can support people with complex needs.

What relevant quantitative and qualitative data do you have?

Overview

Although nearly 42% (10,049) of our non-elective activity in 2016/17 was attributed to the 65 and over population, this population group accounted for 58% (£27.3m) of the total health emergency admission spend in that year. In 2016/17 34% (£16.1m) of emergency admission spend was on the 80 and over population, which accounted for nearly 23% (5,495) of admissions in 2016/17. We estimate that some 28% (1.553) of emergency admission for the 80 and over population group were avoidable or deferrable, which is based on the proportion of admissions resulting in a length of stay of between 0

and 1 days.
Nearly 46% of the Council's gross spend on care for older people in 2016/17 was on care homes (residential and nursing). This made Hillingdon the 15th lowest in London (18 boroughs have a higher proportion spend than Hillingdon). However, the desired trajectory would be towards the 40% level, focusing on people who can be better supported in their usual place of residence.

Population 65 +

Hillingdon's Joint Strategic Needs Assessment (JSNA) shows that in 2017 there are a total of 40,355 people over the age of 65 in Hillingdon, out of which 40,355 (46%) are men, and 21,881 (54 %) are women. Older People's (65+) population is predicted to increase by 6% (2,470) by 2020 and 10% (4,440) by 2022.

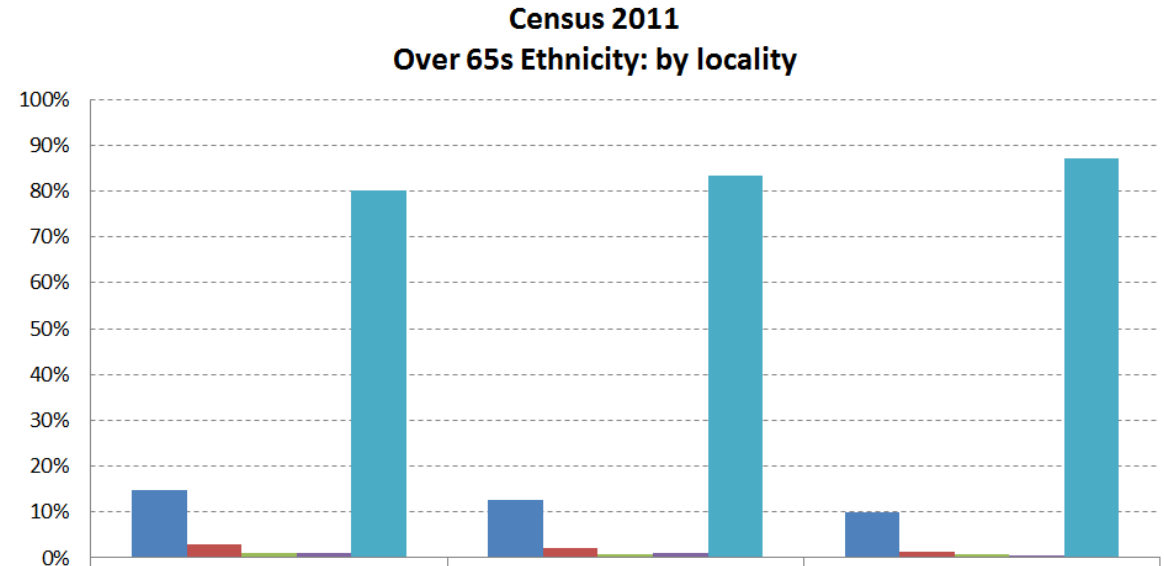
Population 85 +

The projected overall increase in the population of persons aged 85+ is 8% in the next five years compared with 5% in Hillingdon's total population. Currently, the total number of people aged 85+ is 5,616, out of which 2,172 (39%) are men and 3,444 (61%) are women.

Population 65 + and Ethnicity

A key feature of Hillingdon's demography is that ethnic diversity is concentrated in the younger age groups. For each of the five year age bands for people aged 65 and over there is an increasing proportion of White British. It is expected that the lack of diversity within these older age groups will change over the coming decades as the younger age groups grow older, but this is likely to little impact during the period of the 2017/19 BCF plan.

The graph below shows the distribution by ethnicity of Hillingdon's older people population.



	Hayes & Harlington	Uxbridge & West Drayton	Ruislip & Northwood
Asian	14.8%	12.5%	10.1%
Black	2.9%	2.2%	1.4%
Mixed	1.0%	0.9%	0.8%
Other	1.1%	0.9%	0.5%
White	80.2%	83.5%	87.2%

Long-term Conditions

It is estimated that 2% of the most complex patients (all ages), e.g. people living with two or more long-term conditions, comprise 16.2% of CCG spend. 57% of these complex patients are people aged 65 and over; 35% are aged 75 and over and 14% aged 85 and over. In 2016/17 the local health spend on people aged 65 and over living with multiple health conditions was £9.1m.

Within the next 5 years, there is a projected increase of 9% in the number of people aged 65 and over with a limiting long-term illness. This figure is slightly higher than the projections for Ealing and the London region, but close to the percentage increases projected for Hounslow and Harrow. Overall Hillingdon has the highest projected increase in relation to the London region and the forenamed neighbours.

The latest official data on dementia prevalence data (Joint Commissioning Panel for Mental Health, 2013) suggests that at mid-year 2014 there were 2,574 people in the borough living with dementia. This is projected to grow by 13.5% to 2,975 by 2021. The Projecting Older People's Population Information (POPPI) service developed by the Institute of Public Care (IPC) in partnership with Oxford Brookes University suggests that there are currently 2,670 people living with dementia and predicts an increase of 12% to 3,037 by 2020. The dementia diagnosis rate increased to 69.3% in Hillingdon at the end of 2016/17 compared to 41% in 2014/15.

The Royal Society of Psychiatrists' 2009 study *Dementia and People with Learning Disabilities: Guidance on the assessment, diagnosis, treatment and support of people learning disabilities who develop dementia* shows that there is an increased susceptibility amongst this population group to develop dementia once they reach the age of 50. The following figures suggest that the risk is up to four times greater than the general population:

- 1 in 10 of those aged 50 to 64
- 1 in 7 of those aged 65 to 74
- 1 in 4 of those aged 75 to 84
- Nearly three-quarters of those aged 85 or over.

Research undertaken in partnership with the Alzheimers' Society estimates that 1 in 10 people with a learning disability will go on to develop dementia between the ages of 50 and 65 and approximately 50% of those aged 85 and over. For people living with Down's syndrome 1 in 50 are estimated to develop dementia in their 30s and 50% of those aged 60 and over will develop it. The Projecting Adult Needs and Service Information (PANSI) service suggests that there are currently 5,393 adults in Hillingdon with a learning disability and that this will increase by 6% to 5,749 in the period up to 2020. There are approximately 117 people who have Down's syndrome in Hillingdon.

POPPI projections suggest that the number of people aged 65 and over with a body mass index of 30 + was 10,094 in 2015 and that this will increase by 8% to 10,943 by 2020. The numbers of older people living with types 1 & 2 diabetes are projected to increase by nearly 10% from 4,805 in 2015 to 5,307 in 2020.

Stroke

In 2013/14 there were 3,246 people who had been diagnosed with a stroke in Hillingdon. In the same period there were 310 admissions recorded on the Sentinel Stroke National Audit Programme. Atrial fibrillation is a known risk factor for stroke. The diagnosed prevalence in Hillingdon is 1.1% and the estimated prevalence is 2.0%. There could be an additional 2,500 people with undiagnosed atrial

fibrillation in Hillingdon.

Falls and Fractures

The consequences of falls have a significant impact on both NHS and social care services. Falling can precipitate loss of confidence, the need for regular social care support at home, or even admission to a care home. Fractures of the hip require major surgery and inpatient care in acute and often rehabilitation settings, on-going recuperation and support at home from NHS community health and social care teams. In addition, hip fractures are the event that prompts entry to a care home in up to 10% of cases. Indeed, fractures of any kind frequently require a care package for older people to support them at home.

In the UK, 35% of over-65s experience one or more falls each year. About 45% of people aged over 80 who live in the community fall each year. Between 10% and 25% of such fallers will sustain a serious injury.

In 2016/17 there were 816 falls-related admissions to Hillingdon Hospital at a cost of £2.8m.

Life Expectancy

The latest data (2013-15) shows that a male child born in Hillingdon can expect to live for 80.4 years and females for 83.7 years, which is higher than the England average (79.5 years for males and 83.1 for females). Life expectancy in Hillingdon is estimated at 79.4 years for males and 83.5 years for females (data from 2008-12). This is similar to the averages for London and England & Wales. Men in Hillingdon aged 65 now can expect to live to the age of 84.3 years and females 86.4 years.

There are inequalities within the Borough at ward level. The gap in male life expectancy between Eastcote and East Ruislip and Botwell is 6.7 years and the gap in female life expectancy between Eastcote & East Ruislip and Botwell is 8.5 years.

Sedentary Lifestyle

Health Survey for England 2008 Volume 1 Physical activity and fitness shows that approximately 50% of Hillingdon's population aged 65 - 74 year olds spend 6 or more hours sedentary time per day during the week and over 50% at weekends. For the over 75s it is 62% for both week days and at weekends.

Older People Living Alone

The 2011 census identified that 31% of older people lived alone. Projections from the Projecting Older People Population Information System (POPPI) suggest that by 2020 36% (15,580) of the 65 and over population will be living on their own and 64% (9,980) of this number will comprise of people aged 75 and over.

The study *Preventing Suicide in England - a cross-governmental outcomes strategy to save lives* (DH 2012) shows that living alone and becoming socially isolated and experiencing bereavement are contributory factors that can lead to suicide. Available figures show that the number of suicides amongst the 65 + age group in Hillingdon is small, e.g. 5 in 2010, 4 in 2011 and 3 in 2012, but they predominantly occur amongst men.

Carers

Carers are people who provide care and support to vulnerable relatives or friends for no financial payment and should not be confused with care workers, who are paid for the work they do.

The 2011 census shows that there were at least 25,702 Carers in Hillingdon; in fact, this figure was and is probably much higher when taking into consideration the fact that some people who are providing care to their partner or other relatives do not identify themselves as Carers. These 'hidden Carers' may not be accessing the support and advice that is available to them.

The table below provides a breakdown of the age of Carers as identified by the 2011 census.

Age Breakdown of Carers in Hillingdon	
Carer Age Group	**Number**
0 - 24	2,450
25 - 64	18,609
65 +	4,643
TOTAL	**25,702**

The census showed that 11,158 Carers were male and of these 2,264 were aged 65 and over. This compares to 14,544 Carers who were female, 2,379 of which were aged 65 and over.

The census also showed that 36% of the Carers aged 65 and above were providing 50 hours a week or more unpaid care and of those 17% identified themselves as having bad or very bad health.

At the end of 2016/17 there were 5,769 active Adult Carers registered with the Hillingdon Carers' Partnership, which represents nearly 23% of total Carer population in Hillingdon based on 2011 Census data. During 2016-17 there were 750 new adult referrals. At the end of 2016/17 there were also 690 Young Carers, e.g. Carers aged under 18, registered with the Partnership and of these 254 were new referrals during 2016-17.

According to estimates within the Institute of Public Care's 2009 Estimating the prevalence of severe learning disability in adults - working paper 1, there should currently be approximately 400 people living with parents and this should rise to approximately 440 in 2020. Of the 220 people with learning disabilities currently being supported by the Council who live with parents or other relatives who are identified as their main Carers. 77 of these Carers are aged 65 and over and of these 11 are aged 75 and over. This illustrates both the importance of supporting older Carers and the need to plan for a time when they will be unable to continue their caring role because of the effects of old age.

What Older People Want

The 2006 Wanless review, *Securing Good Care for Older People*, showed that only 11% of older people wished to have their care needs met in a care home should these arise, with the preferred options either being to remain in their own home cared for by relatives or friends (62%) or trained care workers (56%). An analysis of Strategic Housing Market Assessment (SHMA) surveys of over 13,500 households aged 50 and over suggests that up to 20% of all older households would consider moving to retirement housing and the application of the Retirement Housing Group (RHG) model suggests that up to 20% of people aged 75 and over would do so if it was available. The key messages from national studies are reinforced by messages received from our local older people population through fora such as the Older People's Assembly.

The review of the experience of the discharge process within Hillingdon Hospital undertaken by Healthwatch Hillingdon in 2016 called *Safely "home" to the right care: The experiences of Older People being discharged from Hillingdon Hospital and the onward care they received in the community* (HWH 2016) showed the importance of timely information about the discharge process as well as good communication and better integration and coordination between organisations and services involved in supporting people back home.

Extra Care Sheltered Housing

Two extra care sheltered housing schemes for the 55 and over population comprising of 95 self-contained flats for rent were opened in 2011 and 2012 respectively. These are Cottesmore House and Triscott House. Two further schemes comprising of a total of 148 self-contained flats are due to open in 2018. Two new schemes totalling an additional 148 self-contained flats, Grassy Meadow Court and Park View Court, are due to open in June and September 2018 respectively.

Did you carry out any consultation or engagement as part of this assessment or previously?

Yes

Who was consulted or engaged?

The following were involved in the assessment:

- Graham Hawkes - CEO, Hillingdon Healthwatch
- Jane Walsh - Older People's Commissioner, HCCG

The following partners were consulted on the content of the EIA:

- Trevor Begg - *Lay Member, HCCG Governing Body*
- Kevin Byrne - *Head of Health Integration and Voluntary Sector Partnerships*
- Sally Chandler - *CEO, Hillingdon Carers*
- Claire Eves - *Operational Head of Hillingdon Health Care Partnership*
- Julian Lloyd - *CEO, Age UK Hillingdon*
- Jo Manley - *Hillingdon ACP Programme Director*
- Kam Rai - *Deputy Borough Director, CNWL*
- Shikha Sharma - *Consultant in Public Health*
- Vicky Trott - *Equality, Diversity and Inclusion Manager, LBH*

The timescale for delivering the EIA did not permit wider consultation to be undertaken. However, the development of the 2017/19 BCF Plan is consistent with feedback from consultation previously undertaken in respect of earlier iterations of the plan. The 2017/19 plan proposals have been raised with the multi-agency Clinical Design Group, Carers' Strategy Group and the Older People's Assembly.

From the consultation what feedback did you receive?

Feedback reflected in response to analysis of impact on protected characteristics.

What changes have been made as a result of the feedback you have received?

Feedback reflected in response to analysis of impact on protected characteristics.

Section 3: Impact

Consider the information gathered in section 2 of this assessment form and assess:

1. Where you think that the strategy could have a **NEGATIVE** impact on any of the equality groups, i.e. it could disadvantage them

2. Where you think that the strategy could have a **POSITIVE** impact on any of the equality groups like promoting equality and equal opportunities or improving relations within equality groups

3. Where you think that this strategy has a **NEUTRAL** effect on any of the equality groups listed below i.e. it has no effect currently on equality groups.

The assessing team felt that the comments raised as part of the 2016/17 plan assessment were still valid. Additions have been made to those comments where the team felt that this was appropriate in view of the content of the 2017/19 proposed plan.

Do you think that the policy impacts on people because of their **age?**

1. Age	Positive	Negative	Neutral	Reasons for your decision
Young (Children and young people, working age)	√			Although the focus of the BCF Plan is older people the introduction in 2017/18 of an integrated, all age home care dynamic purchase system (DPS) will benefit younger people. The needs of Carers aged under 60 are considered under equalities characteristic 2: Carers.
Older (Working age, 60+, and retirement age)	√			The key objective of the BCF Plan is to keep older people out of hospital or ensure a reduction in length of stay where an admission is unavoidable. The plan seeks to promote independence and maximise the quality of life for Hillingdon's older people population. However, the intention behind scheme 3 is embed the principle of a good death where older people are at the end of life.

Do you think that the policy impacts on **Carers**? (e.g. adults providing care for other adults free of charge or people aged under 18 caring for another person free of charge)

2. Carers	Positive	Negative	Neutral	Reasons for your decision
	√			The BCF Plan recognises the importance of supporting Carers and the majority of the resources committed under *scheme 2* are

				dedicated to that purpose. The following summarises other key benefits for Carers deriving from the schemes: • *Scheme 1* - Early identification and case management support empower Carers to make informed choices, thus preventing decisions being made in crisis situations; • *Scheme 1* - Carers should experience a more seamless service as a result of the more widespread use of care planning and effective, joined up use of services to address needs; • *Scheme 3* - Better end of life management helps to reduce stress for the Carer and provides continuing support on the passing of the person at end of life, therefore helping to address their mental wellbeing; • *Scheme 4* - Short term post discharge support from professionals and/or third sector will provide assurance for Carers and help to build their confidence about being able to manage the needs of the person they are caring for; • *Scheme 4* - By ensuring steady flow of activity should reduce readmissions and the stress that this can cause to Carers; • *Scheme 6* - Carers should benefit from the development of the Dementia Resource Centre.

Do you think that the policy impacts on people with a **disability?**

3. Disability	**Positive**	**Negative**	**Neutral**	**Reasons for your decision**
Visually impaired	√			All schemes should have a positive impact on people with sensory impairments and physical disabilities through early identification of residents/patients at risk of moving from lower tiers of risk into higher tiers of risk and facilitating access to preventative pathways (*scheme 1*); possible early provision of major adaptations to address anticipatory needs could improve quality of life for people facing predictable escalation of physical needs (*scheme 1*); provision of rehabilitation and reablement for those experiencing an acute episode (*scheme 4*); reducing length of stay and therefore avoiding hospital acquired infections (*scheme 4*); supporting people locally with an integrated response to their health and wellbeing needs (*scheme 5*);
Hearing impaired	√			
Physically disabled	√			

				preventing admission to hospital from care homes where residents experience an exacerbation by providing professional clinical support to care home staff (*scheme 5*); promoting greater independence in the least restrictive care setting through the development of supported living models with appropriate wrap-around care and support provision (including medical) (*scheme 5*); and addressing safeguarding issues and effectively managing the provider market (*scheme 5*).
Learning disability	√			*Schemes 1 and 4* could lead to the identification of older people with learning disabilities not known to services, i.e. people with learning disabilities from Black, Asian and minority ethnic communities, where there can be stigma attached to having this type of disability. A key benefit to this user group will come under *scheme 2* through identification and the provision of support to older Carers. The susceptibility of people with learning disabilities to develop dementias at a much younger age than the general population will be addressed through *scheme 6*. *Scheme 5* will have a positive effect by ensuring the sustainability of extra care as an alternative to residential care for older people with learning disabilities.
Mental health	√			*Schemes 1 and 6* - Early identification of people living with dementia can help to ensure timely access to treatment that may arrest the progress of the condition. Access to advice about changes in lifestyle habits that may contribute to and accelerate progress could also have the same effect. Engaging with people who are socially isolated can help prevent adverse health impacts, such as depression, that can also lead to other physical health problems. *Scheme 3* - Better management of the end of life pathway should relieve some of the stress experienced both by the person at the end of their life and also their family. *Schemes 1 and 3* in particular would seek to

				address some of the issues that can lead to suicide. The support to Carers deriving from *scheme 2* should help to address stress and anxiety that they face as a result of their caring role. The specific dementia scheme is intended to address the needs of people will organic mental health conditions to maximise their independence for as long as possible. *Scheme 5* seeks to ensure the availability of appropriate care home provision to meet the needs of people with more complex needs, including challenging behaviours.
Other (HIV positive, multiple sclerosis, cancer, diabetes, epilepsy)	√			Risk stratification that is reflected in *scheme 1* will identify people with long-term conditions and ensure that they are linked into the appropriate CCT, which should ensure access to appropriate treatment and information and advice about self-care. This means that the plan as a whole should have a beneficial impact.

Do you think that the policy affects **men and women** in different ways?

4. Gender	Positive	Negative	Neutral	Reasons for your decision
Male	√			As men tend to be more reticent about discussing health needs or problems, *scheme 1* has the potential to be of particular benefit to them.
Female	√			More women than men are likely to benefit from the BCF plan but this is largely due to the fact that they live longer rather than there being anything intrinsically discriminatory about the nature of the schemes.

Do you think that the policy impacts on people because of their **Gender identity (e.g. People in pre or post operation stage and/or where a person/s identify themselves as one gender but require access to their biological gender?**

5. Gender Identity	Positive	Negative	Neutral	Reasons for your decision
Pre operation	√ Scheme 1		√ Other Schemes	*Scheme 1* may have a positive impact by identifying older people whose social isolation may relate to their gender identity but other

				schemes are considered to be neutral at this stage.

Do you think that the policy impacts on people because of **pregnancy or maternity?**

6. Pregnancy or maternity	Positive	Negative	Neutral	Reasons for your decision
			√	None of the schemes were considered to have a positive or negative impact on this characteristic, especially as the focus of the plan is the 65 and over population.

Do you think that the policy impacts on people on the grounds of their **race/ethnicity**?

7. Race	Positive	Negative	Neutral	Reasons for your decision
Promoting equality of opportunity	√			Under *scheme 1* the continued development of the H4All Wellbeing Service will result in links with community groups being established and facilitate more effective sign-posting to appropriate cultural and faith groups. *Scheme 1* - Risk stratification will proactively identify some groups who do not ordinarily access health services whose needs have escalated to the point where they are at risk of a significant loss of independence and high demand on health and care services, e.g. men and particularly men from East African communities. This is a potential positive impact. *Schemes 1 and 4* - Improved linkages between primary care and community services are likely to have a positive benefit for people from seldom seen, seldom heard groups. The use of assistive technology benefits all communities by providing reassurance to service users and patients and their families that there will be a response in a crisis regardless of ethnicity and language. *Scheme 2* - Identification of hidden Carers could particularly benefit people from BAME communities who do not identify themselves as Carers. This could potentially benefit those communities who may not traditionally access health and care services for whatever reason.
Eliminating unlawful discrimination	√			

				Scheme 3 - Identification of preferred place of care (PPC) at end of life and aligning workforce to provide seamless care will prevent distress occurring during handover periods and eliminate any de facto discrimination that may currently be occurring. Identification of PPC also recognises that for some cultures this may actually be hospital. Early identification of people within the last year of life will enable more personalised advanced planning arrangements to either avoid crises or to be able to respond to them in a way that is more sensitive to the needs and wishes of the person at end of life and their families. *Scheme 4* - Neutral as there are no identifiable features of this scheme that would have a positive or negative effect on the population based on their race or ethnic origin. *Scheme 5* - For people who meet the national eligibility criteria for adult social care or the Continuing Health Care criteria personal budgets in the form of Direct Payments or Personal Health Budgets (PHB) respectively, will enable residents to secure more personalised care services. *Scheme 5*: More proactive support for care homes is likely to eliminate discrimination faced by residents based on their race as a result of difficulties in expressing wishes or expressing concerns. *Scheme 6* - The dementia-specific scheme is a positive as it provides the opportunity to address stigma attached to dementia within some ethnic groups, as well as addressing the needs that may arise for people living with the condition who may revert to their mother tongue. This is much more likely to be an issue in the south of the borough, which is much more diverse than the north.
Promoting good race relations			√	There may be positive benefits for the promotion of good race relations emanating from positive impacts on *Promoting equality of opportunity* and *Eliminating unlawful discrimination* but there is no evidence to

				suggest that the schemes will otherwise have other than a neutral impact at this stage.

Do you think that the policy impacts on people because of their **religion or faith?**

8. Religion or Faith	Positive	Negative	Neutral	Reasons for your decision
	√ Schemes 1 & 5		√ Other Schemes	*Scheme 1* could have a positive effect for people because of their religion or faith through sign-posting to more personalised pathways to address their needs. The development of the homecare DPS under *Scheme 5* and expansions of direct Payments and Personal Health Budgets provides opportunities to work more flexibly to reflect religious beliefs but other schemes are likely to be neutral.

Do you think that the policy impacts on people because of their **sexual orientation?**

9. Sexual Orientation	Positive	Negative	Neutral	Reasons for your decision
Lesbian	√ Scheme 1		√ Other Schemes	*Scheme 1* may have a positive impact by identifying older people whose social isolation may relate to their sexual orientation but other schemes are considered to be neutral at this stage.
Gay				
Heterosexual				
Bisexual				
Transsexual				

Do you think that the policy impacts on people because of their **marriage or civil partnership** status**?**

10. Marriage or civil partnership	Positive	Negative	Neutral	Reasons for your decision
			√	The assessment identified no benefits of disbenefits attributed to marriage or civil partnership status.

Do you think that the policy impacts on any **other** people? (e.g. Homeless, veterans, ex-offenders, substance abuse)

11. Other (Please list)	Positive	Negative	Neutral	Reasons for your decision
				No benefits or disbenefits for other groups were considered as part of the assessment.

Section 4: Evaluation / On-going monitoring

If the service this policy refers to already exists please fill out sections 4A and then proceed to section 5. If the service in this policy is a new service please complete section 4B and then proceed to section 5.

Section 4A: Better Care Fund: Existing service

What systems are currently in place to monitor/ record the profile of service users? [e.g. patient or user survey that collects ethnic background]

Community providers collate information in relation to the profile of patients as well as from a patient satisfaction survey.

Equalities information against the protected characteristics are mandatory fields within the Adult Social Care case management system and all providers are required to report against these. There are, however, three characteristics that are not recorded as a matter of course on the care management database and these are: pregnancy/maternity, gender reassignment and marriage/civil partnership status.

How often is this information collected?
For each episode of care.

As a result of this policy will you monitor any additional equality profile information? If yes what additional information will you gather?
The information currently collated will be reviewed and if there are any gaps these can be addressed. Decisions about any additional data collection will be proportionate to the intended outcome and the ease with which the data can be collected.

As a result of this policy will the CCG and/or the Council increase the frequency of which it collects the above data? If yes, what will the increase be? [e.g. monthly to weekly]
No

Who in the CCG and the Council reviews the data collected? Will they continue to review the data? If not who will monitor the information?
The data is reviewed by the HCCG, included in quarterly reports, during provider contract meetings.

Data is reviewed in the Council by the Performance and Intelligence Team and also the Category Management Team for providers.

Section 4B: Better Care Fund Plan: New Services

What equality information will be collected that will assist in evidencing that the service is being accessed and meeting the needs of protected groups identified in section 3?

Equalities information and patient satisfaction surveys are required from providers of services and the data is reviewed by the HCCG, included in quarterly reports from the provider.

Equalities information against the protected characteristics are mandatory fields within the Adult Social Care case management system and all providers are required to report against these.
The information below is also collected as part of the BCF Plan metrics.

Service User Experience Metric

Adult Social Care Survey Q12 - In the past year, have you generally found it easy or difficult to find information and advice about support services or benefits?

Social Care-related Quality of Life

Social care-related quality of life. Adult Social Care Survey:

- ***Control - Q3a***: Which if the following statements best describes how much control you have over your daily life?
- ***Personal care - Q4a***: Thinking about keeping clean and presentable in appearance, which of the following statements best describes your situation?
- ***Food and nutrition - Q5a***: Thinking about the food and drink you get, which of the following statements best describes your situation?
- ***Accommodation - Q6a***: Which of the following statements best describes how clean and comfortable your home/care home is?
- ***Safety - Q7a***: Which of the following statements best describes how safe you feel?
- ***Social participation - Q8a***: Thinking about how much contact you've had with people you like, which of the following statements best describes your situation?
- ***Occupation - Q9a***: Which of the following statements best describes how you spend your time?
- ***Dignity - Q11***: Which of the following statements best describes how the way you are helped and treated makes you think and feel about yourself?

Each question has four possible answers, which are equated with having:

- No unmet needs
- Needs adequately met
- Some needs met
- No needs met

How often will this data be collected?

Equalities information is reported quarterly for the HCCG and the following frequency for the Council is dependent on the size of the contract and associated levels of risk, e.g. quarterly, six monthly or annually.

- Carers Survey - Anonymised data on age, disability, race, religion, gender, sexual orientation reported once every 2 years following national survey.

- User Survey - Anonymised data on age, disability, race, religion, sex, sexual orientation reported once a year following annual survey.
- Performance information to Adult Social Care Senior Management Team - Age (data split between 18-64 and 65+) and disability reported monthly.
- National (NHS Digital) return - Age, disability, gender, and race reported once a year.

Who in the CCG or Council will monitor this information?

Information will be monitored by the HCCG's Patient Public Involvement Equality Committee and by the Quality, Safety and Clinical Risk Committee.

Performance and Intelligence Team in the Council.

Section 5: Assessment

From your responses gathered in section 3 what actions will be taken to reduce inequalities identified in this EIA?

No inequalities were identified as a result of the assessment. However, particular attention will need to be given to how schemes develop to address the greater diversity in the south of the borough. During the lifetime of the plan there are areas for development that may require specific assessments to support decisions made by either HCCG's Governing Body and/or the Council's Cabinet.

Is the policy directly or indirectly discriminatory under the equalities legislation?
No

If the policy is indirectly discriminatory can it be justified under the relevant legislation?

Not applicable.

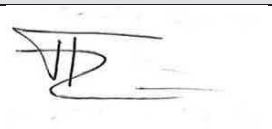
Section 5: Publish Assessment Results

In order demonstrate openness about the way Hillingdon Clinical Commissioning Groups policies, services and partnerships and those of the Council are developed and our commitment to promoting equality and diversity, results of the impact assessment will be published on to the public facing website. www.hillingdonccg.nhs.uk . The assessment will also be available on the Council's website with all the BCF plan-related documents.

Is there any reason why this Equality Impact Assessment should not be published, please use this space to state your reasons:

None known

Section 6: Sign off



Tony Zaman, Corporate Director Adults, Children & Young People's Services
12 September 2017

Caroline Morison, Chief Operating Officer, Hillingdon CCG
13th September 2017

Section 7: Glossary

Listed below are definitions of key words that will provide additional guidance in relation to meeting requirements of an Equality Impact Assessment.

Adverse Impact
This is a significant difference in patterns of representation or outcomes between equalities groups, with the difference amounting to a detriment for one or more equalities groups.

Definition of Disability
The Equality Act, 2010 defines Disability as being:

"an impairment which has a substantial, long term adverse effect on person's ability to carry out normal day-to-day activities".

Differential Impact
Suggests that a particular group has been affected differently by a policy, in either a positive, neutral or negative way.

Direct Discrimination
That is treating people less favourably than others as it would apply to age, disability, gender, race, religion and belief, sexual orientation. There is no justification for direct discrimination

Ethnic monitoring
A process for collecting, storing and analysing data about individuals' ethnic (or racial) background and linking this data and analysis with planning and implementing policies.

Functions
The full range of activities carried out by a public authority to meet its public sector equalities duties.

Indirect discrimination
Applying a provision, criterion or practice that disadvantages people as applies to age, disability, gender, race, religion and belief, sexual orientation and can't be justified as a proportionate means of achieving a legitimate aim. The concept of 'provision, criterion or practice' covers the way in which an intention or policy is actually carried out, and includes attitudes and behaviour that could amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and stereotyping. To find discrimination it will be sufficient to show that a practice is likely to affect the group in question adversely.

Appendix 1

BCF Scheme Summaries

Scheme Number	Scheme Title	Scheme Aim(s)
1.	Early intervention and prevention.	To manage demand arising from demographic pressures by reducing the movement of Hillingdon residents/patients from lower tiers of risk into higher tiers of risk through proactive early identification and facilitating access to preventative pathways.
2.	An integrated approach to supporting Carers.	To maximise the amount of time that Carers are willing and able to undertake a caring role.
3.	Better care at end of life.	To realign and better integrate the services provided to support people towards the end of their life in order to deliver the ethos of a 'good death.' The main goals of the scheme are to: • Ensure that people at end of life are able to be cared for and die in their preferred place of care; and • To ensure that people at end of life are only admitted to hospital where this is clinically necessary or where a hospital is their preferred place of care or death.
4.	Integrated hospital discharge.	This scheme seeks to prevent admission and readmission to acute care following an event or a health exacerbation and enabling recovery through intermediate care interventions with the aim of maximising the person's independence, ability to self-care and remain in their usual place of residence for as long as possible.

		A further objective of this scheme is to support discharge from mental health community beds in recognition of the impact of these delays on patient flow through Hillingdon Hospital.
5.	Improving care market management and development.	This scheme is intended to contribute to the STP 2020/21 outcomes of achieving: • A market capable of meeting the health and care needs of the local population within financial constraints; and • A diverse market of quality providers maximising choice for local people.
6.	Living well with dementia	The objective of this scheme is that people with dementia and their family carers are enabled to live well with dementia and are able to say: • *I was diagnosed in a timely way.* • *I know what I can do to help myself and who else can help me.* • *Those around me and looking after me are well supported.* • *I get the treatment and support, best for my dementia, and for my life.* • *I feel included as part of society.* • *I understand so I am able to make decisions.* • *I am treated with dignity and respect.* • *I am confident my end of life wishes will be respected. I can expect a good death.*

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PHARMACEUTICAL NEEDS ASSESSMENT

Relevant Board Member(s)	Councillor Philip Corthorne
Organisation	London Borough of Hillingdon
Report author	Dan Kennedy, London Borough of Hillingdon
Papers with report	Draft Pharmaceutical Needs Assessment 2018 Appendix 1 – Demography Appendix 2 – Epidemiology Appendix 3 – Pharmacy Provision Appendix 4 – Pharmacy Survey Results Appendix 5 – Pharmacy Services Survey

1. HEADLINE INFORMATION

Summary	From 1 April 2013, the statutory responsibility to publish and keep up to date a statement of the need for pharmaceutical services for the population in its area transferred to Health and Wellbeing Boards from Primary Care Trusts. This statement is known as the Pharmaceutical Needs Assessment (PNA). The PNA assists in the commissioning of pharmaceutical services to meet local priorities. NHS England also use the PNA when making decisions on applications to open new pharmacies. This paper presents to the Hillingdon Health and Wellbeing Board (HWB) the key findings from an update of Hillingdon's PNA and draft recommendations from the updated assessment. The paper seeks agreement of the recommendations and permission from the Board to proceed to a statutory 60-day consultation.
Contribution to plans and strategies	An up-to-date pharmaceutical needs assessment contributes to the development of Hillingdon's Health and Wellbeing Strategy.
Financial Cost	There are no direct financial implications arising from the recommendations set out in this report.
Ward(s) affected	All

2. RECOMMENDATIONS

That the Health and Wellbeing Board is asked to:

1. **agree the draft recommendations set out in Hillingdon's Pharmaceutical Needs Assessment (PNA).**
2. **agree the plan to review and publish Hillingdon's PNA by the required deadline, including the statutory requirement to undertake a minimum 60 day consultation.**

3. **agree to delegate the final approval of Hillingdon's PNA consultation document prior to consultation to Deputy Director Housing, Environment, Education, Health and Wellbeing in consultation with the Chairman of the Health and Wellbeing Board.**

3. INFORMATION

PNA requirements

1. The Health and Social Care Act 2012 established Health and Wellbeing Boards (HWBs) to improve the health and wellbeing of the local population and to reduce health inequalities. The Act transferred the responsibility to develop and update Pharmaceutical Needs Assessments (PNA) from Primary Care Trusts to HWBs, effective from 1 April 2013.

2. The PNA is a statement of the current provision of needs for pharmaceutical services for the population in the area of the HWB. The PNA allows consideration to be given to applications for new pharmacies or changes to existing services by seeing how the services provided will meet an identified need. The PNA also assists in identifying whether changes to commissioned services are required to ensure that both current and future needs are met.

3. HWBs were required to publish their first PNA by 1 April 2015, and the revised PNA will need to be published by 1 April 2018 as set out in the Act. The PNA will need to be revised on a three-yearly cycle. Non-compliance with the regulations may lead to a legal challenge, for example where a party believes that they have been disadvantaged following the refusal of their application to open a new pharmacy business.

4. For the purpose of the assessment, pharmaceutical services include:
   - **Essential services** - Every community pharmacy providing NHS pharmaceutical services must provide essential services which are set out in their terms of service. This includes the dispensing of medicines (including repeat dispensing), medicines disposal, promotion of healthy lifestyles and support for self-care.
   - **Advanced services** – These are services which community pharmacy contractors and dispensing appliance contractors can provide subject to accreditation as necessary. Advanced services include: Medicines Use Reviews (MUR), the New Medicines Service, Appliance Use Reviews and the Stoma Customisation Service, which can be provided by dispensing appliance contracts and community pharmacies.
   - **Locally commissioned services** – These are known as enhanced services. Such services include, but are not restricted to: Patient Group Directions (where specific medicines can be supplied to patients without the need for a doctor to write a prescription), needle and syringe exchange, the provision of advice and support to residents and staff in care homes in connection with drugs and appliances, on demand availability of specialist drugs, and out-of-hours services.

5. The PNA must align with other plans for local health and social care services, including the Joint Strategic Needs Assessment (JSNA). The pharmaceutical needs assessment should be a statement which has regard to the following:
   - the demography of the area.
   - the pharmaceutical services available in the area of the Health and Wellbeing Board.

- whether, in the area, there is sufficient choice with regard to obtaining pharmaceutical services.
- the differing needs of localities within the area
- the pharmaceutical services provided in the area of any neighbouring HWB which affect:
    - the need for pharmaceutical services.
    - whether further provision of pharmaceutical services in the area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type. This could include, for example, new services in response to new housing developments.

6. It is expected that the statement will also include information about:
    - how the assessment was carried out – the localities in the area and how these were determined, the different needs across the localities including those people who share particular characteristics and a report on the consultation undertaken.
    - maps: HWBs are required to include a map in their PNA identifying the premises at which pharmaceutical services are provided. The HWB is required to keep the map up to date.

7. When making an assessment of local pharmacy services, each HWB must take account of likely future needs having regard to likely changes to the number of people who require pharmaceutical services, the demography and the risks to the health or well-being of people in the area. Specifically, the assessment should identify potential gaps in provision that could be met by providing a greater range of services offered by pharmacies or through opening more pharmacies.

Management of the process

8. The update of Hillingdon's PNA has involved reviewing and analysing the most up to date health and wellbeing data, population data as well as information about the provision of pharmacies across the Borough and the services they provide. Feedback has been received from all the pharmacies in Hillingdon.

Draft PNA recommendations

- **<u>Recommendation 1</u> - To recognise that Pharmaceutical services in Hillingdon continues to be well resourced. This suggests the number of pharmacies is sufficient to manage the need of the population over the next 3-5 years.**

  <u>Reason for recommendation</u>
  Pharmacy provision is good across all three localities in Hillingdon. Overall services in pharmacies have increased in the last 3 years. In the pharmacy service survey, pharmacists stated their willingness to provide services that may be required in the future.

- **<u>Recommendation 2</u> - Continue to encourage pharmacies to increase the delivery of Medicines Use Review Services (MURs).**

  <u>Reason for recommendation</u>
  The MUR service has increased in the last 3 years across the Borough. Residents who have more than one condition would benefit from a frequent review of their prescription medicines.

- **Recommendation 3 - Raise awareness of the local pharmacies services to Hillingdon residents.**

  Reason for recommendation
  Many residents may require health advice from a health professional when their GP Practice is closed. The pharmacy could relieve the pressures on GPs and A&E due to the good geographical distribution, long opening hours and level of services provided by pharmacies across Hillingdon.

- **Recommendation 4 - Pharmacies should continue to have an effective health promotion role, targeted to improve the health and wellbeing of Hillingdon residents where needed.**

  Reason for recommendation
  This could include local and national public health campaigns (e.g., NHS health checks, the stop smoking service, influenza immunisation and sexual health services) to address key local health and wellbeing needs.

- **Recommendation 5 - Community pharmacists should use the 'Making Every Contact Count' (MECC) approach while dispensing medicines in order to target individuals with public health messages and improve the health of Hillingdon residents.**

  Reason for recommendation
  Earlier intervention through targeted health promotion advice by health professionals would aid positive life style changes. Contact with residents through local pharmacies in Hillingdon is a good opportunity to promote health and wellbeing.

Key findings and background information included in Hillingdon's updated PNA

The London Borough of Hillingdon

9. Hillingdon has 22 electoral wards within three localities: Ruislip & Northwood in the northern part of the Borough, Uxbridge & West Drayton in the central part of the Borough and Hayes & Harlington in the south.

Demography

10. The population resident in Hillingdon in 2018 is estimated at 314,300 persons. This is split between the three localities of Ruislip & Northwood (31% of the population of the Borough), Uxbridge & West Drayton (34%) and Hayes & Harlington (35%). The population is expected to rise by 1.3% per annum over the next 5 years which is higher than the rate of both London and England. Most wards in Hillingdon will see an increase in their population over the next 5 years. The ward of Uxbridge North is expected to see an increase of 2,500 persons, due to the St Andrews Park development. The ward of Botwell is expected to see an increase of 3,500 persons due to the Hayes Housing Zone development. The main increases in the Borough are expected in the age bands 5-17, 25-39 and 40-64 years. All age groups are expected to see an increase in the proportion of Black and Minority Ethnic groups between 2018 and 2023.

11. The main driver of population growth in Hillingdon over the next 5 years is projected to be natural change (the surfeit of births over deaths). 30% of the population growth is projected to result from net inward migration. The number of births will decrease slightly to 4,200 from 4,482 in 2015. The number of births is higher in Hayes & Harlington, than in Uxbridge & West Drayton, which in turn is higher than Ruislip & Northwood.

12. Hillingdon has a mixed socio-economic profile. The wards in Ruislip & Northwood tend to have the least deprivation while those wards in Hayes & Harlington tend to be more deprived than the Hillingdon average. The highest number of older people (age 60+ years) is in Ruislip & Northwood.

13. Hillingdon is economically prosperous. The Borough has a lower proportion of economically inactive people than London or England. The proportion of the working age population (age 16-64 years) receiving carers allowance is highest in the ward of Townfield (1.97%).

Epidemiology (diseases and their cause within populations)

14. In general, Hillingdon enjoys a higher life expectancy in both males and females than the average for London or England. Botwell, Townfield and Harefield having the lowest life expectancy in both males (age 77) and Botwell and West Drayton having the lowest life expectancy for females (age 80).

15. Mortality rates from all causes have been falling in Hillingdon in line with London and England, both for all ages and for those aged under 75 years.

16. GP register derived prevalence for cardio vascular disease (CVD), coronary heart disease, hypertension, chronic kidney disease, cancer, osteoporosis, obesity, diabetes, chronic obstructive pulmonary disease (COPD) and depression are highest in Ruislip & Northwood.

17. The number of people attempting to quit smoking and the number of people successfully stopping is highest in Hayes & Harlington.

18. Influenza immunisation in Hillingdon is comparable to England as a whole at 68.3%. However, this is below the Chief Medical Officer's (CMO's) target of 75%. Looking at higher risk groups, coverage is 47.8% which is higher than England, but still below the CMO's target of 55%.

19. Teenage pregnancy in Hillingdon has decreased year on year recently and is lower than the England average. However, the rate of conceptions (age <18 years) in the wards of Yiewsley, West Drayton, Townfield, Botwell and Brunel was significantly higher than the England rate for 2012-14. Sexually transmitted infections have been on a general increase over the past 10 years. In comparison with other London boroughs, however, Hillingdon has a relatively low rate of sexually transmitted infections.

20. Drug treatment services achieve more successful outcomes in Hillingdon than across England. Alcohol specific hospital admission rates (rate recorded per 100,000 population) for adults in Hillingdon are slightly lower than rates for England average and London.

Service Provision (pharmacies)

21. The number of pharmacies are evenly geographically distributed across Hillingdon with at least 21 per locality. The number of pharmacies per head of population in Hillingdon exceeds the England and London averages. In Hayes and Harlington, provision is just below the England average rate per head of population. However, there are approximately 20 pharmacies within 1km, but sited in neighbouring boroughs. There appears to be very good accessibility with 99.7% of households in Hillingdon within a 5 minute drive of a pharmacy.

22. Hillingdon's pharmacy provision is within the recognised guidelines. However, it is acknowledged that there are some areas of the community where the pharmacy is more than 15 minutes walking distance. Where this is the case the pharmacies are readily accessible by public transport and road with parking close to the premises. It is also worth noting that the delivery of prescriptions is available in the majority of these pharmacies.

23. Of the 65 pharmacies in Hillingdon:
    - 28 are provided by large multiple providers, 30 are independent pharmacies and 7 are part of chains of fewer than 10 pharmacies.
    - 65 provide a Medicines Use Review (MUR) service, helping people to understand and administer their medications appropriately. 21,500 MURs were conducted in 2016/17.
    - 64 have offered a new medicines service over the last year.
    - 6 pharmacies (2 in each locality) provide a stoma appliance customisation service.
    - Most pharmacies across all three localities would be willing to provide services that they do not yet provide.

Next steps

24. The National Health Service Pharmaceutical and Local Pharmaceutical Services Regulations 2013 state that there is a statutory requirement to undertake a minimum 60-day consultation with stakeholders for the updated PNA. Subject to agreement by the Board of these recommendations, it is proposed that the 60-day consultation will run between 27 September 2017 and 26 November 2017.

25. The following stakeholders are required to be invited to comment on the draft PNA:
    - Local Pharmaceutical Committee (LPC)
    - Local Medical Committee (LMC)
    - Representatives from the local Pharmacists
    - Hillingdon Clinical Commissioning Group
    - Healthwatch Hillingdon
    - Hillingdon Hospitals Trust
    - Other hospital trusts used by Hillingdon residents, e.g., Ealing, and Northwest London Hospitals Trust
    - Neighbouring HWBs
    - NHS England Area Office

26. The full PNA consultation document will be placed on the Council website from 27 September for 60 days. The stakeholders will be contacted by e-mail which will contain the web-link directing them to the consultation document and the following suggested questions:

a. Do you think the purpose of the PNA has been adequately explained?
b. Do you think the PNA provides an adequate assessment of pharmaceutical services in the London Borough of Hillingdon?
c. Do you think the PNA provides a satisfactory overview of the current and future pharmaceutical needs of the population of the London Borough of Hillingdon?
d. Do the recommendations reflect the findings of the PNA?

27. Comments from the consultation will be reviewed and included in the PNA where appropriate. The final PNA will be presented to Hillingdon's Health and Wellbeing Board for consideration and agreement on 7 December 2017. The Health and Wellbeing Board is required to publish the PNA by 1 April 2018.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

28. The recommendations will inform future commissioning decisions to ensure sufficient and effective provision of pharmaceutical services to meet local needs. Failure to produce a robust PNA could lead to legal challenges because of the PNA's relevance to decisions about commissioning services.

Consultation Carried Out or Required

29. There is a statutory requirement to carry out a consultation with key stakeholders on the draft pharmaceutical needs assessment for a minimum period of 60 days.

Policy Overview Committee comments

None at this stage.

5. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

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

Hillingdon Council Legal comments

From the 1 April 2013, *The Health and Social Care Act 2012* placed a statutory obligation on local authorities, through Health and Wellbeing Boards (HWBs), to develop and update Pharmaceutical Needs Assessments (PNAs). Pursuant to *The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013,* HWBs are required to produce their first PNAs by 1 April 2015, and reviewed every three years thereafter. Schedule 1 of the *2013 Regulations* sets out matters to be covered in the PNAs.

6. BACKGROUND PAPERS

NIL.

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Hillingdon Pharmaceutical Needs Assessment 2018

DRAFT

2018

Contents

Executive Summary

The Health and Social Care Act 2012 transferred the responsibility for public health to local Councils. This role includes taking the lead on three new interrelated functions:

1. Undertaking Pharmaceutical Needs Assessments on behalf of the Health and Wellbeing Board
2. Commissioning certain public health services from community pharmacies
3. Providing a broader strategic role in supporting the development of community pharmacies with an increased role in public health and health improvement.

This Pharmaceutical Needs Assessment describes the needs related to pharmaceutical services for the population of Hillingdon.

Demographic and Epidemiological Analysis

Information from Hillingdon's Joint Strategic Needs Assessment was reviewed alongside priorities set by the Hillingdon Health and Wellbeing Board in the Joint Health and Wellbeing Strategy (JHWS). Demographic data for Hillingdon was considered and an epidemiological needs assessment undertaken to ascertain the current health status of the population, past trends and future projections. Distribution of various illnesses and their risk factors is crucial for understanding the health needs in a population. Hillingdon's geography, population diversity is described in Appendix 1 and the epidemiological data is described in Appendix 2.

Analysis of existing services

Pharmaceutical services include essential services, advanced services, and locally commissioned services (known as enhanced services). These include the provision of dispensing services, services to support patients in appropriate use of medicines, advice and support to residents and staff in care homes in connection with drugs and appliances, on demand availability of specialist drugs, and out-of-hours services; and delivery of public health services. Appendix 3 and Appendix 4 describe the location of community pharmacies, types of pharmacies based on opening hours, travel distances and services provided by local pharmacies. This information includes pharmaceutical services provided in Hillingdon. The analysis took into account future changes predicted in the population within localities and the impact of any housing developments.

A survey of the existing 65 pharmacies in Hillingdon along with those in neighbouring areas was completed, with the support of the Local Pharmaceutical Committee. The 100% response rate from those pharmacies in Hillingdon secured a robust and up to date collection of information to support the assessment of need. Appendix 5 shows the survey used.

Maps are included in the PNA identifying the premises at which pharmaceutical services are provided.

Management of the development of the PNA

As set out in the Health and Social Care Act 2012 the Health and Wellbeing Board managed the development and update of the PNA. Partners consulted include the Local Medical Committee, the Hillingdon Hospital NHS Foundation Trust, CNWL NHS Trust, local community pharmacies, the voluntary sector and neighbouring Health and Wellbeing Boards.

Consultation: Subject to agreement from the HWB it is proposed that the statutory 60-day consultation will take place between September 27th 2017 and November 26th 2017. The draft PNA was available on the Hillingdon Council website during the consultation period.

Recommendations:

- **<u>Recommendation 1</u> - To recognise that pharmaceutical services in Hillingdon continues to be well resourced. This suggests the number of pharmacies is sufficient to manage the need of the population over the next 3-5 years.**
  Pharmacy provision is good across all three localities in Hillingdon. Overall services in pharmacies have increased in the last 3 years. In the pharmacy service survey pharmacists stated their willingness to provide services that may be required in the future.

- **<u>Recommendation 2</u> - Continue to encourage pharmacies to increase the delivery of Medicines Use Review Services (MURs).**
  The MUR service has increased in the last 3 years across the Borough. Residents who have more than one condition who would benefit from a frequent review of their prescription medicines.

- **<u>Recommendation 3</u> - Raise awareness of the local pharmacy services to Hillingdon residents.**
  Many residents may require health advice from a health professional when their GP Practice is closed. The pharmacy could relieve the pressures on GPs and A&E due to the good geographical distribution, long opening hours and level of services provided by pharmacies across Hillingdon.

- **<u>Recommendation 4</u> - Pharmacies should continue to have an effective health promotion role, targeted to improve the health and wellbeing of Hillingdon residents where needed.**
  This could include local and national public health campaigns (e.g. NHS health checks, the stop smoking service, influenza immunisation and sexual health services) to address key local health and wellbeing needs.

- **<u>Recommendation 5</u> - Community pharmacists should use the 'Making Every Contact Count' (MECC) approach while dispensing medicines in order to target individuals with public health messages and improve the health of Hillingdon residents.**
  Earlier intervention through targeted health promotion advice by health professionals would aid positive life style changes. Contact with residents through local pharmacies in Hillingdon is a good opportunity to promote health and wellbeing.

1. Introduction

Local government's new role in relation to pharmaceutical services

The Health and Social Care Act 2012 transferred the responsibility for public health to councils, which has included leading on three new interrelated functions:

- Undertaking Pharmaceutical Needs Assessments on behalf of Hillingdon's Health and Wellbeing Board
- Commissioning certain public health services from community pharmacies
- Providing a broader strategic role in supporting the development of community pharmacies with an increased role in public health and health improvement.

This Pharmaceutical Needs Assessment describes the needs related to pharmaceutical services for the population of Hillingdon. The NHS Act (the "2006" Act), amended by the Health and Social Care Act 2012 established Health and Wellbeing Boards (HWBs) in each local area and transferred responsibility to develop and update Pharmaceutical Needs Assessments (PNAs) from PCTs to HWBs. Responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list transferred from PCTs to NHS England from April 1st 2013. This means that the decisions on whether to open new pharmacies are not made by the HWB. However, the PNA will help in the commissioning of pharmaceutical services in the context of local priorities.

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013, which set out the legislative basis for developing and updating PNAs and can be found at: http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/

2. Pharmaceutical Needs Assessment (PNA)

A Pharmaceutical Needs Assessment, as defined in the Regulations, is the statement of the needs for pharmaceutical services which each HWB is required to publish by virtue of section 128A of the 2006 Act (Pharmaceutical Needs Assessments), whether it is the statement of its first assessment or of any revised assessment, is referred to in these Regulations as a Pharmaceutical Needs Assessment. The contents of the PNA as defined by the Regulations are:

- All the pharmaceutical services provided by pharmacies in Hillingdon under arrangements made by the NHS England. These will include dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users
- Other services, such as dispensing by GP surgeries, and services available in neighbouring HWB areas that might affect the need for services in Hillingdon

- Demographics of Hillingdon, Borough wide population in different localities and wards, and their needs
- Identification of gaps that could be met by providing more pharmacy services, or through opening more pharmacies, taking into account likely future needs
- Relevant maps relating to Hillingdon and its pharmacies
- Alignment with other plans for local health and social care, including the Joint Strategic Needs Assessment (JSNA).

The content of this PNA was developed in accordance to regulations 3-9 Schedule 1 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

The findings and recommendations of the report regarding the potential opportunities for pharmaceutical services to provide support in meeting the health needs of the population of Hillingdon are based upon a comprehensive analysis and review of the data and information that has been considered in the following pages, including:

- demographic review, in particular the current population and population projections, including key groups such as children, older people and those living in deprivation
- epidemiological review, in particular those identified by GPs with diseases and with long term conditions
- community pharmacy locations, including information about 100 hour opening times per week
- pharmaceutical services provided at each location
- local priorities arising from the JSNA and those highlighted in the H&WB strategy 2014-17 which is currently being reviewed by the HWB.

3. Key findings and background information

The London Borough of Hillingdon

Hillingdon is the second largest of London's 32 boroughs covering an area of 42 square miles (11,571 hectares), over half of which is countryside and woodland. Hillingdon has always been a transport hub and home to Heathrow Airport - the world's busiest international airport. It is also the home of RAF Northolt, and shares its borders with Hertfordshire, Buckinghamshire, Surrey, Hounslow, Ealing, and Harrow. Hillingdon has 22 electoral wards within three localities: Ruislip & Northwood in the northern part of the Borough, Uxbridge & West Drayton in the central part of the Borough, and Hayes & Harlington in the southern part of Hillingdon. Ruislip & Northwood consists of eight wards, and Uxbridge & West Drayton and Hayes & Harlington both consist of seven wards.

Hillingdon is traversed by the Grand Union Canal, the M4 motorway, the A40, the A4020 and the Great Western Railway. With all those road networks and three of London's underground lines (Piccadilly, Metropolitan and Central lines) starting and

ending in the Borough, Hillingdon is a major transport hub. The south of the Borough is home to the world's busiest international airport Heathrow, which occupies 1,227 hectares land, and handled 75.7 million passengers in 2016. The arrival of Crossrail in 2018, with new stations at West Drayton and Hayes will open up access to central London even further.

Demography

The population resident in Hillingdon in 2018 is estimated at 314,300 persons. This is split between the three localities of Ruislip & Northwood (31% of the population of the Borough), Uxbridge & West Drayton (34%) and Hayes & Harlington (35%). There are higher numbers of younger people in Hayes and Harlington and higher numbers of older people (60+) in Ruislip and Northwood.

The population increase in Hillingdon over the next 5 years is expected to be 7%, around 1.3% per annum which is higher than the rate of both London (5.8%) and England (3.5%). The key driver of population growth in Hillingdon over the next 5 years is projected to be natural change (the greater number of births than deaths). 30% of population growth is projected to result from net inward migration. The highest increases in the Borough are expected in the age bands 5-17, 25-39 and 40-64 years. Most wards in Hillingdon will see an increase in their population over the next 5 years, with the age group 20-44 being the most transient. The ward of Uxbridge North is expected to see an increase of 2,500 persons, due to the St Andrews Park development. The ward of Botwell is expected to see an increase of 3,500 persons due to the Hayes Housing Zone development.

The number of births is expected to decrease to 4,200 (4482 in 2015) per annum over the next 5 years. The number of births is higher in Hayes & Harlington, than in Uxbridge & West Drayton, which in turn is higher than Ruislip & Northwood.

GLA ethnic group projection (2015) estimate that Hillingdon is becoming more diverse with Black and Minority Ethnic (BAME) groups accounting for 48% and white ethnic groups accounting for 52% of the 2018 resident population. This proportion of BAME groups is higher than across London (43%). All age groups are expected to see an increase in the proportion of BAME groups between 2018 and 2023. In Hillingdon BAME groups are likely to account for 52% of the population by 2023.

Hillingdon has a mixed socio-economic profile. The 2015 English Index of Deprivation ranks (with 1st being the most deprived) Hillingdon as 162nd out of 326 Local Authority areas in England and 23 out of 32 London boroughs (excluding the City of London). The average deprivation score masks the differences at ward level - the wards in Ruislip & Northwood tend to have the least deprivation while those wards in Hayes & Harlington tend to have a higher level of deprivation than the Hillingdon average.

Hillingdon is economically prosperous. The Borough has a lower proportion of economically inactive people than London or England. In 2016 the unemployment rate in Hillingdon (4.4%) was lower than both London (5.7%) and England (4.8%). In

August 2016, Hillingdon's Job Seekers Allowance (JSA) claimant level was 2,070 which is the lowest level since February 2010 (6,070).

According to the 2011 Census (this is the only data source where this granularity of intelligence is collected) 9.6% of residents of Hillingdon provide unpaid care to family or friends.

Detailed analysis of the demography of Hillingdon can be found in Appendix 1.

Epidemiology (diseases and their cause within populations)

In general Hillingdon residents enjoy a higher life expectancy in both males and females, 80.5 years and 83.7 years respectively, than the average for London (80.2 and 84.1 respectively) and England (79.5 and 83.1 respectively). There is some variation by ward and by locality within the Borough with Botwell, Townfield and Harefield wards have the lowest life expectancy in males (age 77) and Botwell and West Drayton having the lowest life expectancy in females (age 80).

Analysis of numbers on GP registers show some differences in ward and locality disease prevalence generally relating to the age profiles of the areas within the Boroughs.

GP register derived prevalence for cardio vascular disease (CVD), coronary heart, stroke, disease, hypertension, chronic kidney disease, cancer, osteoporosis, obesity, diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation, peripheral arterial disease (PAD), dementia, asthma and depression are highest in Ruislip & Northwood.

Mortality rates from all causes have been falling in Hillingdon in line with London and England, both for all ages and for those aged under 75 years. Circulatory disease and cancers are the two major causes of death in Hillingdon.

Smoking is identified as a major risk factor for many diseases. In Hillingdon the estimated prevalence of smoking is 16.9% of the population aged over 18 which is slightly higher than the London average (16.3%) and the same as the England average. The number of people attempting to quit smoking and the number of people successfully stopping is highest in Hayes & Harlington.

Influenza immunisation in Hillingdon is comparable to England as a whole at 68.3%. However, this is below the Chief Medical Officer's (CMO) target of 75%. Looking at higher risk groups, coverage is 47.8% which is higher than England, but still below the CMO target of 55%.

Teenage pregnancy in Hillingdon has decreased year on year recently and is lower than the England and London average. However, the rate of conceptions (age <18 years) in the wards of Yiewsley, West Drayton, Townfield, Botwell and Brunel was significantly higher than the England rate for 2012-14.

Sexually transmitted infections represent an important public health issue in London which has the highest rate of STIs in England. In comparison with other London boroughs however, Hillingdon has a relatively low rate of sexually transmitted infections.

Drug treatment services in Hillingdon achieve proportionately more successful outcomes in Hillingdon than across London and England.

Alcohol specific hospital admission rates (rate recorded per 100,000 population) for adults in Hillingdon are slightly lower than rates for England average and London.

Hillingdon will liaise with other boroughs in North West London and NHS England with the aim to agree themes for the six local campaigns which community pharmacies can deliver on an annual basis.

Detailed analysis of the epidemiology of Hillingdon can be found in Appendix 2.

Service Provision (pharmacies)

There are 65 community pharmacies in Hillingdon. The numbers of pharmacies are evenly geographically distributed across Hillingdon with at least 21 per locality. The number of pharmacies per 100,000 of the population in Hillingdon is similar to that of England and London, for more details please see Appendix 3.

Hllingdon's pharmacy provision is within the recognised guidelines. However, it is acknowledged that there are some areas of the community where the pharmacy is more than 15 minutes walking distance. Where this is the case the pharmacies are readily accessible by public transport and road with parking close to the premises. It is also worth noting that the delivery of prescriptions is available in the majority of these pharmacies.

Access to pharmacy services is very good for Hillingdon residents. 99.7% of households in Hillingdon are within a 5 minute drive of a pharmacy.

Of the 65 pharmacies in Hillingdon:

- 28 are provided by large multiple providers, 30 are independent pharmacies and 7 are part of chains of fewer than 10 pharmacies
- 65 provide a Medicines Use Review (MUR) service, helping people to understand and administer their medications appropriately. 21,500 MURs were conducted in 2016/17
- 64 have offered a new medicines service over the last year
- 6 pharmacies (2 in each locality) provide a stoma appliance customisation service.

The Pharmaceutical Needs Assessment survey received a 100% response rate from Hillingdon pharmacies with details of their services provided.

Residents across the Hillingdon localities have access to a range of services from the essential dispensing services to screening and monitoring, vaccination and disease specific services.

All pharmacies across all three localities would be willing to provide a lot of the services that they do not yet provide if they were commissioned to do so.

4. Recommendations:

1. **To recognise that pharmaceutical services in Hillingdon continue to be well resourced. This suggests the number of pharmacies is sufficient to manage the need of the population over the next 3-5 years.**
    - Pharmacy provision is good across all three localities in Hillingdon. Overall services in pharmacies have increased in the last 3 years. In the pharmacy service survey pharmacists stated their willingness to provide services that may be required in the future**.**

2. **Continue to encourage pharmacies to increase the delivery of Medicines Use Review Services (MURs).**
    - The MUR service has increased in the last 3 years across the Borough. Residents who have more than one condition who would benefit from a frequent review of their prescription medicines.

3. **Raise awareness of the local pharmacy services to Hillingdon residents.**
    - Many residents may require health advice from a health professional when their GP Practice is closed. The pharmacy could relieve the pressures on GPs and A&E due to the good geographical distribution, longer opening hours and level of services provided by pharmacies across Hillingdon.

4. **Pharmacies should continue to have an effective health promotion role, targeted to improve the health and wellbeing of Hillingdon residents where needed.**
    - This could include local and national public health campaigns (e.g. NHS health checks, the stop smoking service, influenza immunisation and sexual health services) to address key local health and wellbeing needs.

5. **Community pharmacists should be encouraged to use the 'Making Every Contact Count' (MECC) approach while dispensing medicines in order to target individuals with public health messages and improve the health of Hillingdon residents.**
    - Earlier intervention through targeted health promotion advice by health professionals would aid positive life style changes. Contact with residents through local pharmacies in Hillingdon is a good opportunity to promote health and wellbeing.

5. Community pharmacy provision within Hillingdon

NHS England North West London Area Team commissions 65 community pharmacies in Hillingdon to provide pharmaceutical services.

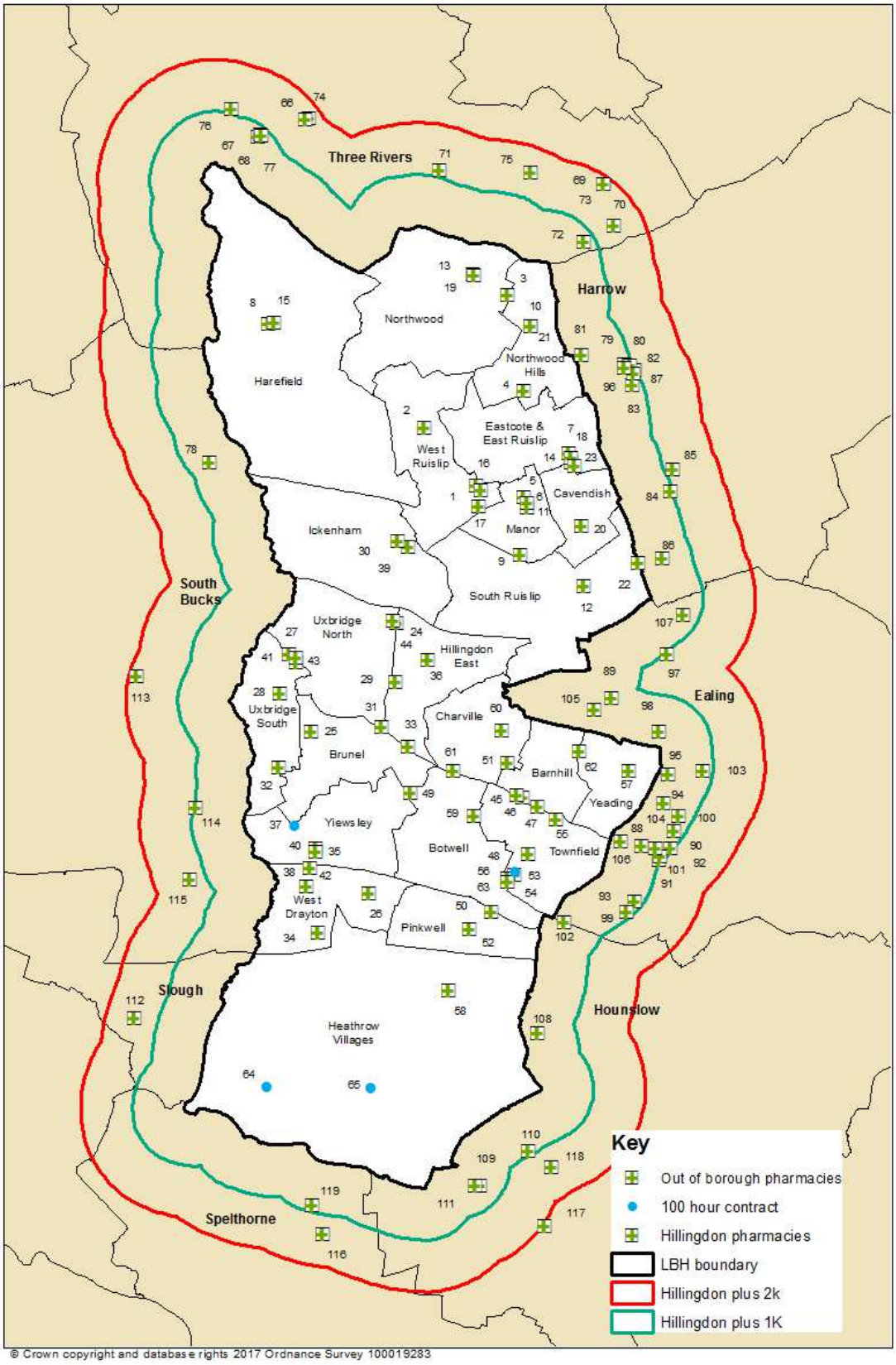
Provision of community pharmacies in Hillingdon by ward and locality

Locality / ward	Population in 2018 (GLA demographic projections, 2015) published 2016	Number of pharmacies per 100,000 population
Ruislip & Northwood	**Total = 96,200**	**Total = 23**
Cavendish	12,442	
Eastcote & East Ruislip	14,182	
Harefield	7,964	**Rate per 100,000 population = 23.9**
Manor	12,129	population = 96,200 number of pharmacies = 23
Northwood	11,231	
Northwood Hills	12,427	
South Ruislip	13,418	
West Ruislip	12,407	
Uxbridge & West Drayton	**Total = 103,100**	**Total = 21**
Brunel	14,510	
Hillingdon East	13,648	
Ickenham	10,933	**Rate per 100,000 population = 20.3**
Uxbridge North	15,303	population = 103,100 number of pharmacies = 21
Uxbridge South	15,396	
West Drayton	18,390	
Yiewsley	14,945	
Hayes & Harlington	**Total = 108,100**	**Total = 21**
Barnhill	14,147	
Botwell	19,672	
Charville	13,131	**Rate per 100,000 population = 19.4**
Heathrow Villages	13,442	population = 108,100 number of pharmacies = 21
Pinkwell	16,152	
Townfield	16,859	
Yeading	14,685	
22 wards	**307,400 population**	**65 pharmacies**

Hillingdon rate per 100,000 population = 21.1
(population = 307,400 number of pharmacies = 65)

Access to pharmaceutical services: in Borough and out of Borough

Map: Pharmacies in Hillingdon, and those within 2km of the boundary (Three Rivers, South Bucks, Slough and Spelthorne) and 1km of the boundary (London Boroughs of Harrow, Ealing and Hounslow):



Hillingdon pharmacies:

Key	Pharmacy name	Location
1	Ashworths Pharmacy	Ruislip
2	Howletts Pharmacy	Ruislip
3	Carter Chemist & Ability	Northwood
4	Carters Pharmacy	Eastcote
5	Chimsons Ltd	Ruislip Manor
6	Dana Pharmacy	Ruislip Manor
7	Eastcote Pharmacy	Eastcote
8	Harefield Pharmacy	Harefield
9	Nu-Ways Pharmacy	Ruislip
10	Ross Pharmacy	Northwood
11	Ruislip Manor Pharmacy	Ruislip Manor
12	Lloyds Pharmacy in Sainsbury's	South Ruislip
13	Sharman's Chemist	Northwood
14	Superdrug	Eastcote
15	The Malthouse Pharmacy	Harefield
16	Boots, 67 High Street	Ruislip
17	Boots, Wood Lane Medical Centre	Ruislip
18	Boots	Eastcote
19	Boots	Northwood
20	Boots, Whitby Road	Ruislip
21	Boots	Northwood Hills
22	Boots, 716 Field End Road	South Ruislip
23	Boots, 171 Field End Road	Eastcote
24	Adell Pharmacy	Hillingdon
25	Brunel Pharmacy	Uxbridge
26	Carewell Chemists	West Drayton
27	Flora Fountain Ltd	Uxbridge
28	H A McParland Ltd	Uxbridge
29	Hillingdon Pharmacy	Hillingdon
30	Anglebond Pharmacy	Ickenham
31	Lawtons Pharmacy	Hillingdon
32	Mango Pharmacy	Cowley
33	Oakleigh Pharmacy	Hillingdon

Key	Pharmacy name	Location
34	Orchards Pharmacy	West Drayton
35	Phillips Pharmacy	Yiewsley
36	Puri Pharmacy	Hillingdon
37	Tesco In-Store Pharmacy ●	West Drayton
38	Winchester Pharmacy	West Drayton
39	Winchester Pharmacy	Ickenham
40	Yiewsley Pharmacy	Yiewsley
41	Boots, High Street	Uxbridge
42	Boots	West Drayton
43	Boots, Intu Shopping Centre	Uxbridge
44	Boots, 380 Long Lane	Hillingdon
45	Daya Ltd	Hayes
46	Grosvenor Pharmacy	Hayes
47	H.A. McParland Ltd	Hayes
48	Hayes Town Pharmacy ●	Hayes
49	Joshi Pharmacy	Hayes
50	Kasmani Pharmacy	Hayes
51	Lansbury Pharmacy	Hayes
52	Medics Pharmacy	Hayes
53	Nuchem Pharmacy	Hayes
54	Pickups Chemist	Hayes
55	Lloyds Pharmacy in Sainsburys	Hayes
56	Superdrug	Hayes
57	Tesco In-Store Pharmacy	Yeading
58	The Village Pharmacy	Harlington
59	Vantage Chemists	Hayes
60	Vantage Pharmacy	Hayes
61	Boots, 1266 Uxbridge Road	Hayes
62	Boots, 236 Yeading Lane	Hayes
63	Boots, 28-30 Station Road	Hayes
64	Boots, Terminal 5 ●	Heathrow Airport
65	Boots, Terminal 3 ●	Heathrow Airport

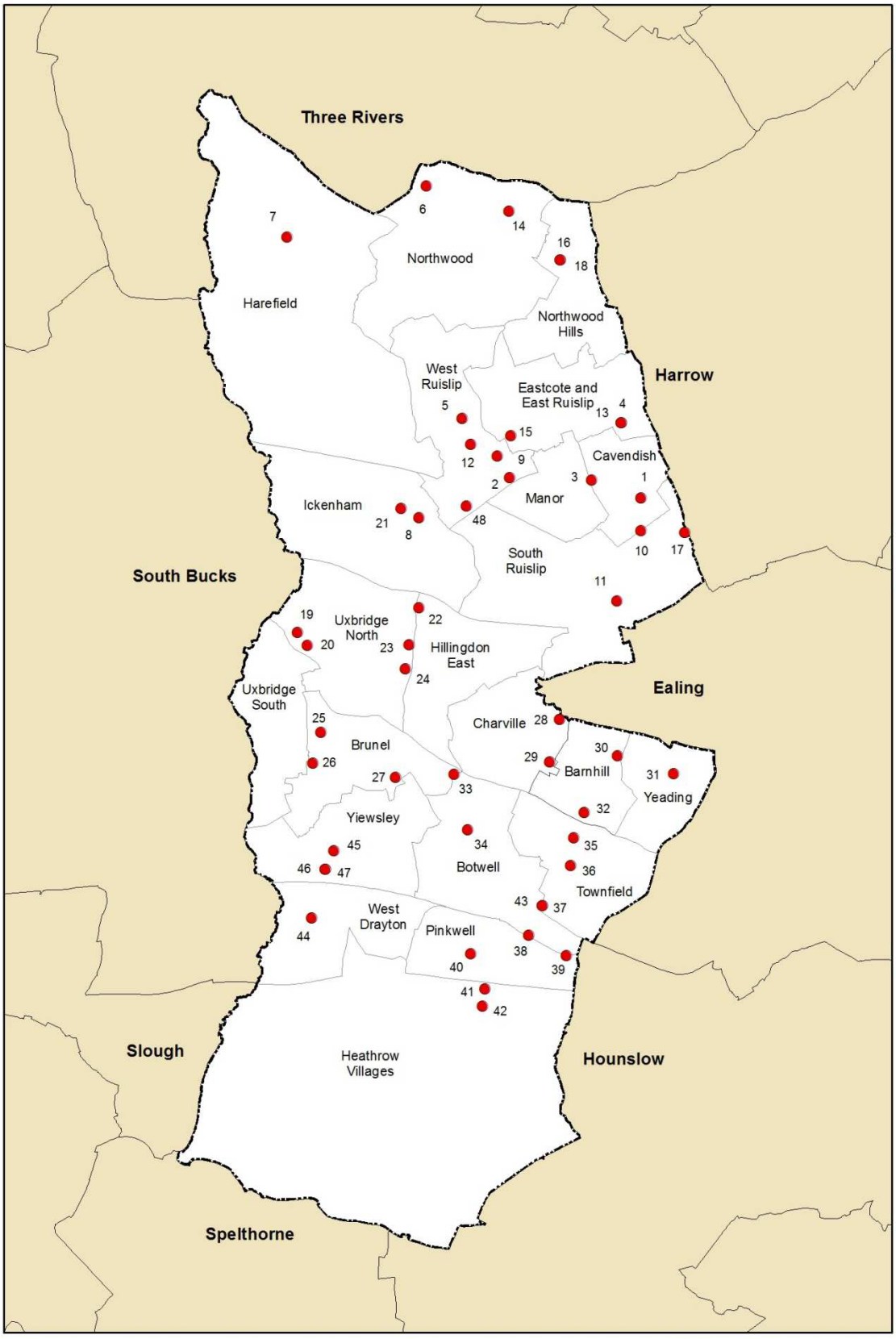
● = 100 hour contract

Out of Borough pharmacies:

Key	Pharmacy name	Location
66	Boots, 78 High Street	Rickmansworth
67	Dave Pharmacy	Rickmansworth
68	Delite Chemist	Rickmansworth
69	Esom Chemist	South Oxhey
70	Lex Pharmacy	South Oxhey
71	Loomrose Pharmacy	Moor Park
72	Prestwick Pharmacy	South Oxhey
73	Viks Pharmacy	South Oxhey
74	Riverside Pharmacy	Rickmansworth
75	Medco Pharmacy	South Oxhey
76	Tudor Pharmacy	Rickmansworth
77	The Chief Cornerstone	Rickmansworth
78	Boots	Denham
79	Angie's Chemist	Pinner
80	Carters Chemist	Pinner
81	Tesco In-Store Pharmacy	Pinner
82	Gor Pharmacy, Pinn Medical Centre	Pinner
83	Gor Pharmacy	Pinner
84	Jade Pharmacy	Harrow
85	Jade Pharmacy	Harrow
86	Kings Pharmacy	South Harrow
87	Lloyds Pharmacy in Sainsburys	Pinner
88	Alchem Pharmacy	Southall
89	Alpha Chemist	Northolt
90	Anmol Pharmacy	Southall
91	Chana Chemist	Southall
92	Chana Chemist	Southall
93	Fountain Pharmacy	Southall
94	H.J. Dixon Chemist	Southall
95	Lady Margaret Pharmacy	Southall

Key	Pharmacy name	Location
96	Boots	Pinner
97	M Gokani Chemist	Northolt
98	Northolt Pharmacy	Northolt
99	Puri Pharmacy	Southall
100	Shah Pharmacy	Southall
101	Sherrys Chemist	Southall
102	Tesco In-Store Pharmacy, Bulls Bridge	Southall
103	Chana Chemist	Southall
104	Boots	Southall
105	Touchwood Pharmacy	Northolt
106	Woodland Pharmacy	Southall
107	Boots	Northolt
108	Dunns Chemist	Cranford
109	Edwards & Taylor	Bedfont
110	Tesco In-Store Pharmacy	Feltham
111	Boots	Bedfont
112	Colnbrook Pharmacy	Colnbrook
113	Jeeves Pharmacy	Iver Heath
114	Lloyds Pharmacy	Iver
115	Saleys Chemist	Iver
116	Tesco	Stanwell
117	Boots	Feltham
118	Boots	Feltham
119	Hermans	Stanwell

Map: GP practices in Hillingdon



GP practices in Hillingdon:

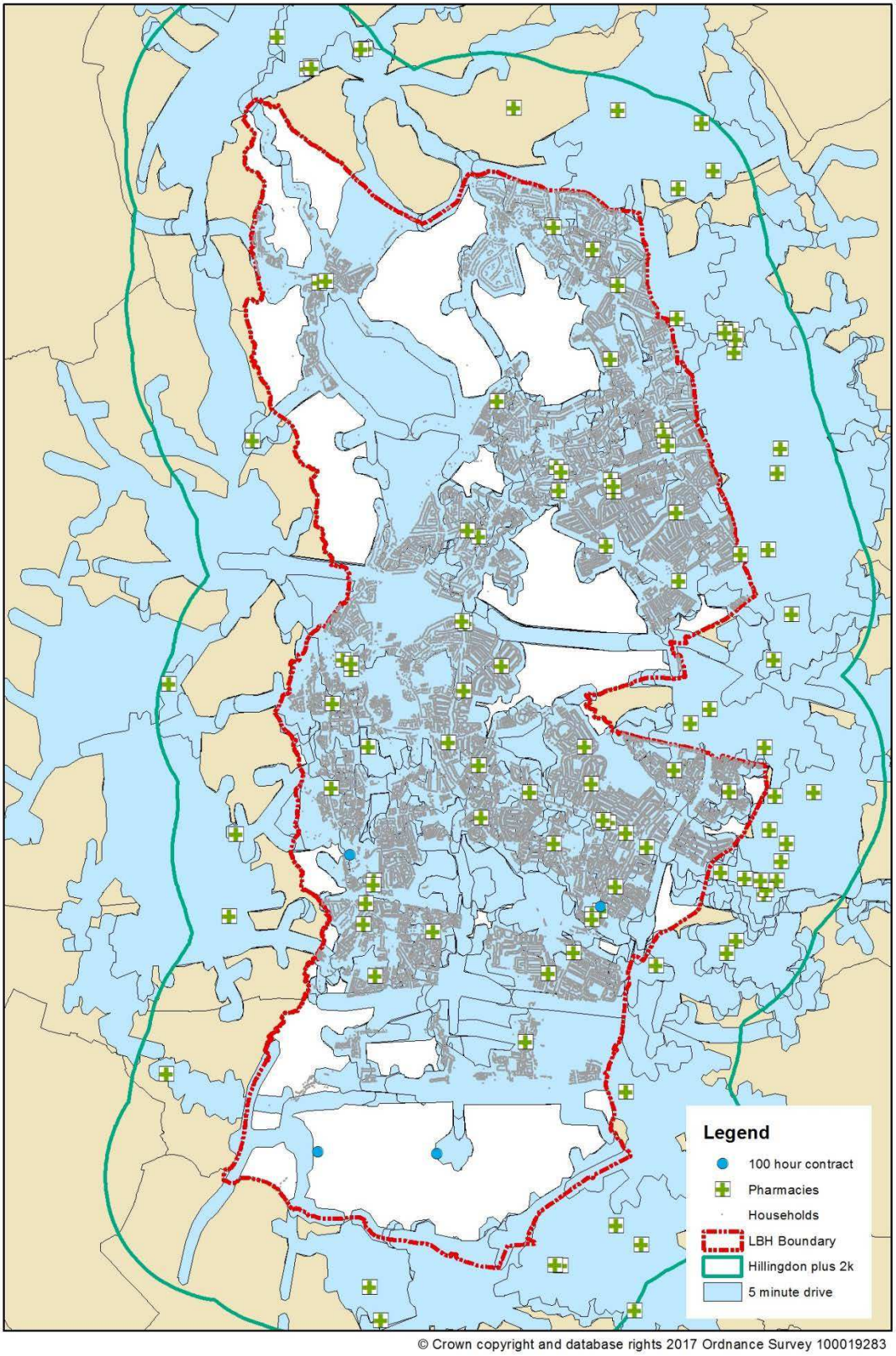
Key	Practice name
1	Oxford Drive Medical Centre
2	Wood Lane Medical Centre
3	Cedars Medical Centre
4	The Abbotsbury Practice
5	Dr Karim's Practice, Ladygate Lane
6	The Mountwood Surgery
7	The Harefield Practice
8	Swakeleys Medical Centre
9	King Edwards Medical Centre
10	The Medical Centre, Queenswalk
11	Dr Siddiqui's, Walnut Way
12	Southcote Clinic
13	Devonshire Lodge
14	Eastbury Surgery
15	St Martin's Medical Centre
16	Acre Surgery
17	Acrefield Surgery
18	Carepoint Practice
19	The Belmont Medical Centre
20	Uxbridge Health Centre
21	Wallasey Medical Centre
22	Hillingdon Health Centre
23	Oakland Medical Centre
24	Acorn Medical Centre

Key	Practice name
25	Brunel Medical Centre
26	Church Road Surgery
27	West London Medical Centre
28	Cedar Brook Practice
29	The Pine Medical Centre
30	Yeading Court Surgery
31	Willow Tree Surgery
32	The Warren Practice
33	Parkview Surgery
34	Kingsway Surgery
35	Townfield Doctors Surgery
36	Kincora Doctor's Surgery
37	Hayes Town Medical Centre
38	Hayes Medical Centre
39	North Hyde Practice
40	Shakespeare Surgery
41	Heathrow Medical Centre
42	Glendale House Surgery
43	Orchard Practice
44	The Medical Centre, The Green
45	Otterfield Medical Centre
46	Yiewsley Family Practice
47	The High Street Practice
48	St Martin's Medical Centre

Hospital services

NHS hospital trusts and private hospitals do not provide pharmaceutical services as defined for the purposes of the PNA however, as part of the integrated services for patients being discharged from acute and secondary care into community, liaison between hospital pharmacy and community pharmacies is important for providing seamless discharge of patients.

Map: Access by car: Pharmacies within a 5 minute drive time, by residential postcodes



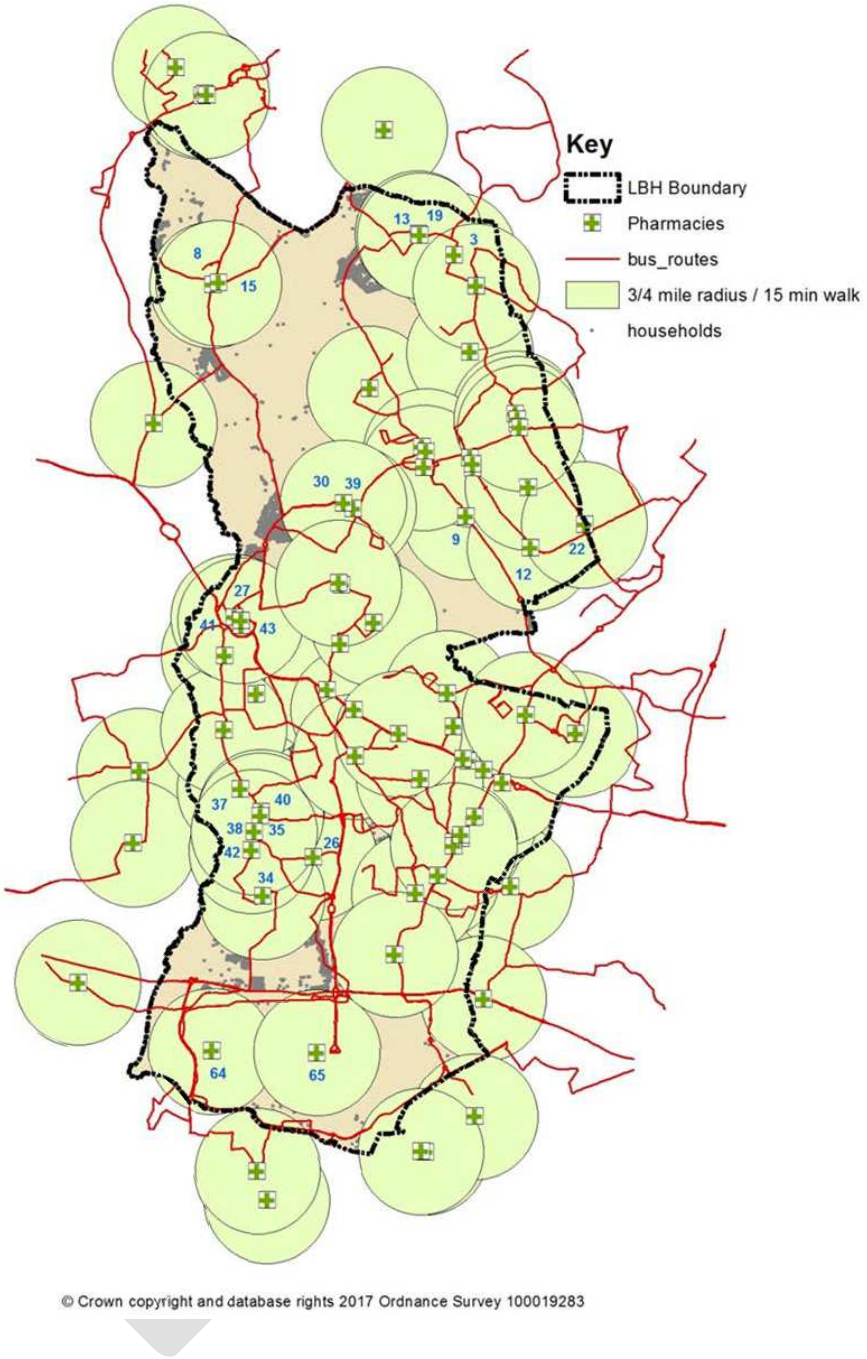
Geographic Information System (GIS) drive time layers at 1 minute intervals were commissioned; the number of Borough households found to be within and not within the following drive times to pharmacies are:

Drive time	Within drive time:		Outside drive time:	
	Number of households	Percentage	Number of households	Percentage
1 minute	46,404	42.7%	62,203	57.3%
2 minutes	91,485	84.2%	17,122	15.8%
3 minutes	105,142	96.8%	3,465	3.2%
4 minutes	108,171	99.6%	436	0.4%
5 minutes	108,335	99.7%	272	0.3%
6 minutes	108,592	99.9%	15	<0.1%

*based on 108,607 households

Driving in light urban traffic and keeping within the posted speed limits, 97% of households are within a 3 minute drive or within a 30 minute walk away from a community pharmacy.

Access to pharmacies - 15 minutes walking distance



The map shows (from the overlapping ¾ mile circles), a 15 minute walking distance around each pharmacy.

It is acknowledged that there are some areas of the community where a pharmacy is more than 15 minute walk away. Where this is the case pharmacies are readily accessible by bus and road with parking close to the premises. The majority of borough pharmacies are within a 15 minute walk of another pharmacy which is currently serving their geographical location.

6. Definition of pharmaceutical services

Section 126 of the 2006 Act places an obligation on NHS England to put arrangements in place so that drugs, medicines and listed appliances ordered via NHS prescriptions can be supplied to persons. This section also makes provision for the types of healthcare professionals that are authorised to order drugs, medicines and listed appliances on an NHS prescription.

Therefore, *pharmaceutical services* in relation to PNAs include:

Essential services: Every community pharmacy providing NHS pharmaceutical services must provide (as set out in their terms of service) the dispensing of medicines, dispensing appliances, repeat dispensing, disposal of unwanted medicines, promotion of healthy lifestyles and signposting and support for self-care.

Advanced services: These are the services that community pharmacy contractors and dispensing appliance contractors can provide subject to accreditation as necessary based on premises, training or notification to the NHS England (NHSE) Area Team – these are Medicines Use Reviews (MURs), the New Medicines Service (NMS) for community pharmacists and Appliance Use Reviews (AURs) and the Stoma Appliance Customisation Service (SACS) for dispensing appliance contractors. At this time a pharmacy may undertake up to 400 MURs per annum if they have informed NHS England of their intention to provide the service. Pharmacy staff may also undertake a limited number of AURs linked to the dispensing of appliances and as many SACS as required.

Locally commissioned services (known as enhanced services): Only NHS England can commission the enhanced services. However, community pharmacy can provide services commissioned by local authorities and CCGs (through NHS England) which mirror enhanced services. Therefore to give a complete picture of the local provision, these need to be considered alongside pharmaceutical service provision.

Enhanced Services - Only those contractors directly commissioned by NHS England can provide these services in line with the PNAs produced by Health and Wellbeing Boards.

The National Health Service Act 2006, The Pharmaceutical Services (Advanced & Enhanced Services) (England) Directions 2013, Part 4 14 (1) - lists the enhanced services as:

- Anticoagulant Monitoring Service
- Care Home Service
- Disease Specific Medicines Management Service
- Gluten Free Food Supply Service
- Independent Prescribing Service
- Home Delivery Service
- Language Access Service
- Medication Review Service

- Medicines Assessment and Compliance Support Service (this is more clinical than MURs)
- Minor Ailments Service
- Needle and Syringe Exchange Service
- On Demand Availability of Specialist Drugs Service
- Out of Hours Service
- Patient Group Direction Service (this would include supply of any Prescription Only Medicine via PGD)
- Prescriber Support Service
- Schools Service
- Screening Service
- Stop Smoking Service
- Supervised Administration Service
- Supplementary Prescribing Service.

7. Public health services

Alongside their more traditional role, community pharmacies are increasingly delivering a wide range of locally commissioned services like smoking cessation, emergency hormonal contraception, needle and syringe exchange schemes, influenza immunisations and more. Commissioning of such public health services transferred to local authorities with effect from 1 April 2013. The following Enhanced Services were listed in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2012:

- Needle and syringe exchange
- Screening services such as Chlamydia screening
- Stop smoking
- Supervised administration service
- Emergency hormonal contraception services through patient group directions.

Where such services are commissioned by local authorities, they no longer fall within the definition of enhanced services or pharmaceutical services as set out in legislation and therefore should not be referred to as enhanced services.

A recent progress report from the Pharmacy and Public Health Forum outlined why community pharmacies are considered an ideal setting for the provision of public health services:

- Community pharmacies offer easy access, including for people from deprived communities who may not access other conventional NHS services
- Many provide long opening hours
- They are a health resource on the high street, in supermarkets, in every shopping centre
- They provide anonymity and confidentiality, where appropriate, in a flexible setting within an informal environment

- They have a workforce that tends to reflect the social and ethnic backgrounds of the population they serve, making it easier to provide health promoting interventions.

8. Pharmaceutical lists and NHS market entry

The legislative framework in England is set out in the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the 2013 regulations). Part 6 of the 2013 regulations provides a framework for ensuring the suitability of contractors who provide pharmaceutical services. Regulations in Part 6 make provisions for NHS England to manage admission, suspension and removal from their lists on fitness grounds. Under the Medicines Act 1968, a registered pharmacist must be in charge of each community pharmacy, which can be owned by a pharmacist sole trader, a limited liability partnership (where all partners are pharmacists) or bodies corporate (where a superintendent pharmacist must be appointed). These are collectively called *pharmacy contractors*.

9. Purpose of the PNA and its content

Based on the Department of Health (DH) guidance, this PNA will serve the following key purposes:

- It will be used by NHS England Area Team to make decisions about applications for opening new pharmacies in Hillingdon and dispensing appliance contractor premises; or applications from current pharmaceutical providers to change their existing regulatory requirements.
- Include a statement of the pharmaceutical services that the HWB has identified as services which are provided (within or outside Hillingdon) and are *necessary* to meet the need for pharmaceutical services in Hillingdon.
- A statement of the other (*relevant*) services which are provided, which are not needed, but which have secured improvements or better access to pharmaceutical services in the area.
- A statement of the services that the HWB has identified as not being provided, but which would, if they were to be provided, secure improvements or better access to pharmaceutical services in the area.
- A statement of other NHS services provided by a local authority, the NHS Commissioning Board (NHS England), a Clinical Commissioning Group (CCG) or an NHS Trust, which affect the needs for pharmaceutical services.
- An explanation of how the assessment has been carried out (including how the consultation was carried out).
- A map of providers of pharmaceutical services and other relevant maps that explain the scope of pharmaceutical services provided in Hillingdon and neighbouring boroughs, which impact on pharmaceutical need in Hillingdon.

The following are included in a pharmaceutical list for the purpose of PNA:

- **Pharmacy contractors** are healthcare professionals working for themselves or as employees who practice in pharmacy, the field of health sciences focusing on safe and effective medicines use
- **Dispensing appliance contractors** - appliance suppliers are a specific sub-set of NHS pharmaceutical contractors who supply, on prescription, appliances such as stoma and incontinence aids, dressings, bandages etc.; they cannot supply medicines. However, some pharmacy contractors can choose to dispense appliances, provide AURs and SACS as part of the essential and advanced services
- In addition, there are two other types of pharmaceutical contractor - **dispensing doctors,** who are medical practitioners authorised to provide drugs and appliances in designated rural areas known as *controlled localities*, and **local pharmaceutical services (LPS) contractors** who provide a level of pharmaceutical services in some HWB areas. A Local Pharmaceutical Service (LPS) contract allows NHS England to commission community pharmaceutical services tailored to specific local requirements. It provides flexibility to include within a single locally negotiated contract a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under national pharmacy arrangements set out in the 2013 Regulations. All LPS contracts must, however, include an element of dispensing.

10. Context for the Pharmaceutical Needs Assessment

This PNA was undertaken in accordance with the requirements set out in Regulations 3-9 Schedule 1 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013; and forms the basis for commissioners of pharmaceutical services to consider the current provision and identify gaps in relation to local health needs and local priorities. Detailed analysis of the local health needs including demographic, epidemiological and survey based assessment can be found in Appendices 1 - 3; while local priorities stem from the Joint Strategic Needs Assessment (JSNA) and described in the Joint Health and Wellbeing Strategy (JHWS).

11. Links with other strategies and plans

The PNA draws on and takes into account a range of other relevant plans and strategies prepared by the Council and its strategic partners in order to prevent duplication of work and multiple consultations with health groups, patients and the public. These include:

a. The Joint Strategic Needs Assessment

The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for HWBs in relation

to JSNAs. The aim of the JSNA is to improve the health and wellbeing of the local community and reduce inequalities for all ages, identifying those groups where health and care needs are not being met and those which are experiencing comparatively different outcomes. Hillingdon JSNA is a continuous, ongoing and iterative process, which is used to determine what actions Hillingdon Council, the NHS and other partners need to take to meet health and social care needs and to improve health outcomes and address health inequalities. The JSNA pulls together all local needs assessments, strategies, and plans which can be found on https://www.hillingdon.gov.uk/jsna.

The development of PNA is a separate task to that of developing JSNA, as PNAs will inform commissioning decisions by local authorities (public health services from community pharmacies) and by NHS England and clinical commissioning groups (CCGs). Therefore JSNA provides a starting point for the PNA, but once produced it will inform the JSNA as well as the Joint Health and Wellbeing Strategy.

b. Joint Health and Wellbeing Strategy (JHWS)

A new JHWS for Hillingdon is being developed for the period 2018-2021. The policy towards the integration of health and social care has set a new context for local strategies.

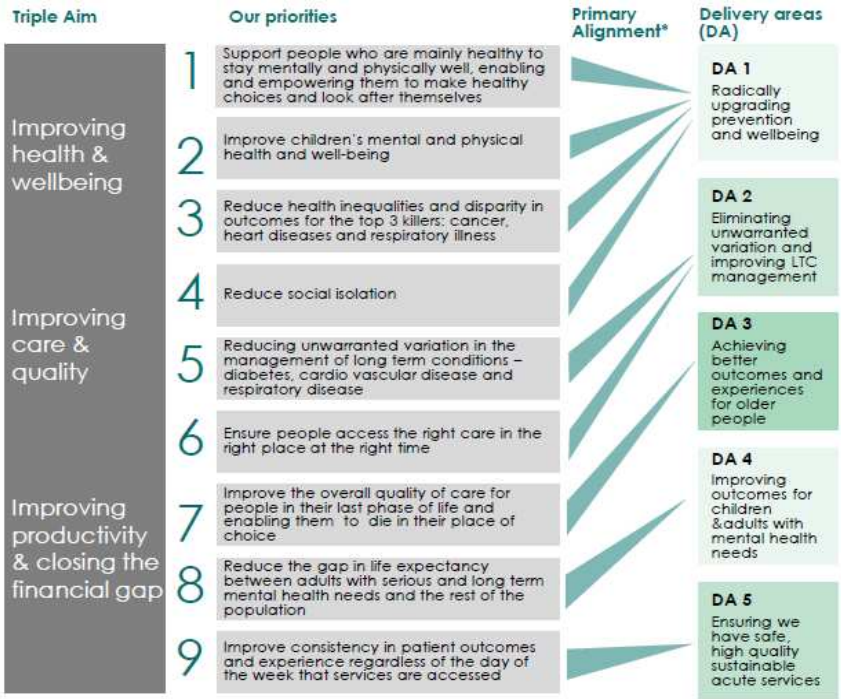
The NHS Five Year Forward View began the process in 2014 by setting out ambitions to dissolve traditional boundaries between GPs, hospitals, social care and mental health.

The Better Care Fund has introduced pooled budgets to move resources away from hospitals into social care and community services. From December 2015, NHS England has encouraged the NHS and its partners to create area-based health and social care plans - 'Sustainability and Transformation Plans'. STPs are expected to set out how local services will improve the quality of care, promote better health, and become more financially sustainable.

The North West London STP is one of 44 nationally. It identifies five broad Delivery Areas (DA) which form the basis for the development of the JHWS in Hillingdon:

- DA1 - Radically upgrading prevention and wellbeing
- DA2 - Eliminating unwarranted variation and improving the management of long-term conditions
- DA3 - Achieving better outcomes and experiences for older people
- DA4 - Improving outcomes for children with mental health needs
- DA5 - Ensuring we have safe, high quality, sustainable acute services

The North West London STP set out 9 priorities with three overarching aims. The diagram below shows the aims, priorities and delivery areas and how they will be aligned within the overarching strategy.



c. Hillingdon Health and Wellbeing Board

The Health and Wellbeing Board has a statutory requirement to improve the health and wellbeing of residents. Hillingdon's Health and Wellbeing Board was established as part of government changes to the NHS. It became a statutory committee of the Council on 1 April 2013.

The Board is the place for local councillors, the NHS, public health and social care representatives and providers to work together to improve the health and wellbeing of the people of the Borough. The partnership seeks to identify opportunities for collaboration and integration across agencies and develop direct links to services users, patients and local residents via Healthwatch Hillingdon.

The Board has the duty to produce a Joint Health and Wellbeing Strategy containing priorities for action for Hillingdon.

d. Hillingdon Clinical Commissioning Group (HCCG) and Community Pharmacy

The CCG recognises that community pharmacists provide comprehensive and valuable services and support to patients, carers and residents. They are trusted as highly qualified professionals whether located in a busy high street or at the heart of a community. GPs provide high quality and cost-effective diagnostic, support, referral and prescribing services. They share a common purpose with community pharmacists in ensuring that patients optimise the use of their medicines.

Hillingdon CCG's Medicines Management Team support GPs by providing evidence-based information to ensure patients receive safe and effective medicines, improve compliance and reduce wasteful prescribing. They understand the importance of harnessing the expertise and experience of community pharmacy in optimising medicines use and improving patient safety.

There are many areas of joint working between community pharmacists and the CCG Medicines Management Team, such as:

- Attending each organisations' medicines-related committees
- Working jointly on specific projects e.g. promotion of low acquisition cost blood glucose testing strips
- Setting up and implementing a Support with Medicines Use Pathway across the hospital, community, CCG, social care and primary care (GP and community pharmacy) interfaces.

The CCG no longer commissions NHS Pharmaceutical Services as this is the responsibility of NHSE. However the CCG can and does commission local services using the NHS Standard Contract. Currently these include:

1. An extended minor ailments service.
2. An out-of-hours palliative care service.
3. A sharps bin collection service.
4. A medicines use pathway across all health and social care interfaces which is managed by LBG alongside the other community pharmacy public health services.

The CCG will continue to work closely with local community pharmacists and commission further services to meet the needs of the local population. Further opportunities will arise when community pharmacists take on a wider role in improving medicines optimisation by ensuring patients get the best outcomes from the medicines they are prescribed and as a result of relevant public health initiatives.

e. Healthwatch Hillingdon

Healthwatch Hillingdon is a part of the national network of local Healthwatch organisations led and supported by Healthwatch England. It is commissioned by Hillingdon Council but is independent of the NHS and the local authority. As a health watchdog run by and for local people, it helps Hillingdon residents get the best out of their health and care services through signposting information and advice. It also provides a voice for influencing and challenging service provision throughout Hillingdon.

Healthwatch Hillingdon is a statutory member of Hillingdon Health and Wellbeing Board, and a member of Hillingdon Clinical Commissioning Group's Governing Body.

11. Outcomes frameworks for public health, NHS and social care

The Public Health Outcomes Framework (PHOF) for England 2016-2019 sets the overall vision for health improvement at a population level, *to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest*.

This vision is underpinned by two outcome measures:

- Outcome 1: Increased healthy life expectancy
- Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities through greater improvements in more disadvantaged communities.

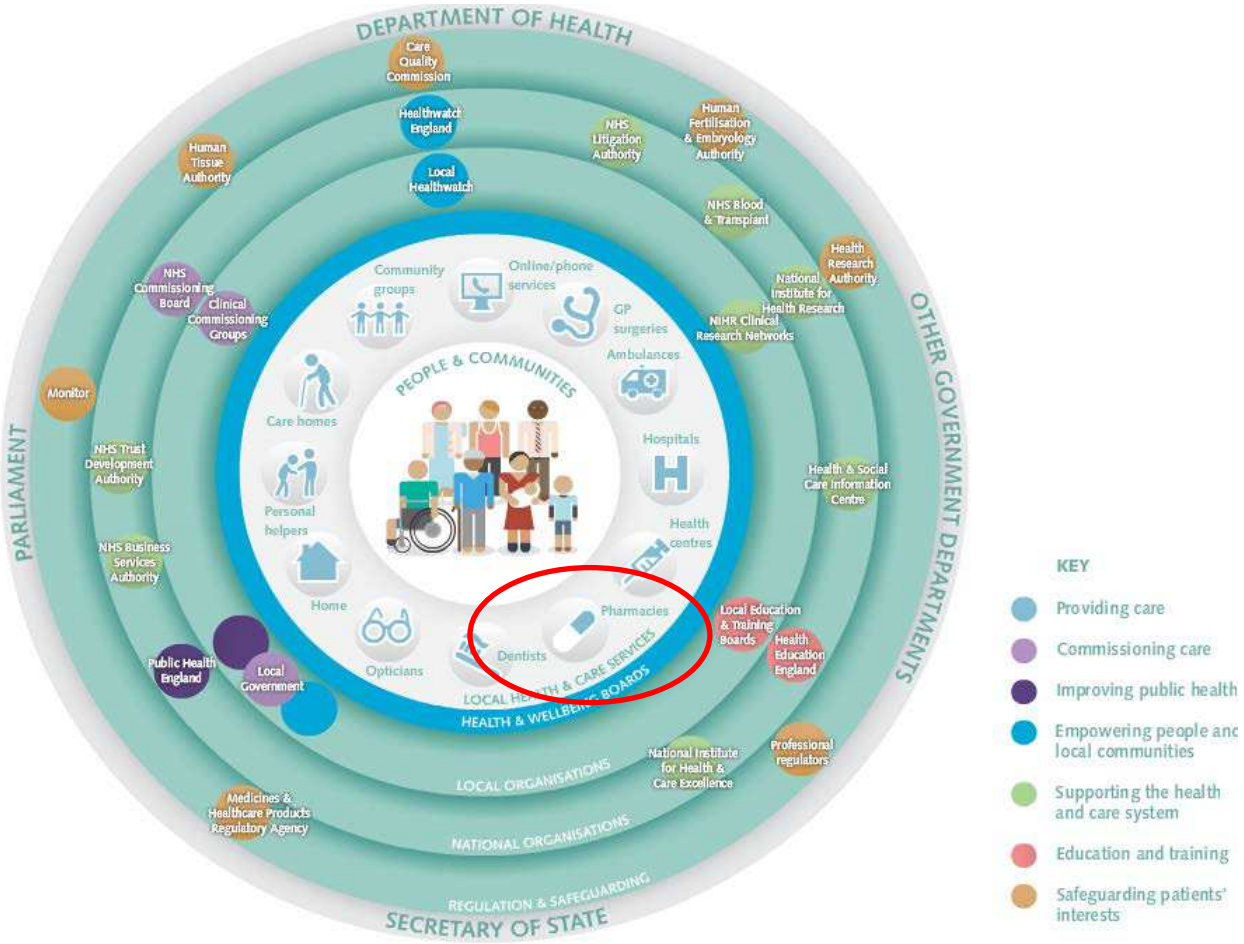
These two measures would work as a package covering both morbidity and mortality, addressing within-area differences and between area differences.

A set of supporting public health indicators that help focus our understanding of how well we are doing year by year nationally and locally on those things that matter most to public health, which we know will help improve the outcomes stated above. These indicators are grouped into four domains:

- improving the wider determinants of health
- health improvement
- health protection
- healthcare public health and preventing premature mortality.

Surveillance of public health data and quarterly monitoring of public health indicators is undertaken by the Public Health Team supported by the Business Performance Team.

12. Pharmaceutical services within the national and local context



The picture above shows the role community pharmacy has in relation to the other stakeholders such as:

- Residents (the innermost white circle)
- Other local health and care services communities (in the grey ring alongside pharmacies)
- Health and Wellbeing Board (bright blue circle)
- The other local and national organisations in the outer rings.

The health system underwent a radical restructuring in 2013. NHS allocations for 2017/18 show that local CCGs have received £72 billion, which includes funding for NHS England's public health responsibilities on behalf of Public Health England, for mainly immunisation, screening. The responsibility and funding for public health transferred from the NHS to local authorities in 2013, which meant that local authorities commission public health services such as smoking cessation, NHS Health Checks, Health Visiting, sexual and reproductive health and substance misuse services as part of their duty to improve public health.

Local authorities received over £2.5 billion from the DH in ring fenced funds in 2013/14. For 2017/18 the total public health grant to local authorities is £3.30 billion, a reduction of 2.5% from the 2016/17 baseline of £3.38 billion. The grant continues to be ring fenced for use on pubic health functions exclusively for all ages.

Health and Wellbeing Boards have the responsibility for encouraging integrated working between commissioners of services across health, social care, public health and children's services. This provides an opportunity for HWBs to work closely with health and care providers and local residents to tackle challenges such as smoking, obesity, alcohol and drug misuse, sexual transmitted infections and teenage conceptions. Healthwatch Hillingdon also has a role to become an effective voice of the public, to influence commissioning intentions and to hold services to account.

13. Hillingdon Pharmaceutical Needs Assessment 2015

Prior to starting work on this PNA, the previous PNA for Hillingdon (produced by the London Borough of Hillingdon in 2015) was reviewed alongside feedback received from NHS England Area Office for London.

The London Borough of Hillingdon produced a Pharmaceutical Needs Assessment in 2015, which concluded:

- **To recognise that pharmaceutical services in Hillingdon are well resourced. This suggests the number of pharmacies is sufficient to manage the need of the population over the next 3-5 years.**

- **Pharmacy services should be promoted to the local population.**

- **Pharmacies should continue to have an effective health promotion role, targeted to improve the health and wellbeing of Hillingdon residents where needed.**

- **Encourage pharmacies to increase the delivery of Medicines Use Review Services (MURs).**

- **Community pharmacists should use the *Making Every Contact Count* (MECC) approach while dispensing medicines in order to target individuals with public health messages and improve the health of Hillingdon residents**

The 2018 PNA has been further developed since the 2015 PNA and is compliant with the requirements of the NHS (Pharmaceutical and Local Pharmaceutical Services regulations) 2013.

14. Process for developing the PNA

A similar methodology was used to that of the 2015 PNA. A briefing was prepared for HWB to seek approval for the process at its meeting on 27 June 2017. Key steps included:

a) Agree the dataset required for reviewing epidemiological and demographic need at borough level, and review of the JSNA and JHWS

b) Agree localities, and having assessed information about population characteristics and health status, assess the needs for pharmaceutical services at locality level, considering ward and super output area level local intelligence where available

c) Consider the different needs of different localities in Hillingdon, based on population age, disability, gender, pregnancy and maternity rates, race and ethnicity, deprivation, distribution of illness and underlying factors e.g. lifestyle and living conditions (wider determinants), and provision of health services (e.g. hospitals, primary care) and other services

d) Review and revisit maps for community pharmacies in Hillingdon and in neighbouring areas. Conduct a survey of community pharmacy within Hillingdon and neighbouring areas

e) Consultation with stakeholders throughout the process, and a statutory 60 day consultation.

15. Stakeholder involvement in the PNA

In order to ensure full involvement of the local stakeholders, the following committees and organisations were invited to comment on the analysis and emerging recommendations:

- Local Pharmaceutical Committee (LPC)
- Local Medical Committee (LMC)
- Representatives from the local Pharmacists (LPS)
- Hillingdon Clinical Commissioning Group (HCCG)
- Healthwatch Hillingdon
- Hillingdon Hospitals Trust
- Other hospital trusts used by Hillingdon residents e.g. Ealing, and North West London Hospitals Trust
- Neighbouring HWBs
- Local Patient, Consumer, and Community Groups
- NHS England Area Office
- Local Voluntary Sector partners

How stakeholders were involved

Hillingdon HWB agreed the process to establish methodology, structure and design of the PNA. The LPC, Hillingdon CCG, Hillingdon LMC and Healthwatch Hillingdon were contacted during the PNA process.

A survey was sent out to all of the 65 community pharmacies in Hillingdon, and to a further 54 community pharmacies identified in the neighbouring boroughs which are within 1km of the Hillingdon boundary on the London side and within 2km of the Hillingdon boundary on the Home Counties sides. Hillingdon Council, with the help of the Local Pharmaceutical Committee, maintained regular contact with community pharmacists in Hillingdon to achieve a 100% response rate.

60 Day Statutory Consultation

The statutory consultation will take place at the end of September, subject to agreement from the Health and Wellbeing Board, to seek the views of wider stakeholders and members of the public, on whether they agreed with the analysis in this PNA and whether it addressed issues that they considered relevant to the provision of pharmaceutical services.

Backing Papers:

Appendix I – Demography

Appendix 2 – Epidemiology

Appendix 3 - Community Pharmacy Provision

Appendix 4 – Pharmacy Survey Results

Appendix 5 – Pharmacy Survey

Glossary

AUR – Appliance Use Review
BAME – Black and Minority Ethnic
BNF – British National Formulary
CCG – Clinical Commissioning Group
CMO – Chief Medical Officer
CNWL – Central & North West London
COPD – Chronic Obstructive Pulmonary Disease
CVD – Cardiovascular Disease
DH – Department of Health
EHC - Emergency Hormonal Contraception
ESA – Employment Support Allowance
ESP – Essential Small Pharmacy
GLA – Greater London Authority
GIS – Geographical Information System
GP – General Practitioner
H&H – Hayes and Harlington Locality
HCCG – Hillingdon Clinical Commissioning Group
HSCIC – Health & Social Care Information Centre
HSSS - Hillingdon Stop Smoking Service
HWB – Health and Wellbeing Board
IFR – Individual Funding Requests
JHWS – Joint Health and Wellbeing Strategy
JSNA – Joint Strategic Needs Assessment
LA – Local Authority
LINk – Local Involvement NetworK
LMC – Local Medical Committee
LPC – Local Pharmaceutical Committee
LPS – Local Pharmaceutical Service
LSOA – Lower Super Output Area
MECC – Making Every Contact Count
MUR – Medicines Use Review
NHS – National Health Service
NHSE – National Health Service (NHS) England
NIC – Net Ingredient Cost
NMS – New Medicines Services
NOMIS – Official Labour Market Statistics from the ONS
ONS – Office for National Statistics
PCT – Primary Care Trust
PDU – Problematic Drug Users
PGD – Patient Group Direction
PHE – Public Health England
PHOF – Public Health Outcomes Framework
PNA – Pharmaceutical Needs Assessment
QOF - Quality Outcomes Framework
PPwT – Planned Procedures with a Threshold
R&N – Ruislip and Northwood Locality
SACS – Stoma Appliance Customisation Services
SMR – Standardised Mortality Ratio
STI – Sexually Transmitted Infection
STP - Sustainability and Transformation Plans
TB – Tuberculosis
U&WD – Uxbridge and West Drayton Locality

Hillingdon Pharmaceutical Needs Assessment 2018

Appendix 1: Demography

March 2018

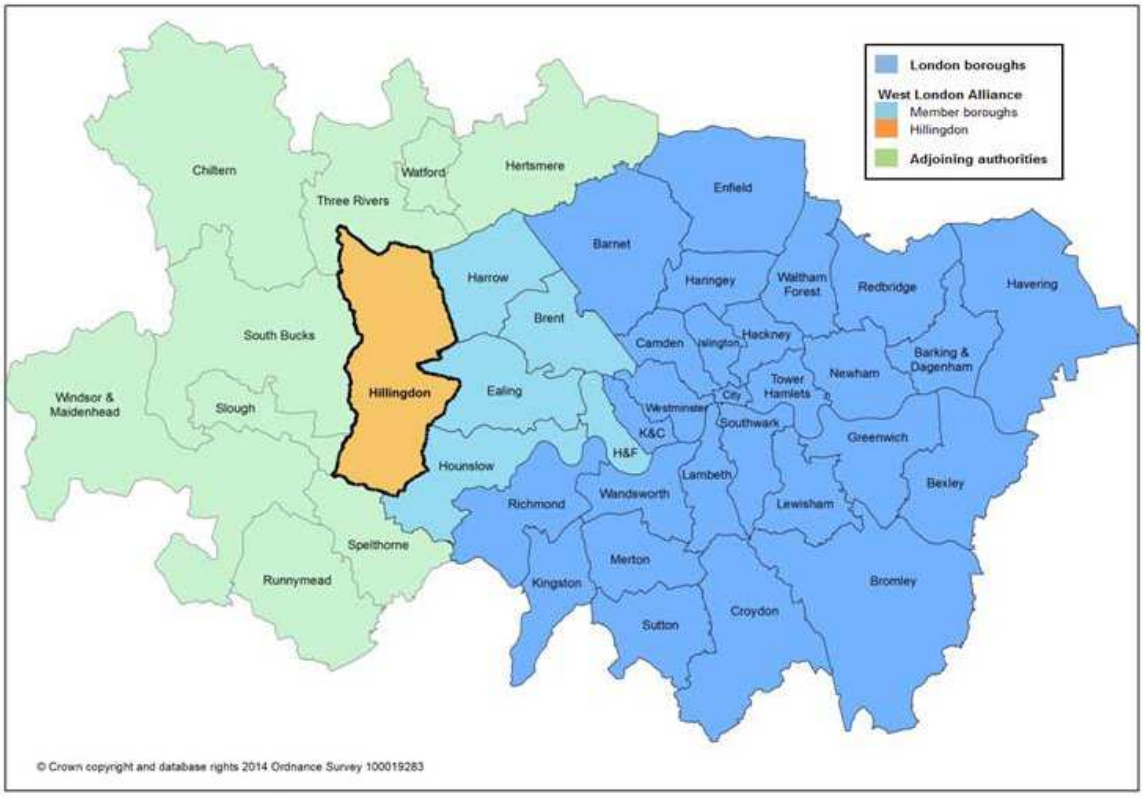
Pharmaceutical Needs Assessment 2018

Appendix 1: Demography

Demographic review of the London Borough of Hillingdon

Hillingdon is the second largest of London's 32 boroughs covering an area of 42 square miles (11,571 hectares), over half of which is countryside and woodland. Hillingdon has always been a transport hub, and home to Heathrow Airport - the world's busiest international airport. It is also the home of RAF Northolt, and shares its borders with Hertfordshire, Buckinghamshire, Surrey, Hounslow, Ealing, and Harrow.

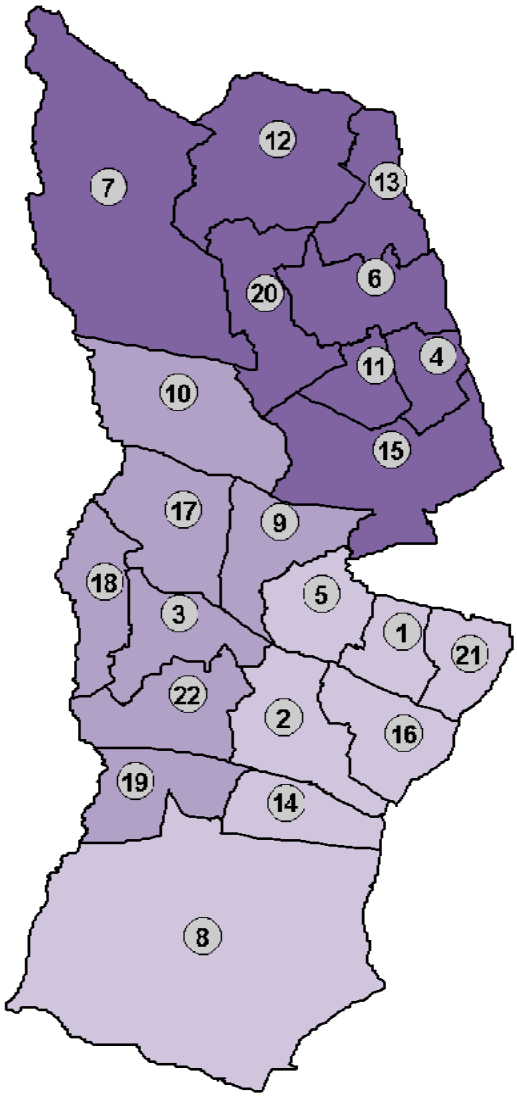
Location of Hillingdon



Hillingdon is traversed by the grand union canal, the M4 motorway, A40, A4020 and the Great Western Railway. With all those road networks and three of London's underground lines (Piccadilly, Metropolitan and Central lines) starting and ending in the Borough, Hillingdon is a major transport hub. South of the Borough is home to the world's busiest international airport Heathrow, which occupies 1,227 hectares land, and handled 75.7 million passengers in 2016. The arrival of Crossrail in 2018, with new stations at West Drayton and Hayes will open up access to central London even further.

Hillingdon has 22 electoral wards within three localities: Ruislip & Northwood in the northern part of the Borough, Uxbridge & West Drayton in the central part of the Borough, and Hayes & Harlington in the southern part of Hillingdon. Ruislip & Northwood consists of eight wards, and Uxbridge & West Drayton and Hayes & Harlington both consist of seven wards.

Hillingdon's wards within each locality

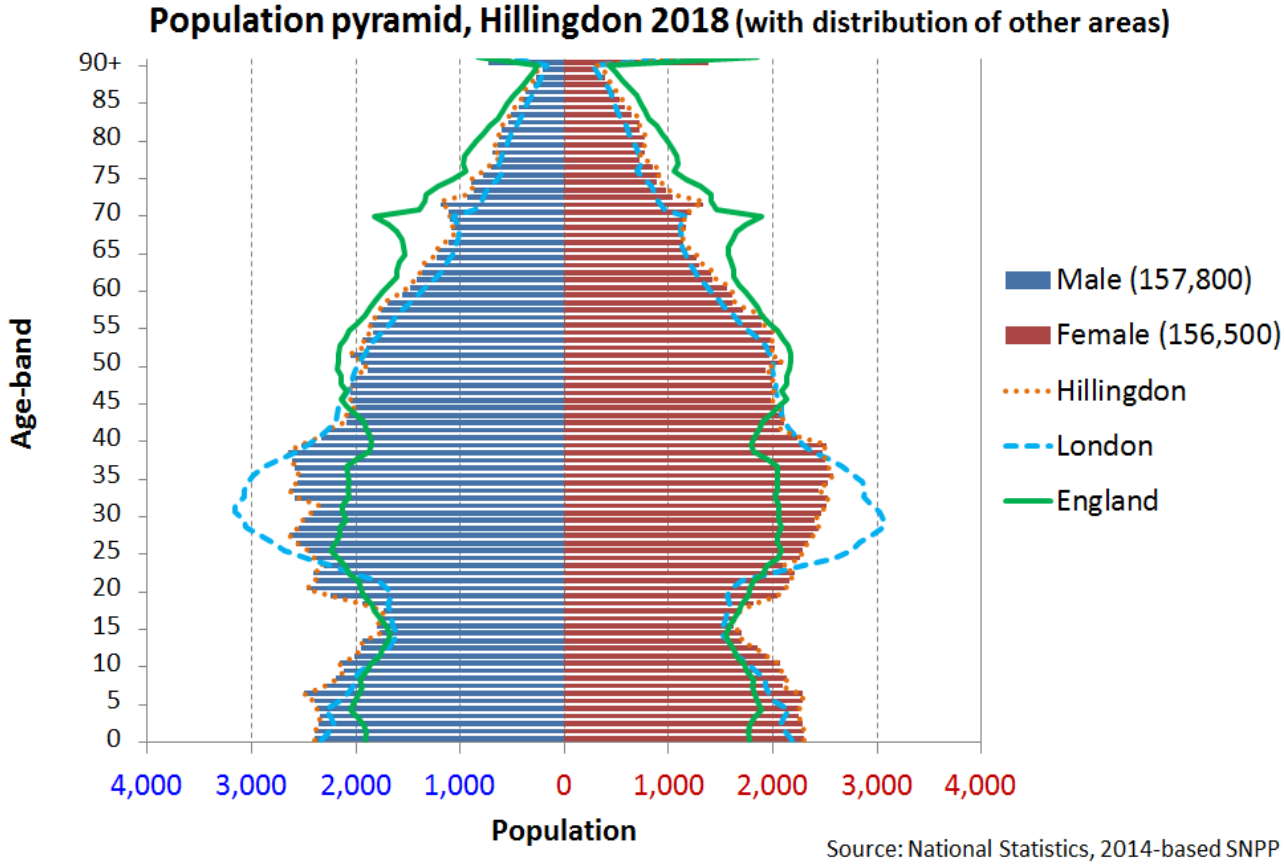
Ruislip & Northwood 4 Cavendish 6 Eastcote & East Ruislip 7 Harefield 11 Manor 12 Northwood 13 Northwood Hills 15 South Ruislip 20 West Ruislip	
Uxbridge & West Drayton 3 Brunel 9 Hillingdon East 10 Ickenham 17 Uxbridge North 18 Uxbridge South 19 West Drayton 22 Yiewsley	
Hayes & Harlington 1 Barnhill 2 Botwell 5 Charville 8 Heathrow Villages 14 Pinkwell 16 Townfield 21 Yeading	

Demographic analysis in the next section is aimed at establishing current and future needs of Hillingdon residents. Community pharmacy plays an increasingly important role in meeting population health needs, which generally vary based on age, gender, ethnicity, levels of affluence, living and working conditions and geography.

1. Population age and ethnicity

The Office for National Statistics estimates the Hillingdon population to be 314,300 in 2018.

The figure shows the age and sex distribution of the population in Hillingdon in 2018. The figure also shows the comparative age and sex distribution of London and England were they too to have a population of 314,300.



Source: National Statistics, 2014-based SNPP

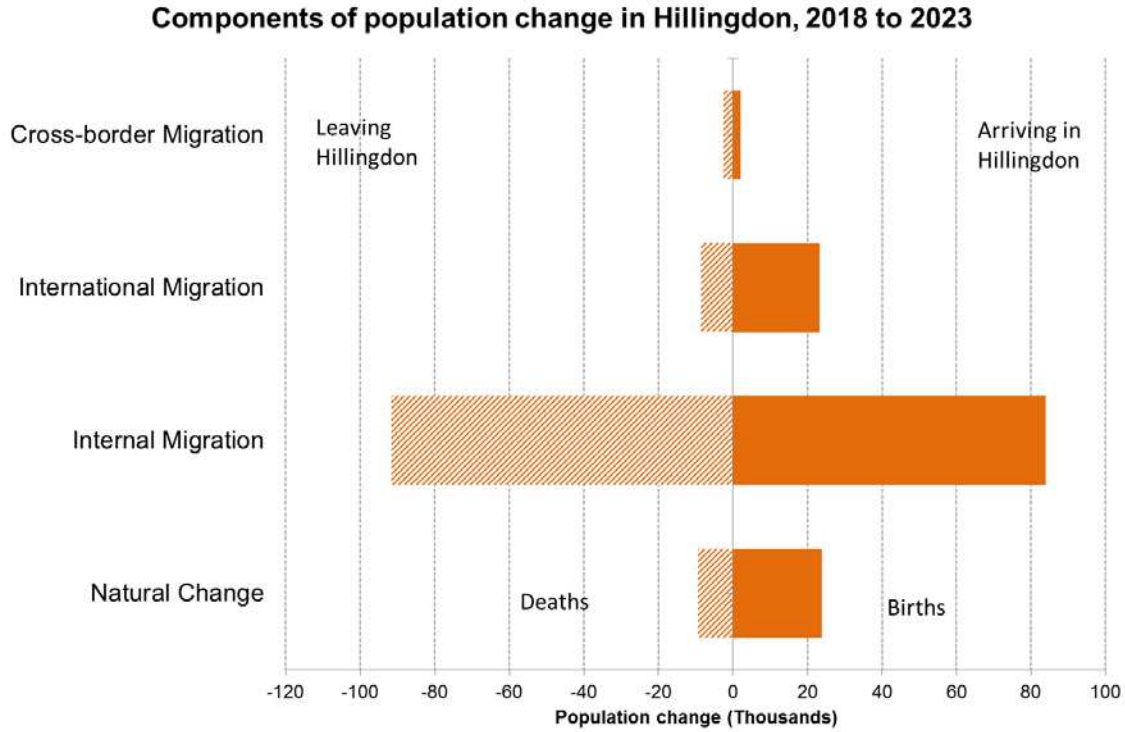
Hillingdon age breakdown: 2018

Age Band	Persons
Age 0-4	23,200
Age 5-15	44,900
Age 16-64	205,000
Age 65-74	21,700
Age 75+	19,400

The age and sex population distribution in Hillingdon is similar to England for the 11-18 age group. The age and sex population distribution in Hillingdon is similar to London for the 0-4 and 45+ age groups. The proportion of the population in Hillingdon is higher than the proportion in London and England for the age groups 5-10 and 19-22. For the 25-42 age group, the proportion of the population living in Hillingdon lies between the distribution expected in England and London.

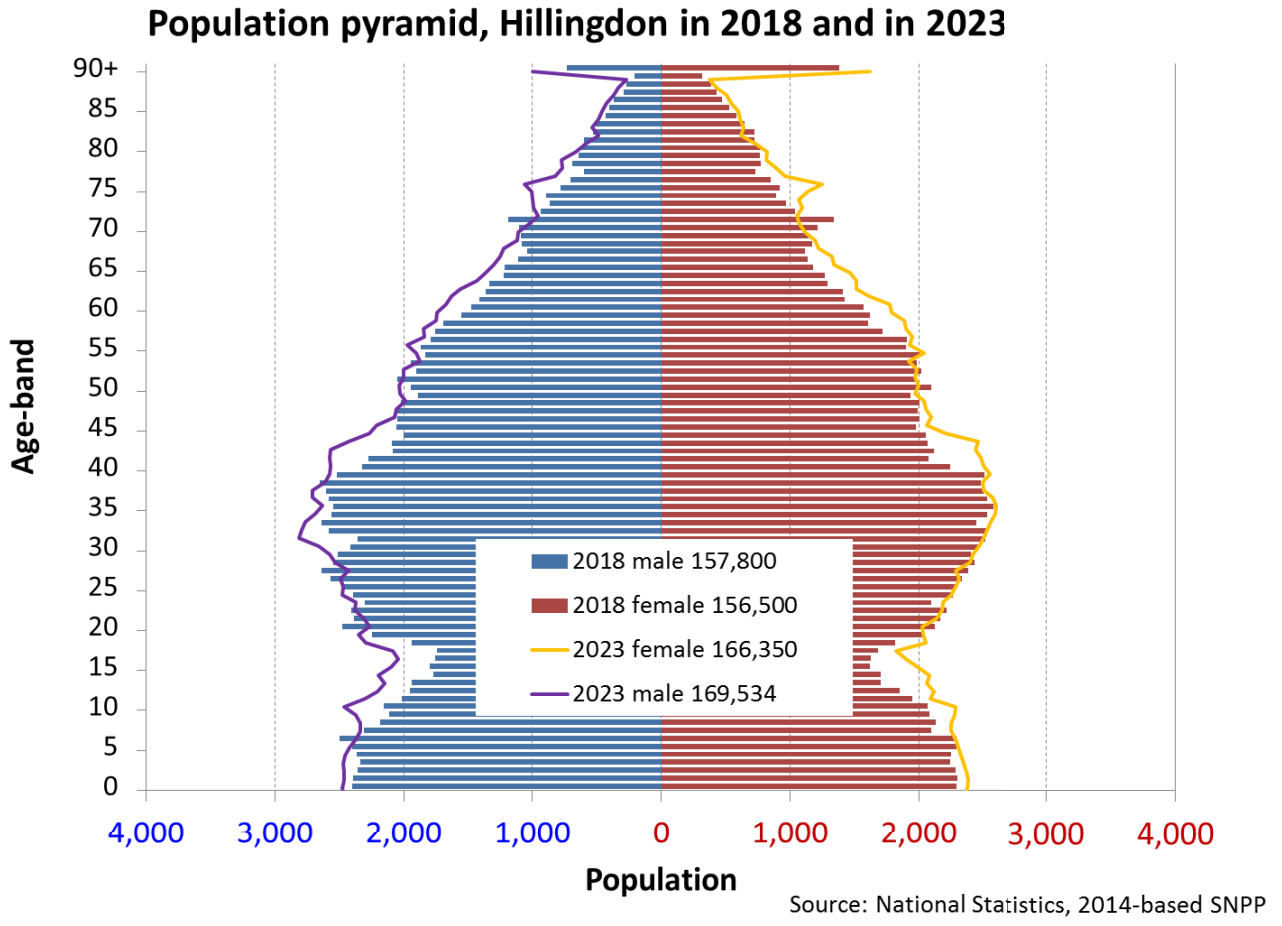
Current population and population projections

The population increase in Hillingdon between 2018 and 2023 is expected to be 21,600 or 7% (approximately 1.3% per annum). The corresponding 5-year increase in London is 5.8% and in England overall is 3.5%.

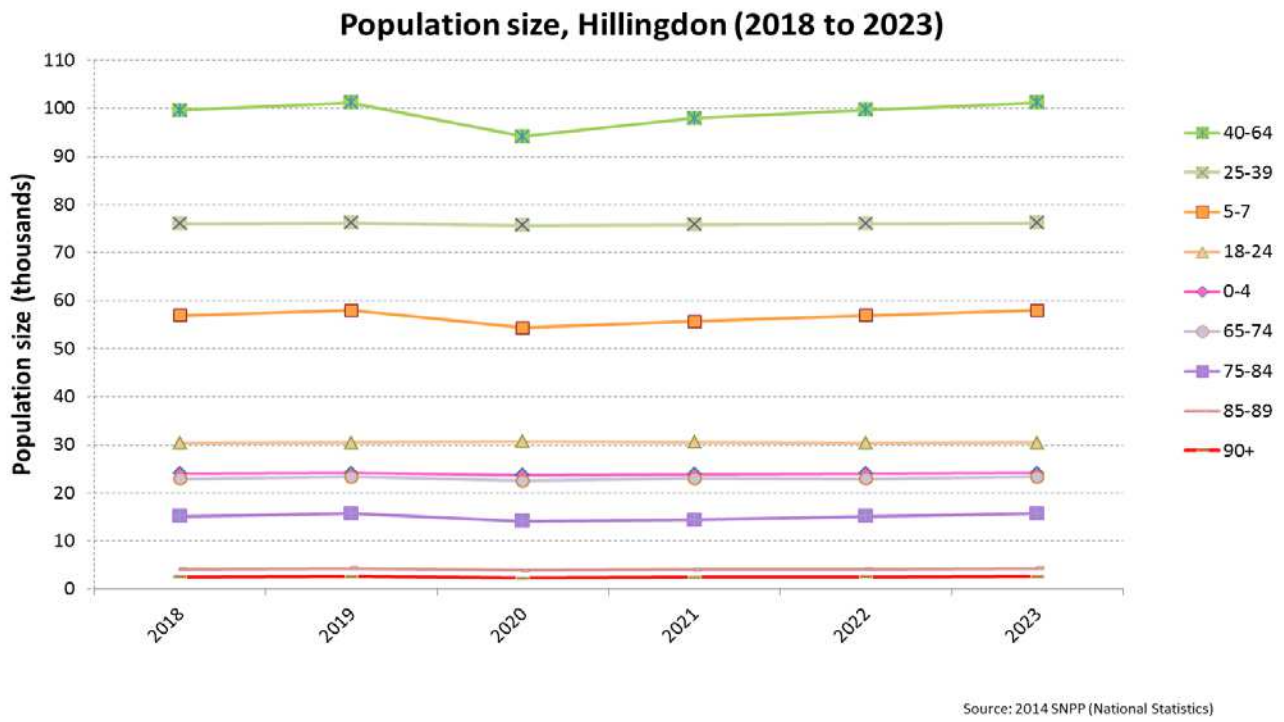


Source: National Statistics, SNPP Components of Change

The main driving force behind the increase in the population between 2018 and 2023 is natural change, ie 14,600 more births than deaths. Net migration is expected to account for around 7,000 persons over the same period (30% of the population increase of 21,600 between 2018 and 2023).



According to the Sub National Population Projections, the number of people in the following age bands are expected to increase in the next 5 years: 5-17, 25-39, 40-64. All the other age bands are expected to increase only slightly or remain flat until 2023.



Population at ward level

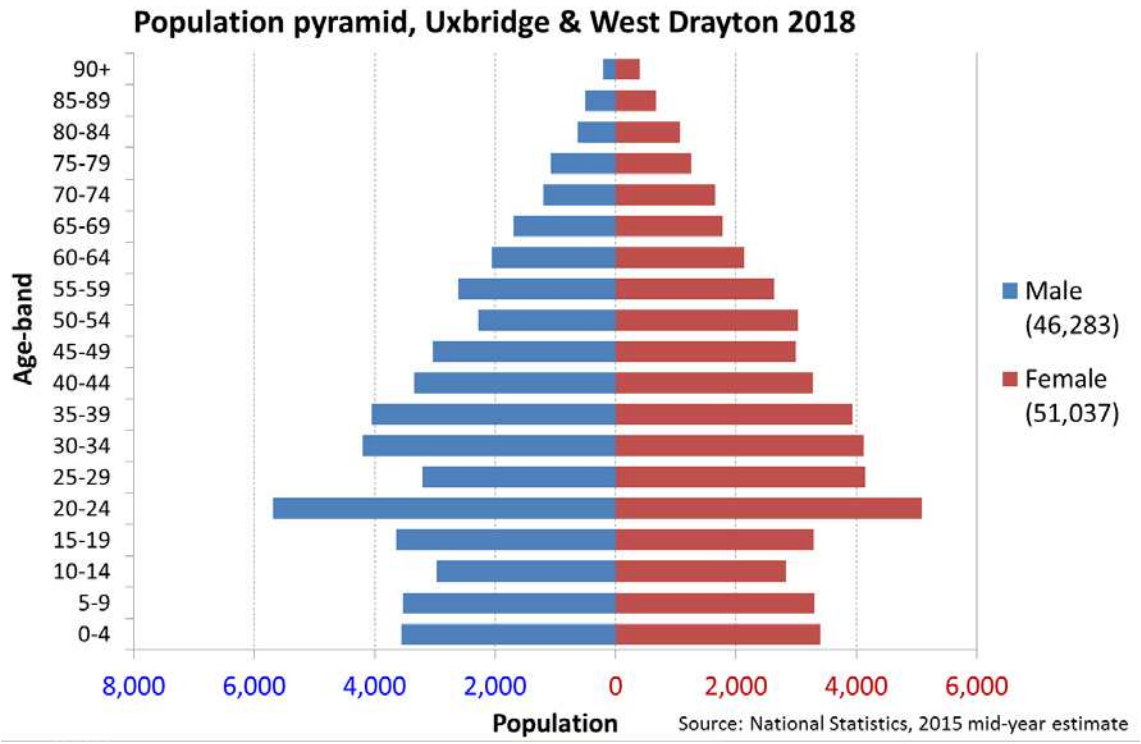
The Greater London Authority (GLA) Round of Demographic Projections (published in 2017) estimates that the population across the 3 localities will be as follows in 2018:

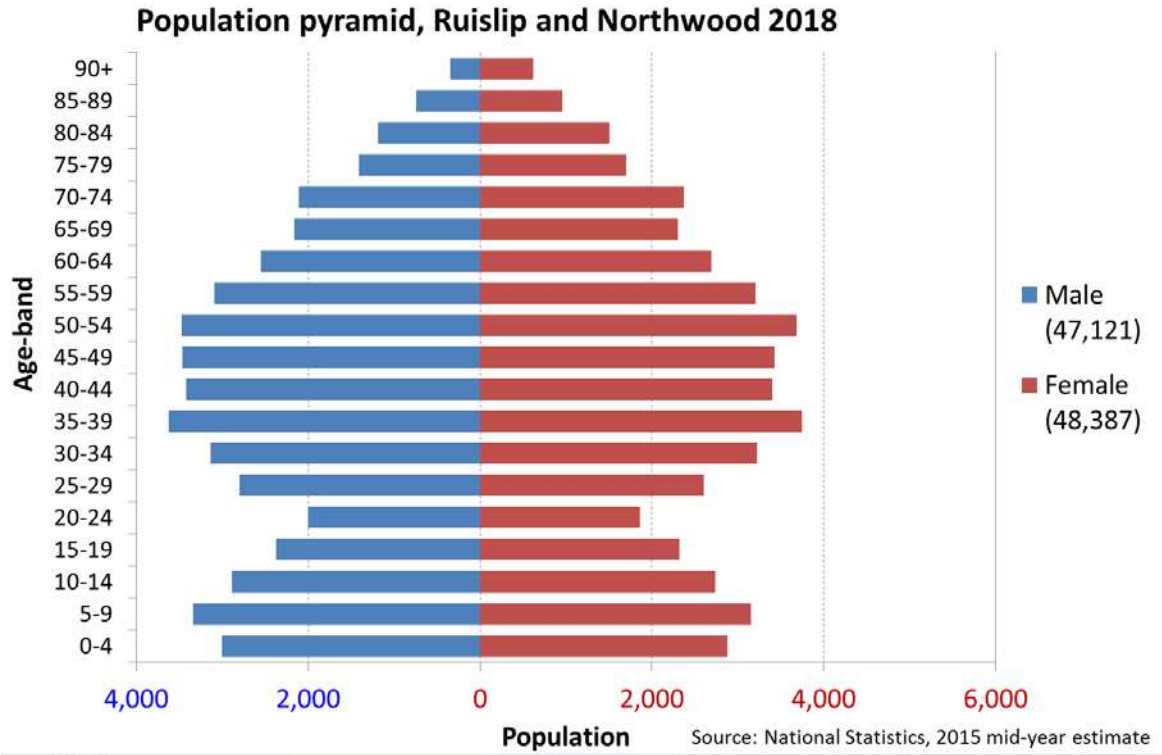
Ruislip & Northwood	96,200 (31%)
Uxbridge & West Drayton	103,100 (34%)
Hayes & Harlington	108,100 (35%)
Total	307,400*

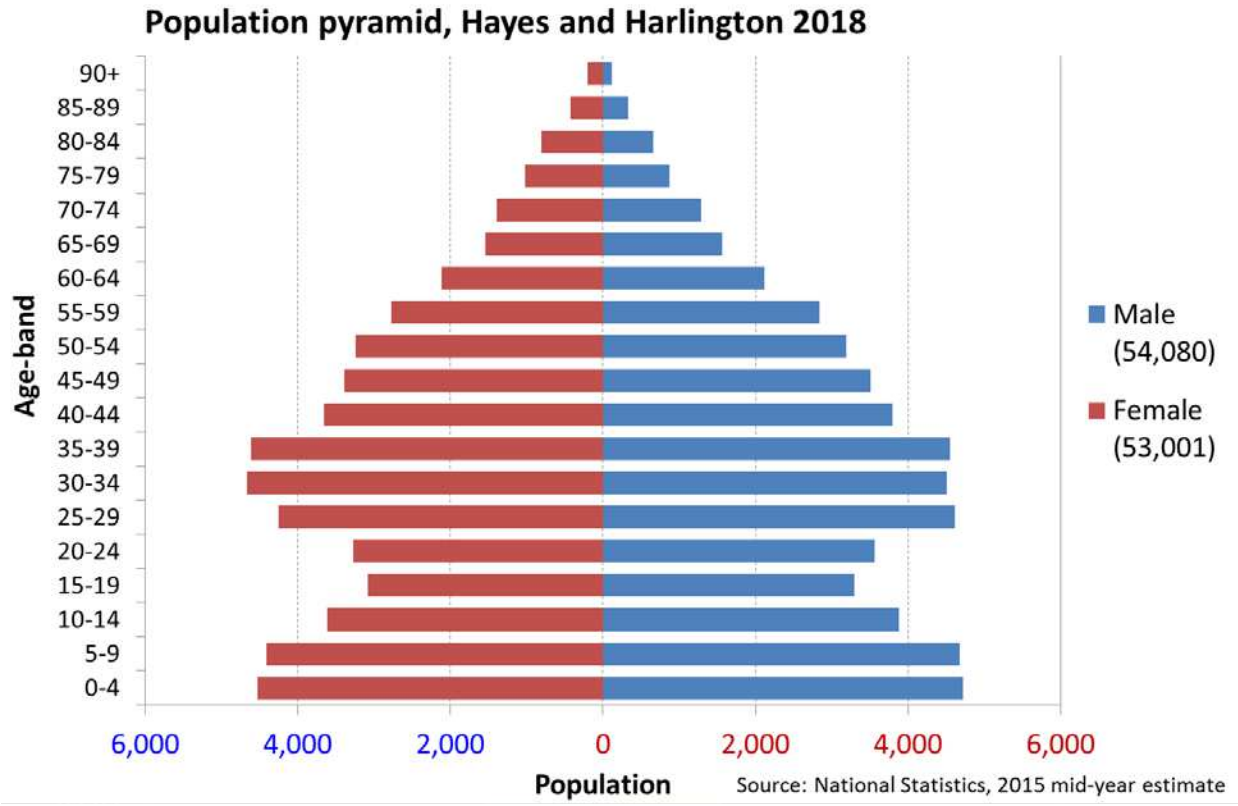
*note the difference in the population total in the GLA figures from the SNPP figure; both figures are correct but the SNPP figures are at borough level, and the GLA figures are at ward level (aggregated to borough level).

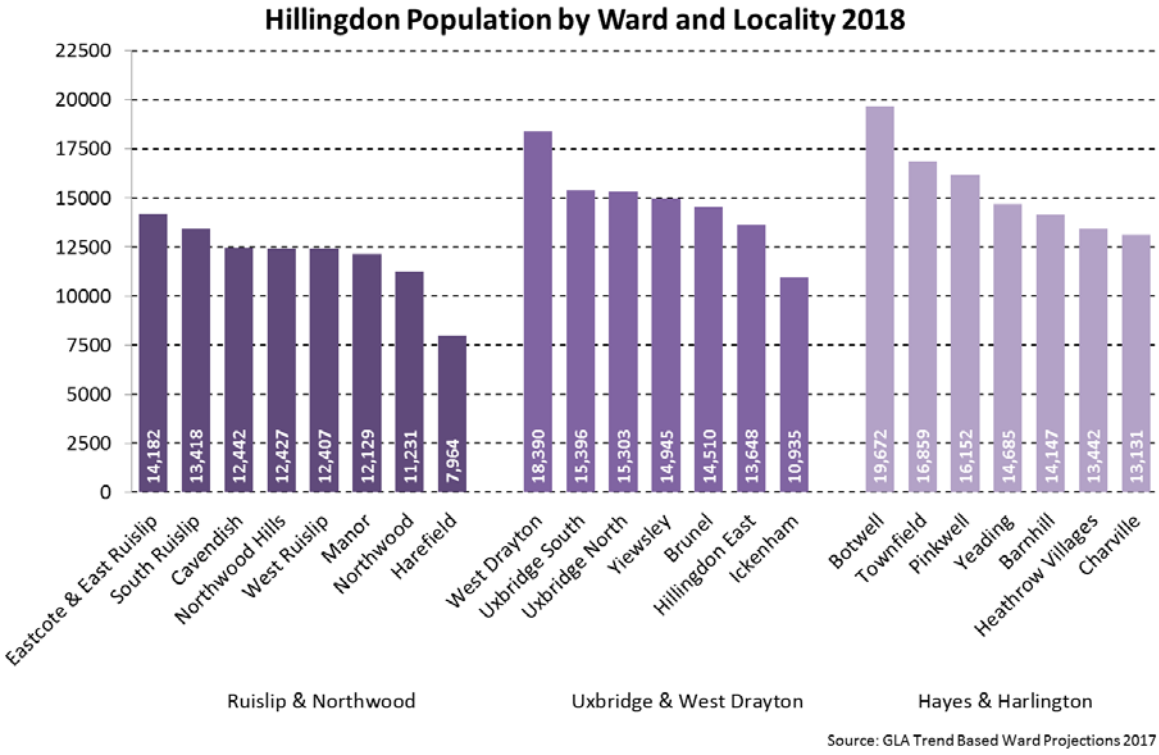
Population pyramids at locality level

These graphs show the population pyramids for Hillingdon's localities, and show the population split by age and sex.



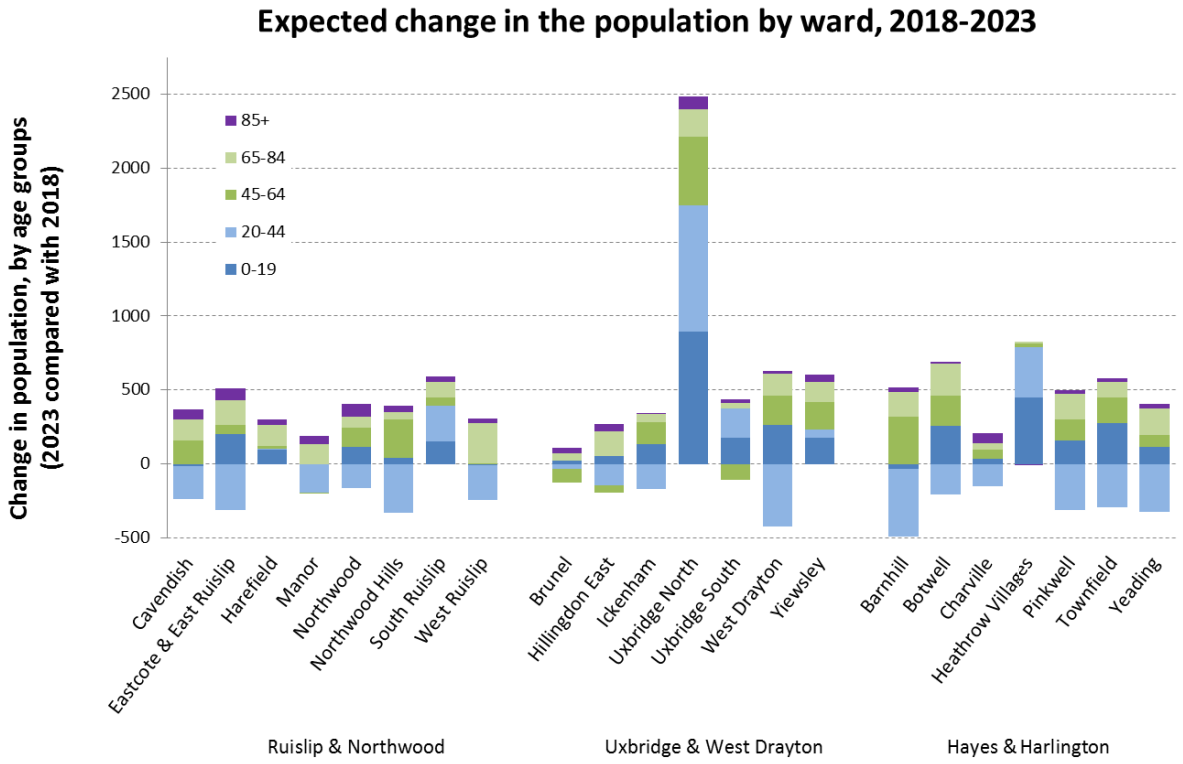






The percentages of the population living in each locality is approximately evenly split with 35% of residents living in Hayes & Harlington, 34% living in Uxbridge & West Drayton and

31% living in Ruislip & Northwood. Population change between 2018 and 2023 by ward is estimated on the next graph.



Source: 2015 Round of Demographic Projections - Ward projections, SHLAA-based; Capped Household Size model, GLA 2016

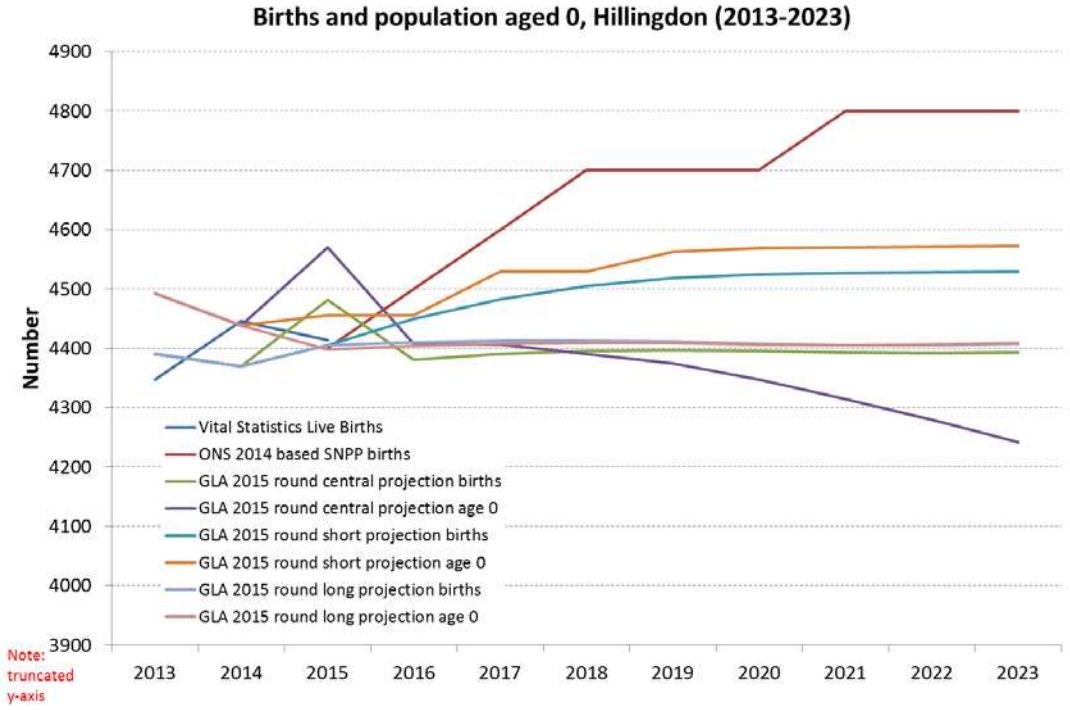
Information on the distribution of community pharmacies across Hillingdon shows that the provision of community pharmacy in Ruislip & Northwood locality is higher with 23 pharmacies than Uxbridge & West Drayton (21) and Hayes & Harlington localities (21). The proportion of community pharmacies per 100,000 population is therefore higher in Ruislip & Northwood (23.9) when compared with the other two localities (U&WD=20.3 and H&H=19.4), London (20.4) and England (20.8).

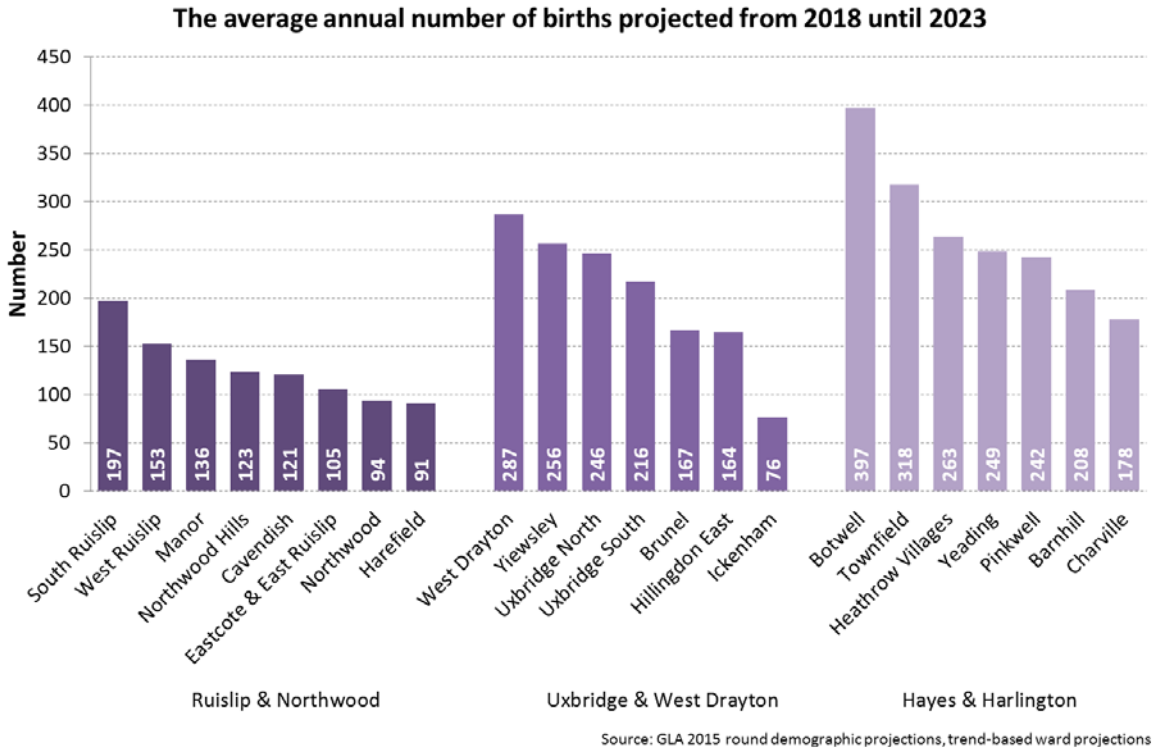
Given the higher population increases predicted for Uxbridge & West Drayton (due to the development of St Andrew's Park), there will be a need to monitor the provision of pharmaceutical services over medium to long term.

The GLA 2015 Round of Demographic Projections estimates that Uxbridge North will experience the greatest increases over the next 5 years. Within Uxbridge North the development of RAF Uxbridge (St Andrew's Park) will include 1,340 properties alongside leisure and community facilities. The Housing Zone, predominately in Botwell ward, (the development of the Old Vinyl Factory) will result in an estimated 2,500 properties together with other infrastructure developments over the next 5 years. This is not reflected in the GLA projections due to the phasing rate of development and approval of associated planning applications.

2. Births and birth projections

In 2015 there were 4,482 live births and this figure is expected to decrease to 4,200 births per annum over the next 5 years. As the figure below shows, Ickenham has the lowest number of births expected per annum in the five years up until 2023. Wards with the highest projections of births up to 2023 are in the south of the borough.

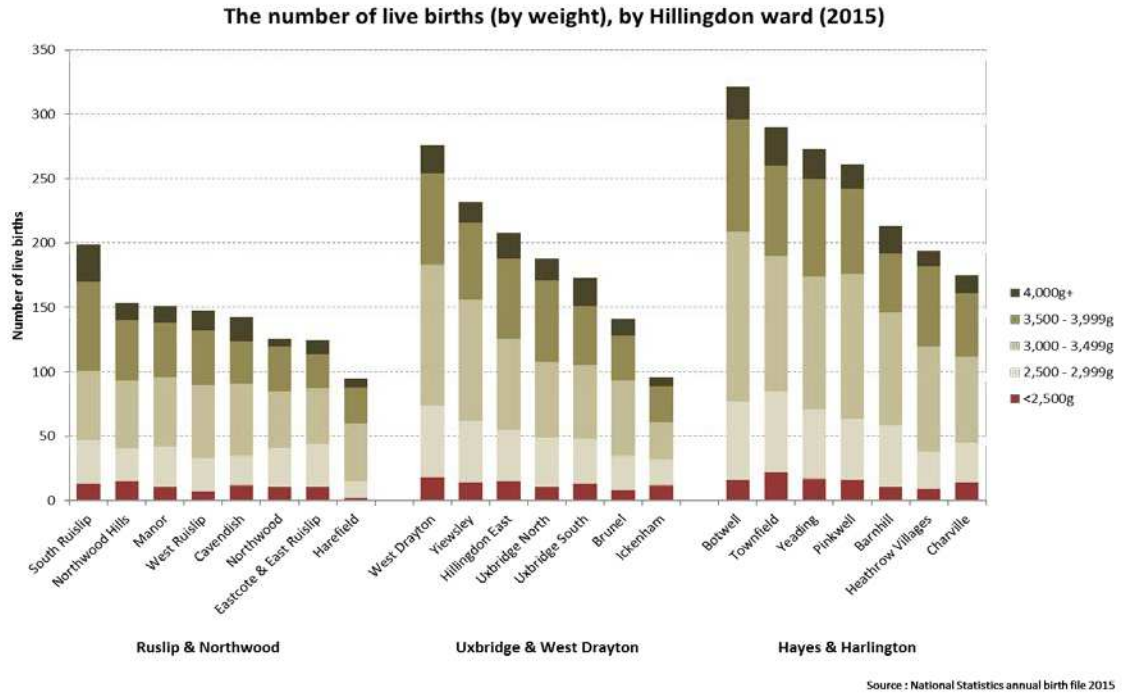




Low birthweight

New-borns that have a birthweight of less than 2,500g are termed low birthweight (LBW). Babies whose birthweight is just below the low birth weight threshold (2,000 to 2,500 grams) are 5 times as likely to die as an infant as those of normal birthweight. Those who have extremely low birthweight (less than 1,000 grams) are 200 times more likely to die as an infant than those of normal birthweight. Reflecting this, two-thirds of all infant deaths are among those born of low birthweight, and more than half of these were born of extremely low birthweight.

In 2015, 6.6% of live births in Hillingdon weighed less than 2,500 grams, the comparable figure for London was 7.1% and England 6.9%.



The graph above shows the number of live births by birthweight for Hillingdon. The highest number of LBW new-borns is in southern wards (Townfield, West Drayton and Yeading). Low birthweight is usually associated with deprivation, hence areas with higher levels of deprivation also show higher levels of low birthweight.

3. Age and ethnicity

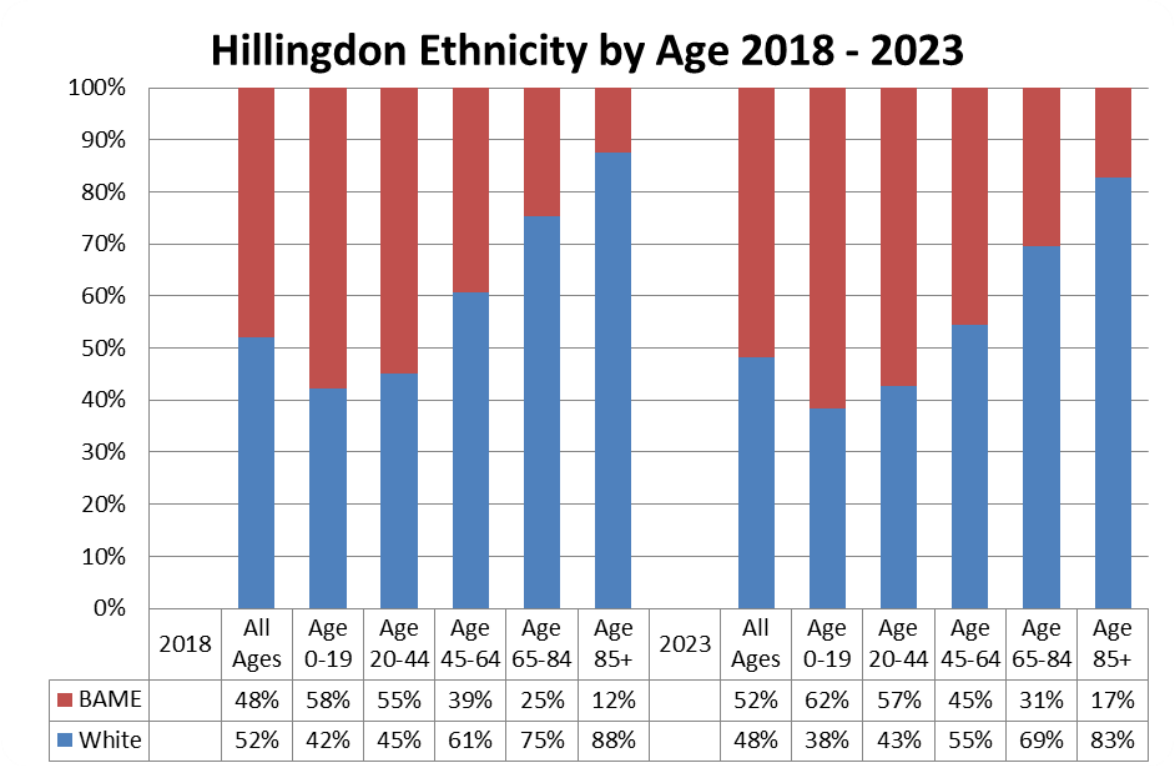
There is a higher proportion of White and older residents in Ruislip & Northwood. The student population in the wards of Brunel and Uxbridge South results in a higher than average 20-24 year age band in the locality of Uxbridge & West Drayton. There is a greater ethnic mix among younger residents in Hayes & Harlington, and proportionally less older residents.

Ethnicity projections

The Greater London Authority 2015 Round Final Ethnic Group projection figures (GLA EGRP 2015, Long Term) for 2018 estimate that Hillingdon is becoming more diverse with Black and Minority Ethnic (BAME) groups accounting for 48% of the usual resident population and White ethnic groups accounting for 52% of the population in 2018. Using the same data set this proportion of BAME groups is higher than across London (43%). The

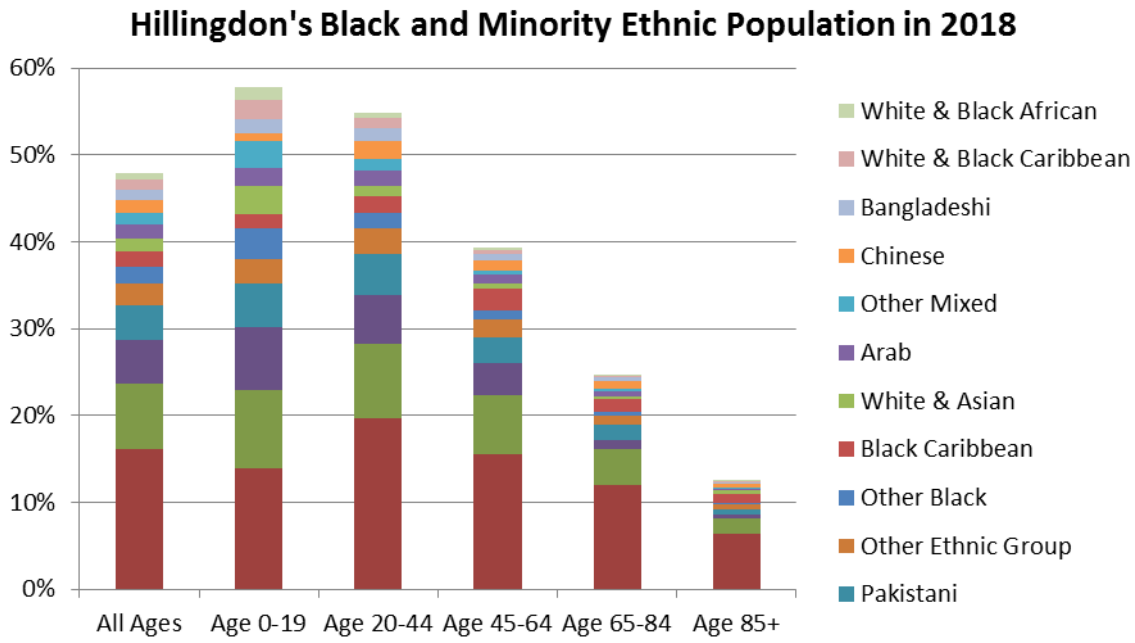
figure below shows that this trend is projected to continue with BAME groups expected to account for 52% of the population in 2023. The age breakdown shows that all age groups are expected to show an increase in the proportion of BAME groups between 2018 and 2023.

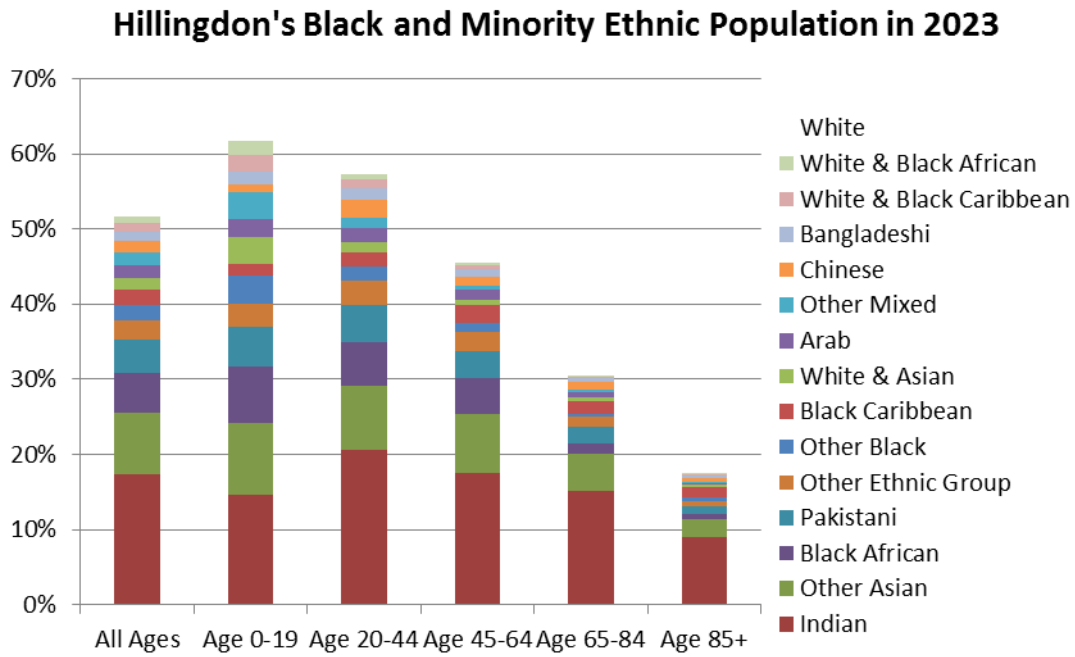
Note that the GLA ethnic group population projections use slightly different ethnic groupings than the Census – these are noted in the key.



	2018	All Ages	Age 0-19	Age 20-44	Age 45-64	Age 65-84	Age 85+	2023	All Ages	Age 0-19	Age 20-44	Age 45-64	Age 65-84	Age 85+
BAME		48%	58%	55%	39%	25%	12%		52%	62%	57%	45%	31%	17%
White		52%	42%	45%	61%	75%	88%		48%	38%	43%	55%	69%	83%

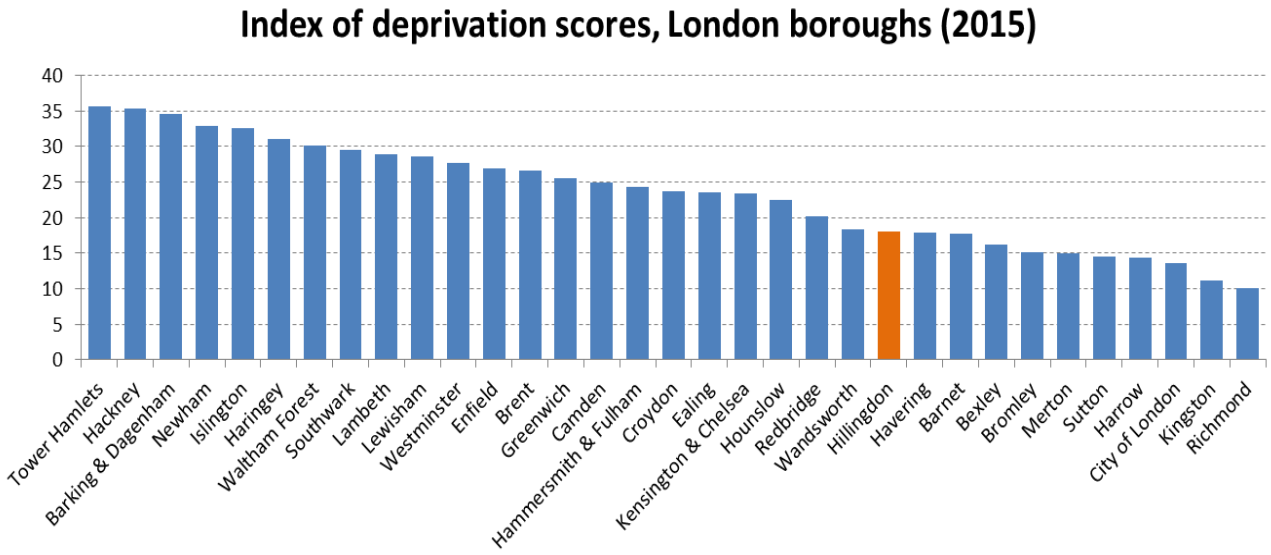
The graphs below show the percentage of different black and minority ethnic population projection categories across Hillingdon in 2018 and 2023





4. Deprivation

The 2015 English Index of Deprivation (IMD 2015) calculates a deprivation score for each lower super output area (LSOA) in England where the most deprived is ranked 1. Average deprivation scores which have been weighted to the size of the LSOA population have been calculated by the Department for Communities and Local Government. Hillingdon is ranked 162nd out of 326 Local Authorities in England and ranked 23rd out of 33 London Boroughs (including City of London); thus Hillingdon on the whole can neither be regarded as deprived nor affluent but presents a mixed picture with areas of both across the Borough.



The following 3 maps show the various versions of IMD ranking in Hillingdon:

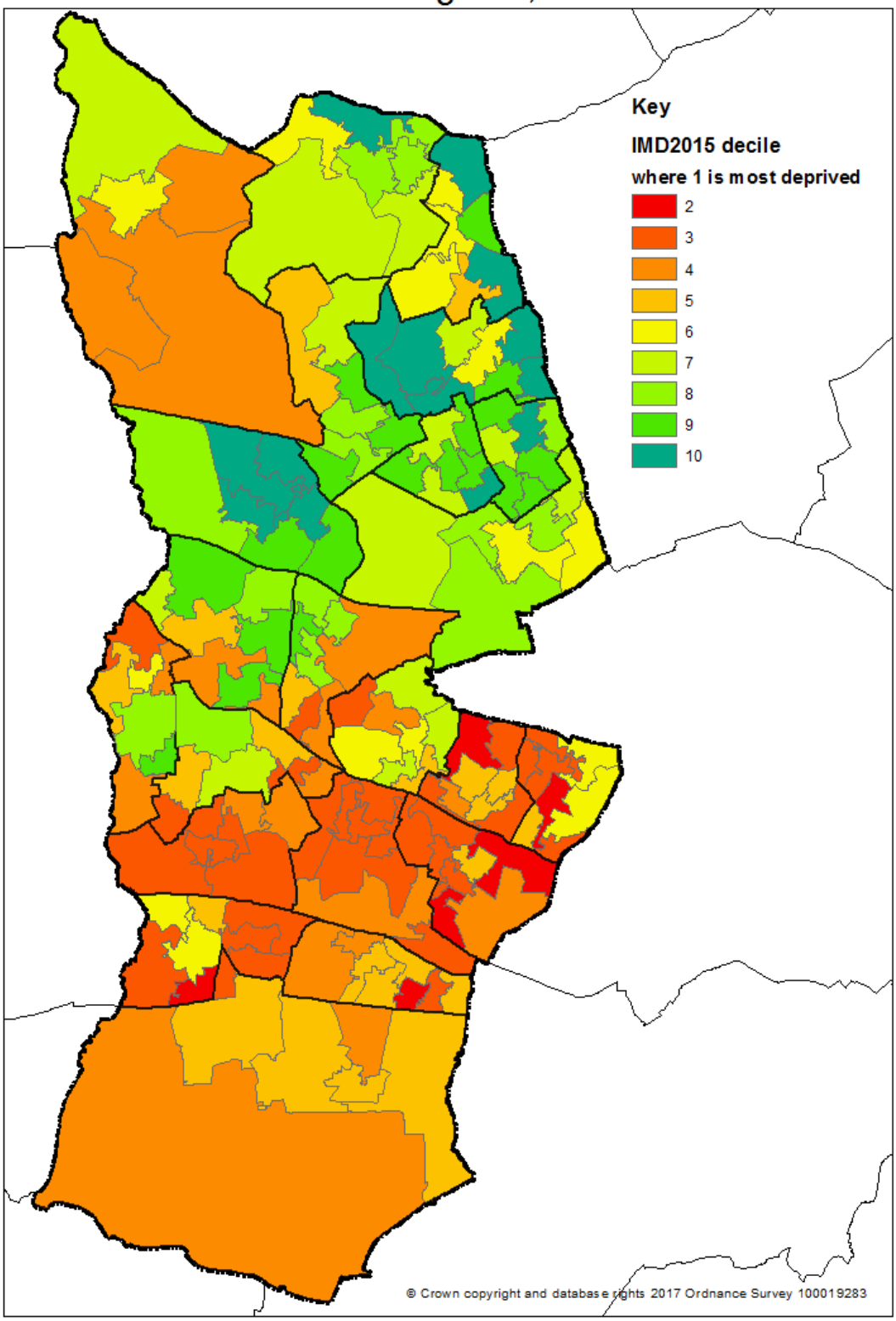
- Overall Indices of Multiple Deprivation (IMD)
  The average deprivation score of Hillingdon Local Authority on the whole masks the differences in deprivation scores that can be seen in Lower Super Output Areas (LSOAs) within wards. Hillingdon has no LSOAs among the 10 per cent most deprived.

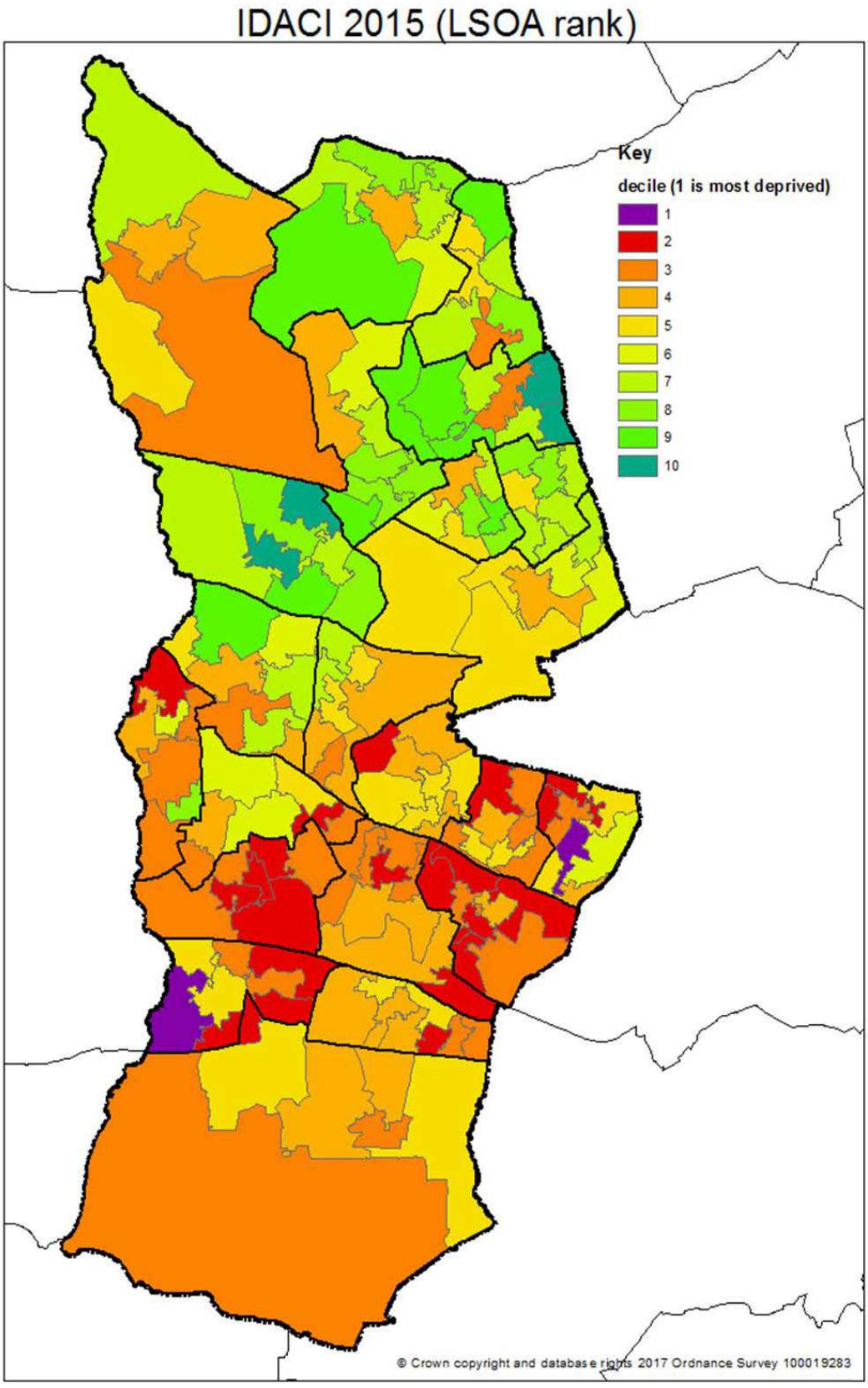
- Income Deprivation Affecting Children Index (IDACI) ranking -
  When looking at the IDACI 2015, Hillingdon has 2 LSOAs within West Drayton and Yeading wards in the most deprived 10% of LSOAs in England.

- Income Deprivation Affecting Older People Index (IDAOPI).
  When looking at the IDAOPI 2015, Hillingdon has 5 LSOAs within Uxbridge South, Yeading and Townfield in the most deprived 10% of LSOAs in England.

  Deprivation in older people is associated with poor health outcomes. Therefore, this has implications for health and care services, including pharmaceutical services.

Hillingdon deprivation in relation to the whole of England, IMD2015




IDACI 2015 (LSOA rank)
Key
decile (1 is most deprived)
1
2
3
4
5
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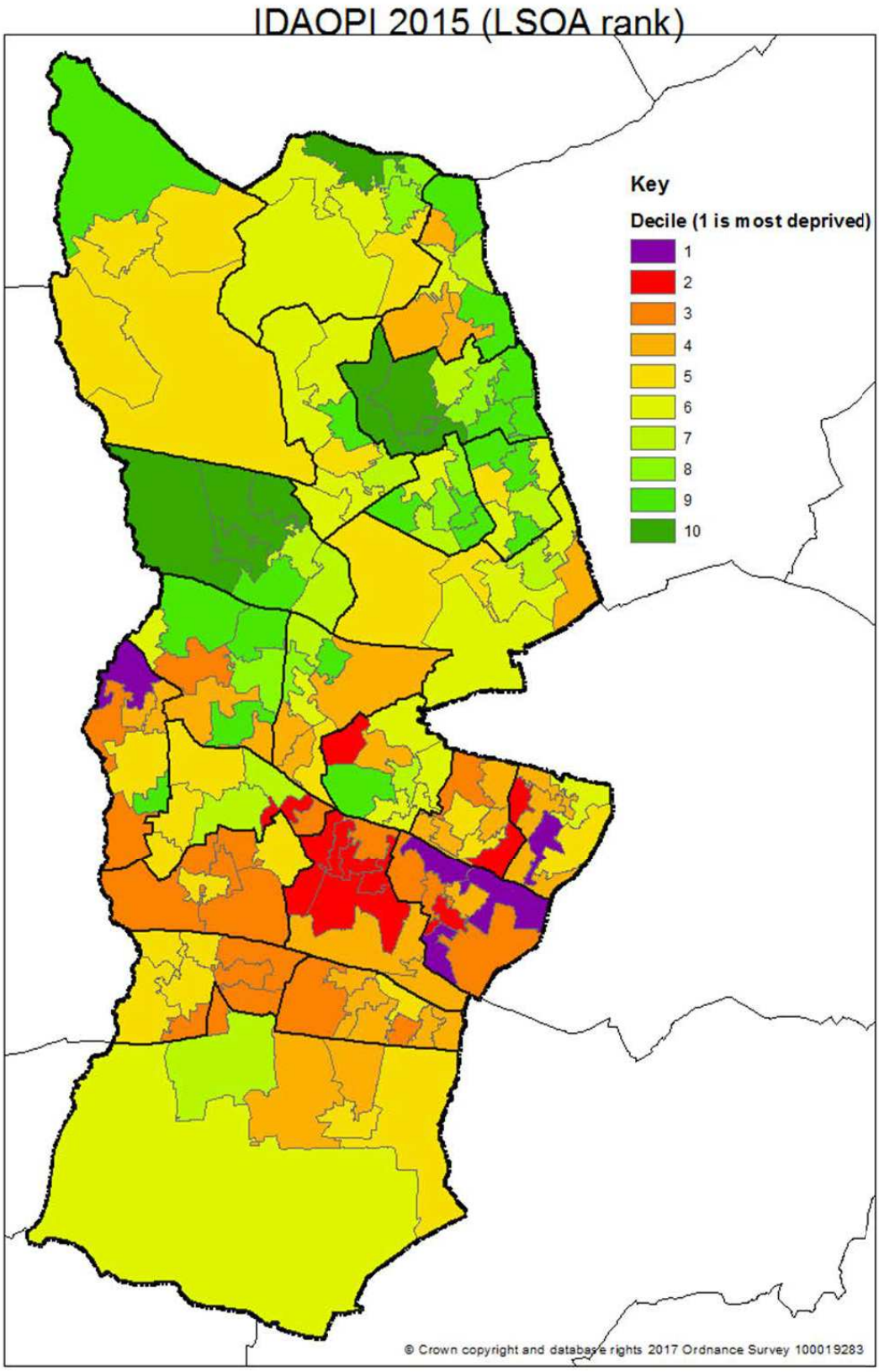
8
9
10
© Crown copyright and database rights 2017 Ordnance Survey 100019283


IDAOPI 2015 (LSOA rank)
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Decile (1 is most deprived)
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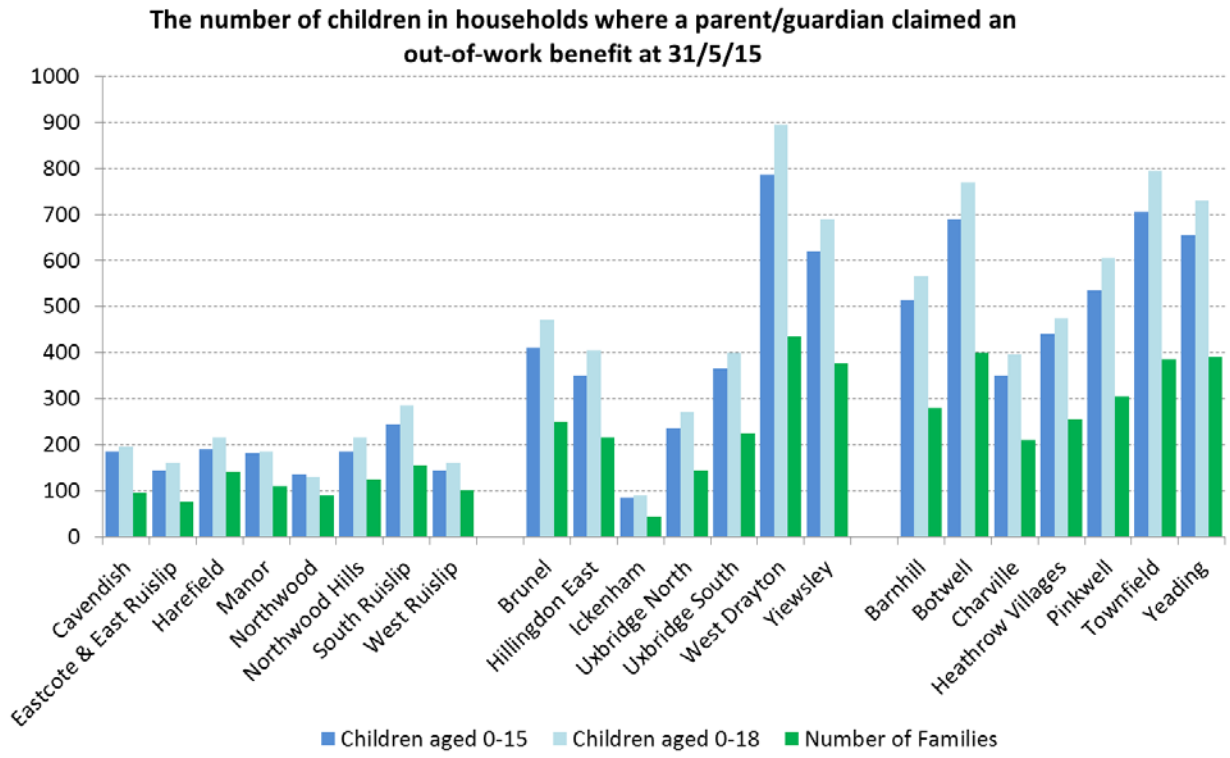
Data estimating the numbers of children and older people in poverty shows that there can be areas of deprivation even in apparently affluent locations.

Poverty and social inequalities in childhood have profound effects on health of children, and the impact on health continues to reverberate throughout the life course into late adulthood. Globally and historically, poverty has been one major determinant of child and adult health and, even in rich nations such as the UK, it remains a major cause of ill health with huge public health consequences.

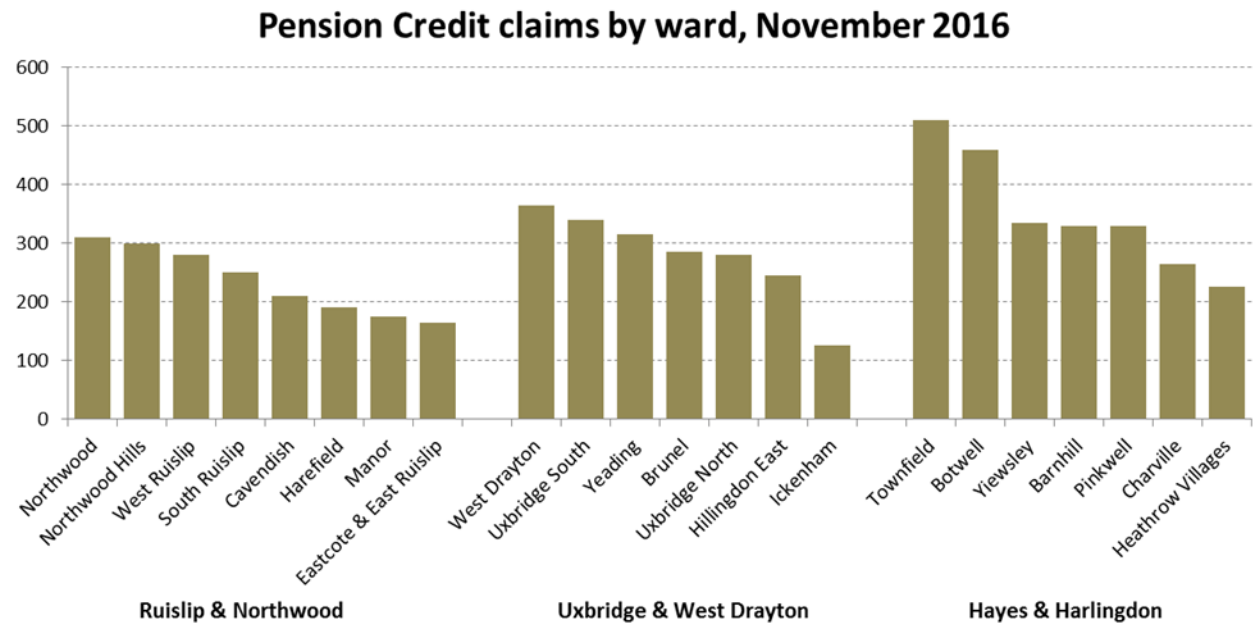
The rapidly growing and developing foetus and child seem to be particularly vulnerable to the adverse effects of poverty providing a further powerful argument for policy initiatives designed to protect children from its worst effects. There is evidence in Hillingdon of higher prevalence of poor outcomes for children living in poorer households e.g. number of accidents, infant and child deaths, rates of illnesses, hospital admissions, poor oral health.



Source: DWP, the number of children who lived in households where a parent or guardian claimed an out-of-work benefit at 31 May 2015 (published 27 July 2016)

In May 2015 wards in the south of the borough had a higher number of children living in households where a parent/guardian claimed an out of work benefit.

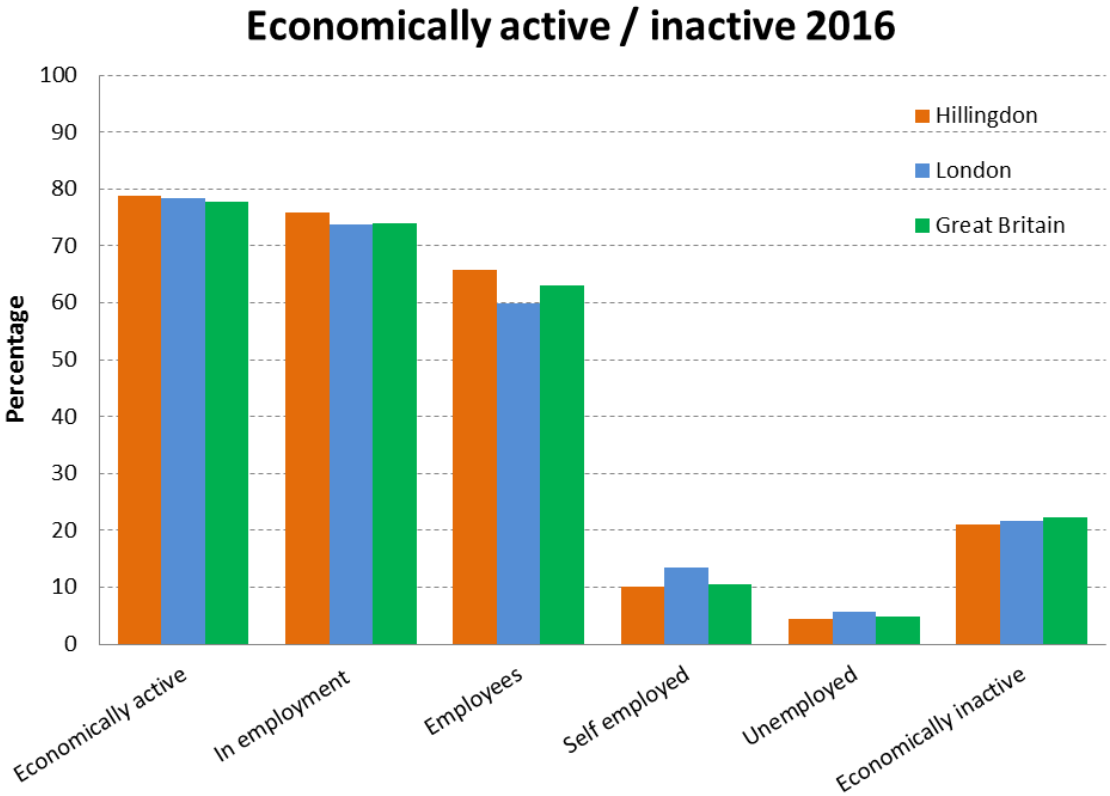
In November 2016 Hillingdon had 6,290 residents claiming pension credit. 77.3% have been claiming for over 5 years, 13.3% between 2-5 years, 4.1% between 1-2 years and a further 5.2% claiming for under 1 year. Nationally, in 2015 89.7% of all prescription items were dispensed free of charge, with 60.4% of all prescription items dispensed free of charge to patients claiming age exemption (aged 60 and over).



Source: NOMIS

5. Economic activity (employment and unemployment)

Economic activity relates to whether or not a person (aged 16 to 64) is working or looking for work. Residents who are unemployed, or who are in poorly paid occupations, tend to have poorer health outcomes. In 2016, Hillingdon had a slightly higher proportion of economically active males (86.5%) compared with London (84.9%). For females in Hillingdon there are a similar proportion of economically active females (71.4%) compared with London (71.6%). In terms of unemployed, Hillingdon's rate of 4.4% is below both London and England (5.7% and 4.8% respectively). Unemployment rates for males and females are not available for Hillingdon in 2016, as the sample size is too small.



Of those residents economically inactive 14.8% are long term sick, 25.8% are looking after family / home and 11.8% are retired.
Source: Local Authority Profile on www.nomisweb.co.uk

6. Access to transport and method of transport to work

Household car and van availability

In 2015 there were 160,300 licensed vehicles registered by postcode within Hillingdon (to 108,000 households). This includes cars, motor cycles and light & heavy goods vehicles.

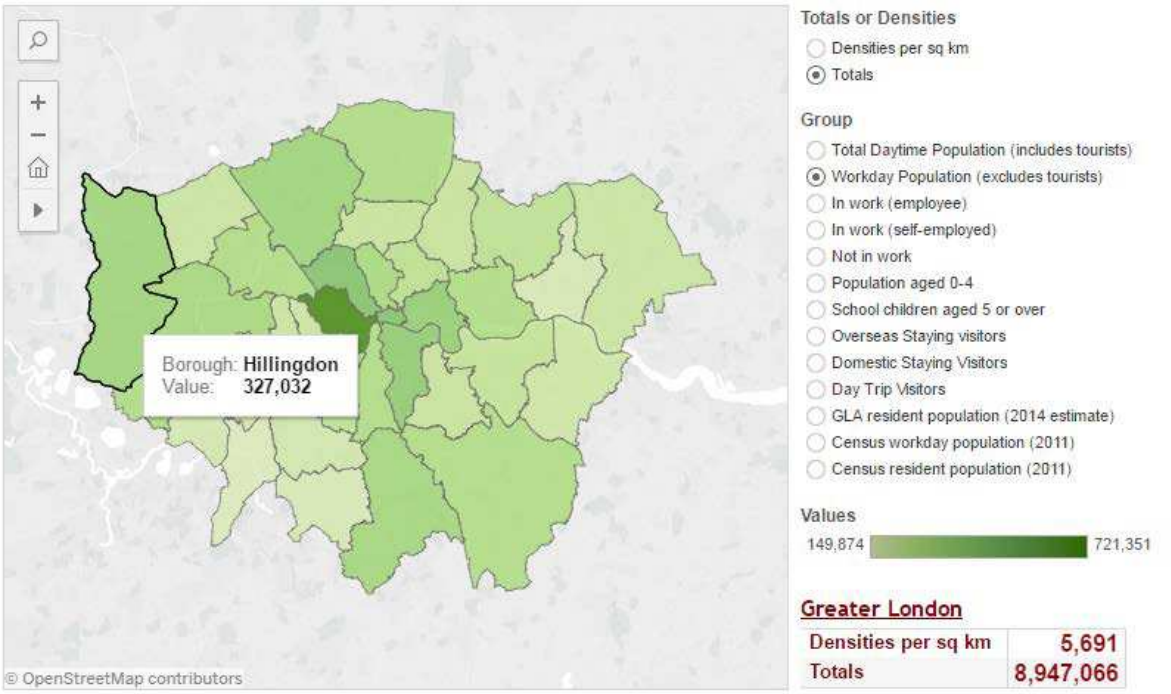
Post Survey

Overall, accessibility to community pharmacies is very good within Hillingdon, and can be described as very good via car where 97% of the population is within 3 minutes driving time (approximately 30 minute walking) of a pharmacy. This compares very well with access nationally, where 99% of the population is within 20 minutes driving distance whereas in Hillingdon, 100% population is within six minute driving distance of the nearest pharmacy. Even when one takes into consideration the variation in car ownership in local areas there are good public transport links due to the predominantly urban character of these areas.

Workday population

The population of London swells to over 10 million people on an average day. Around 2 million people are in just three local authorities – Westminster, City of London and Camden.

Nearly half of London's daytime population comes from people in work while nearly a quarter comes from adults not in work – many of whom are retired. Hillingdon's workday population (in 2014) can be seen on the map:



Source: https://data.london.gov.uk/apps_and_analysis/daytime-population-of-london-2014, October 2015

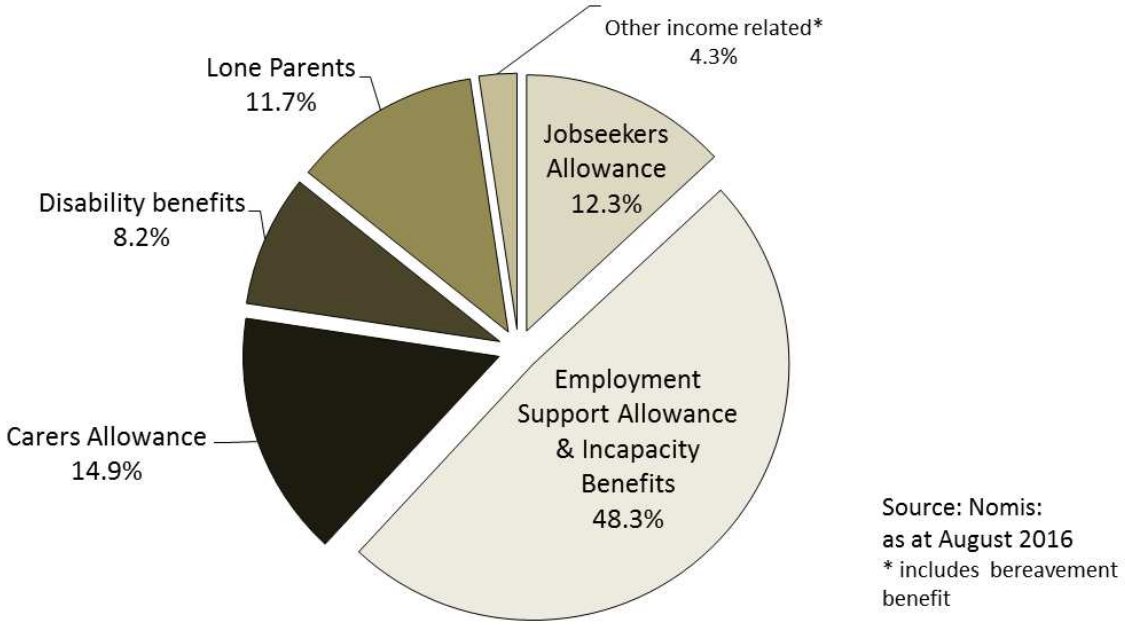
The workday population of Hillingdon could be using a pharmacy in our Borough, just as our Borough residents working, studying or travelling elsewhere may choose to use a pharmacy near their place of work, study or end destination.

7. Benefit claimants

In August 2016, Hillingdon's Job Seekers Allowance (JSA) claimant level was 2,070 which is at its lowest level since February 2010 (6,070). This decline has been significant and reflects the strength of the local economy, the benefit entitlement changes and is supported by closer partnership working to address barriers to employment. Hillingdon has also seen a fall in the numbers of long-term unemployed, down from 570 in December 2014 to 380 in December 2016.

In Hillingdon 56% of benefit claims are for ill health related claims including Employment Support Allowance (ESA) & incapacity benefits and disability benefits. JSA accounts for 12.3% of claimant types with lone parents as 11.7% and those in receipt of Carers Allowance make up 14.9% of the client group. There are around 12,500 people in Hillingdon claiming benefits due to ill health. The chart below refers to benefit claimants in Hillingdon and the breakdown of benefit claims by type.

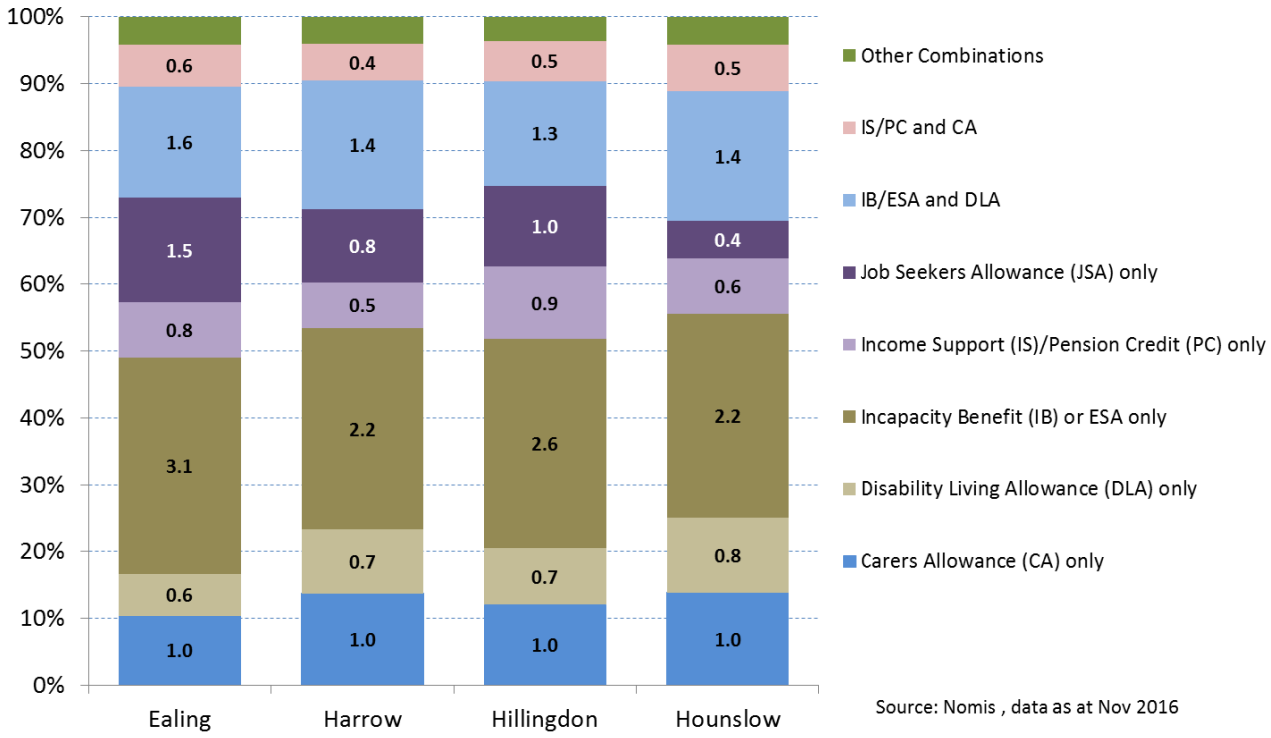
Benefit Claimants: Working Age Client Group



Source: Nomis:
as at August 2016
* includes bereavement benefit

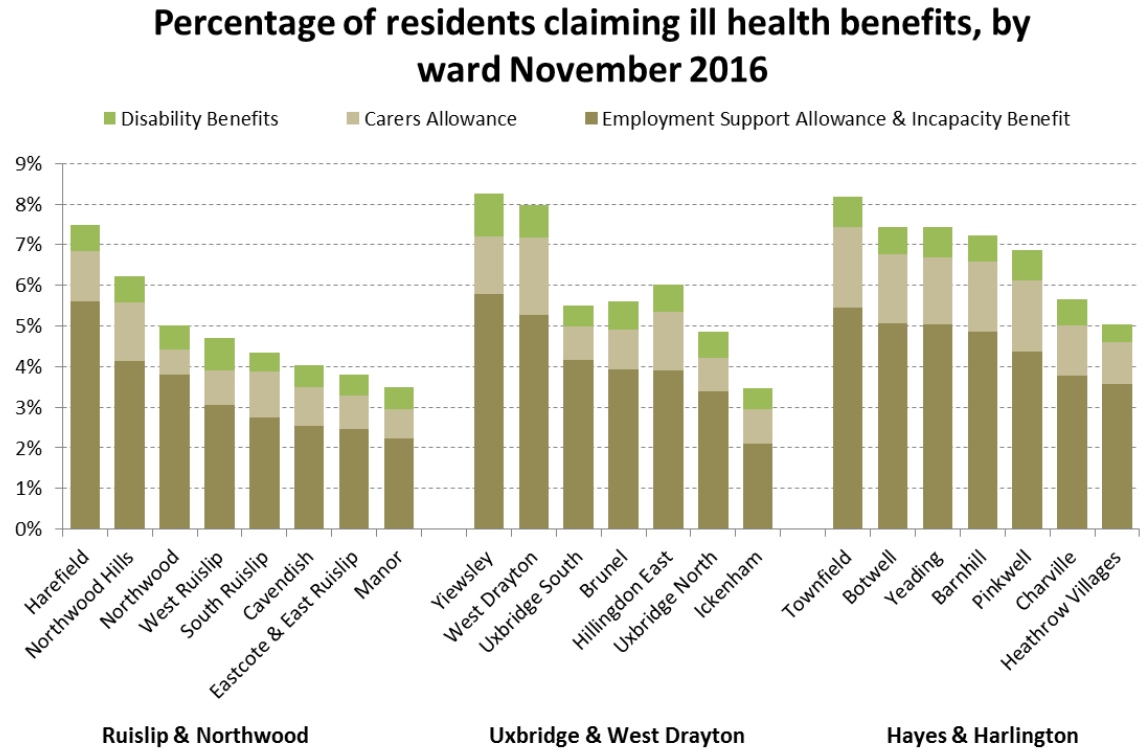
Hillingdon's neighbouring boroughs have similar rates of benefit claimant types. The chart below refers to the proportion of the population claiming benefits and the breakdown of benefit claims by type. NOMIS defines working age as 16-64 years.

Benefit Claims: Hillingdon and Neighbouring Boroughs
Rate per Working Age Population: Age 16-64



Source: Nomis , data as at Nov 2016

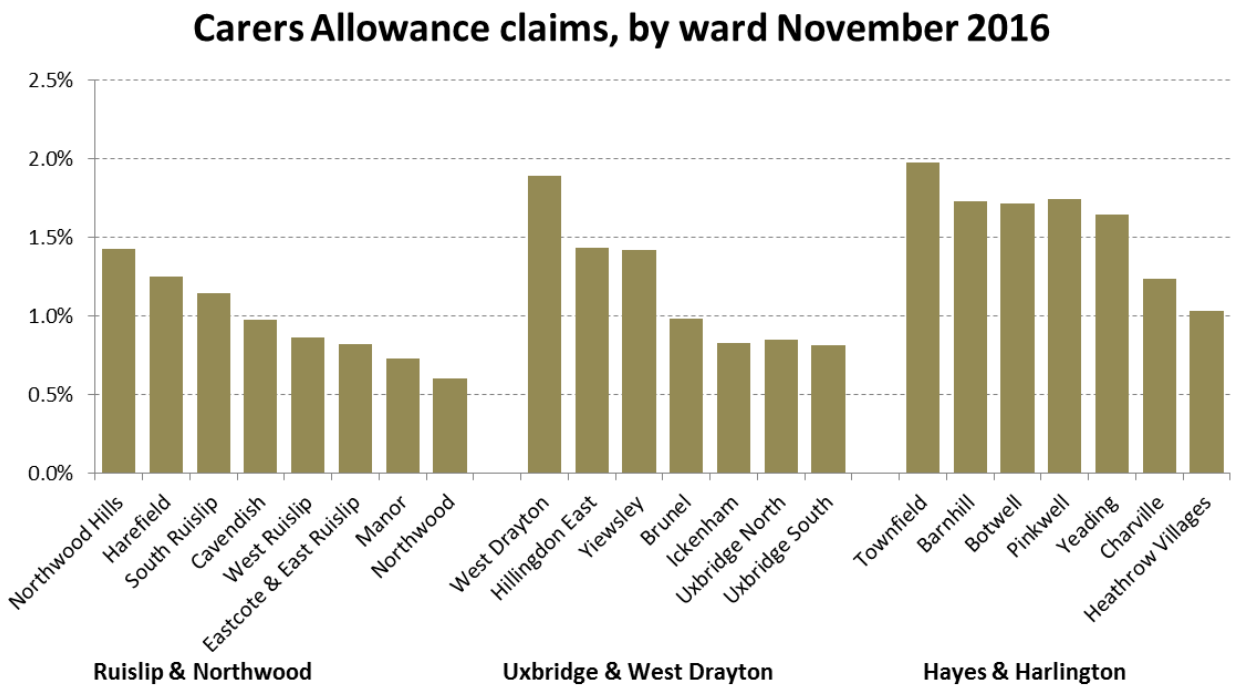
There is some variation between the wards and localities in the numbers and proportions of residents claiming ill health benefits.



Source: Nomisweb

Carers Allowance

According to Department for Work & Pensions data as at November 2016 in Hillingdon there are 1,920 residents in receipt of Carers Allowance and a further 1,040 in receipt of multiple benefits including Carers Allowance (for example Income Support, Pension Credits and Carers Allowance combined). Percentages of working age people receiving state benefits varies by ward in Hillingdon, with generally higher rates in the southern wards and lowers numbers and rates in the northern wards. The chart below sets out the range.



Source: Nomisweb

Community pharmacies play an important and growing role in supporting carers by providing services closer to home like MURs, NMS, immunisations screening, home delivery service and minor ailment service.

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Hillingdon Pharmaceutical Needs Assessment 2018

Appendix 2: Epidemiology

March 2018

Pharmaceutical Needs Assessment 2018

Appendix 2: Epidemiology

1. Life expectancy

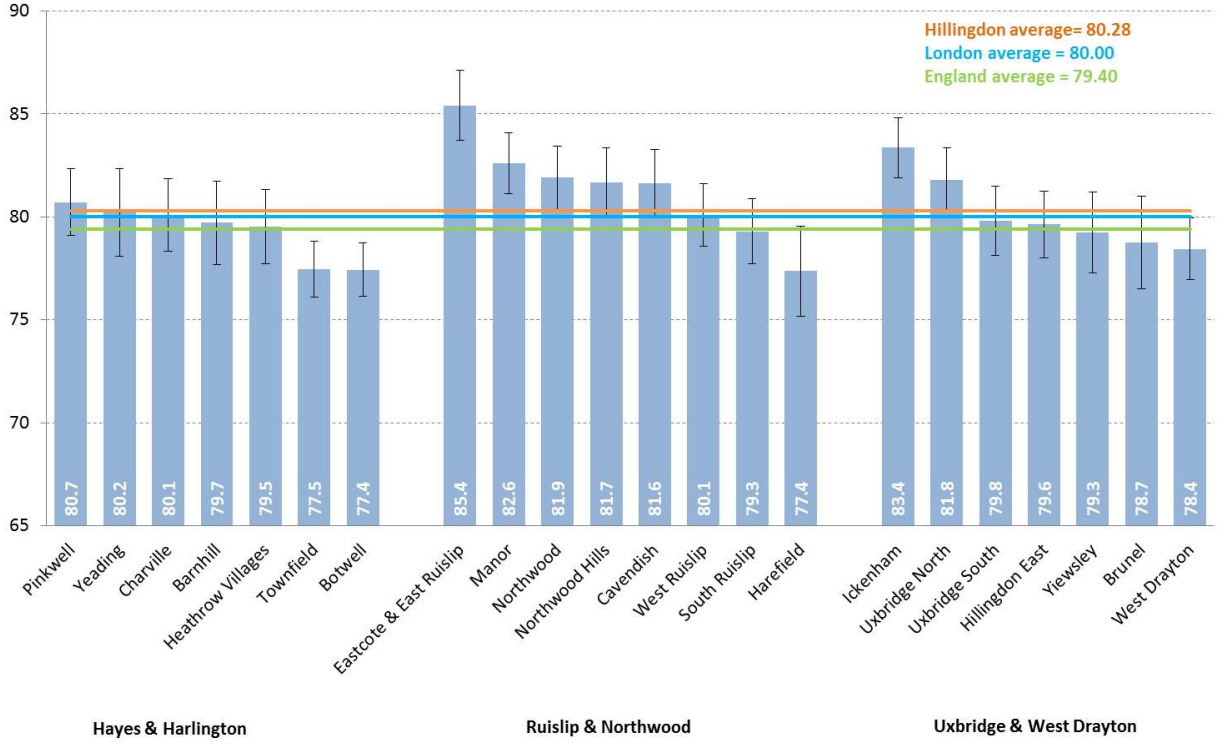
Life expectancy is the number of years a person is expected to live given the age and sex specific mortality rates that are currently experienced by the population.

Hillingdon's male and female life expectancy from birth is 80.5 and 83.7 (based on 2013-15 data), which means that a baby born in Hillingdon can expect to live a similar number of years as the England average for both genders (79.5 and 83.1 respectively) and the London average for both genders (80.2 and 84.1 respectively).

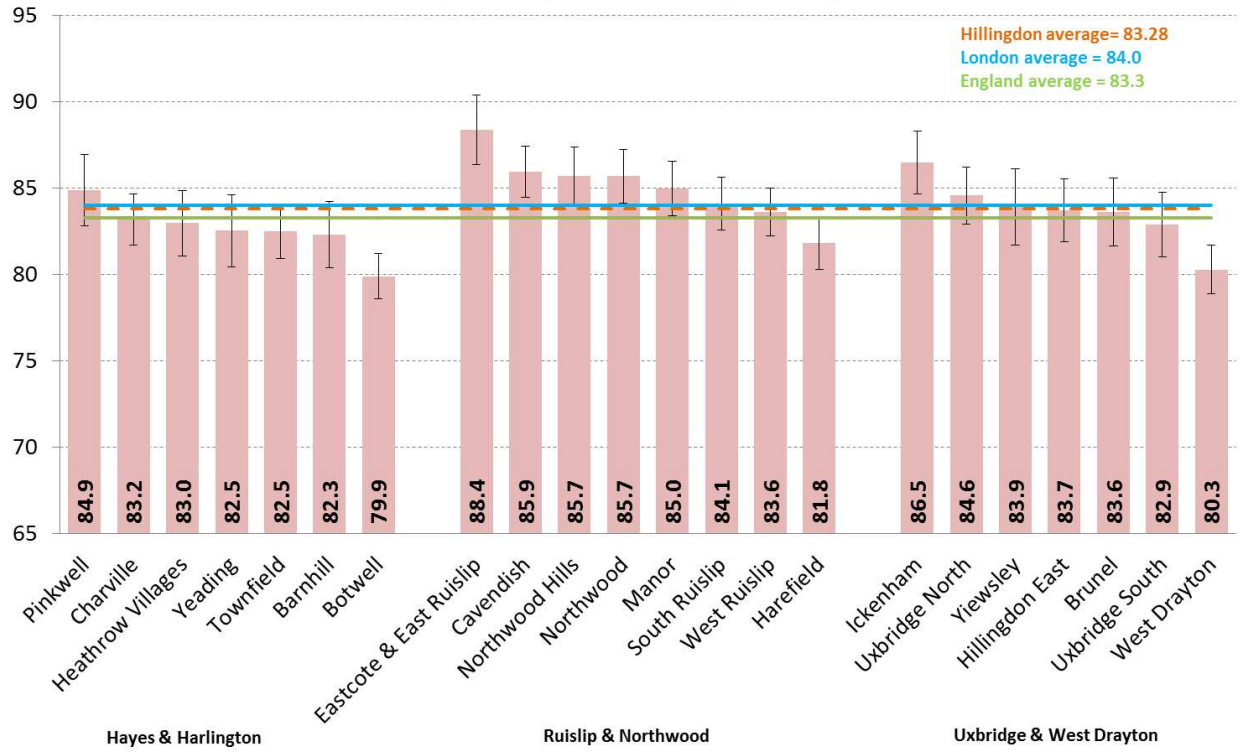
However, there are inequalities within the Borough at ward level; the latest dataset available for life expectancy by ward is 2010-2014 which will no longer be updated by the Office of National Statistics (the ONS are no longer producing mortality data at ward level meaning life expectancy cannot be calculated). From the 2010-2014 data, the gap in male life expectancy between Eastcote & East Ruislip and Botwell & Harefield is 8 years and the gap in female life expectancy between Eastcote & East Ruislip and Botwell is 8.5 years.

Comparing London boroughs the gap is 5.9 years for males (Barking & Dagenham has the lowest life expectancy at 77.5 and Kensington & Chelsea has the highest at 83.4) and 4.6 years for females (Barking & Dagenham has the lowest at 81.8 and Kensington & Chelsea has the highest at 86.4).

Male life expectancy from birth by locality, 2010-2014



Female life expectancy from birth by locality, 2010-2014



Source: Public Health Outcomes Framework, Indicator 0.1ii

Comparing regions within England & Wales the gap is 2.2 years for males (the lowest is the North East and North West at 77.9, compared with the highest in the South East of 80.1) and 2.2 years for females (the lowest is the North East and North West at 81.7, compared with the highest in the South East and South West of 83.9).

2. Mortality

Mortality is the term used for the number of people who die within a population. Age at death and cause of death provide an instant depiction of health status of a given population. Information on trends of death (by causes) can be used to substantiate the healthy behaviours of the population, the quality of the living conditions, local services, treatment and support. The section below examines mortality data in Hillingdon.

Infant mortality

The infant mortality rate is defined as the number of infants aged <1 year that die per 1,000 live births (all maternal ages) in a given area. The infant mortality rate is usually pooled over 3 years so as to provide a more reliable statistic. The infant mortality rate in Hillingdon is 3.3 per 1,000 live births for the 3-year period 2012-14; this is similar to the average rate for London or England (3.6 and 4.0 deaths per 1,000 live births respectively). Infant mortality rates can be analysed in more detail, those that occur within the first 4 weeks and those that occur from 4 weeks up to one year.

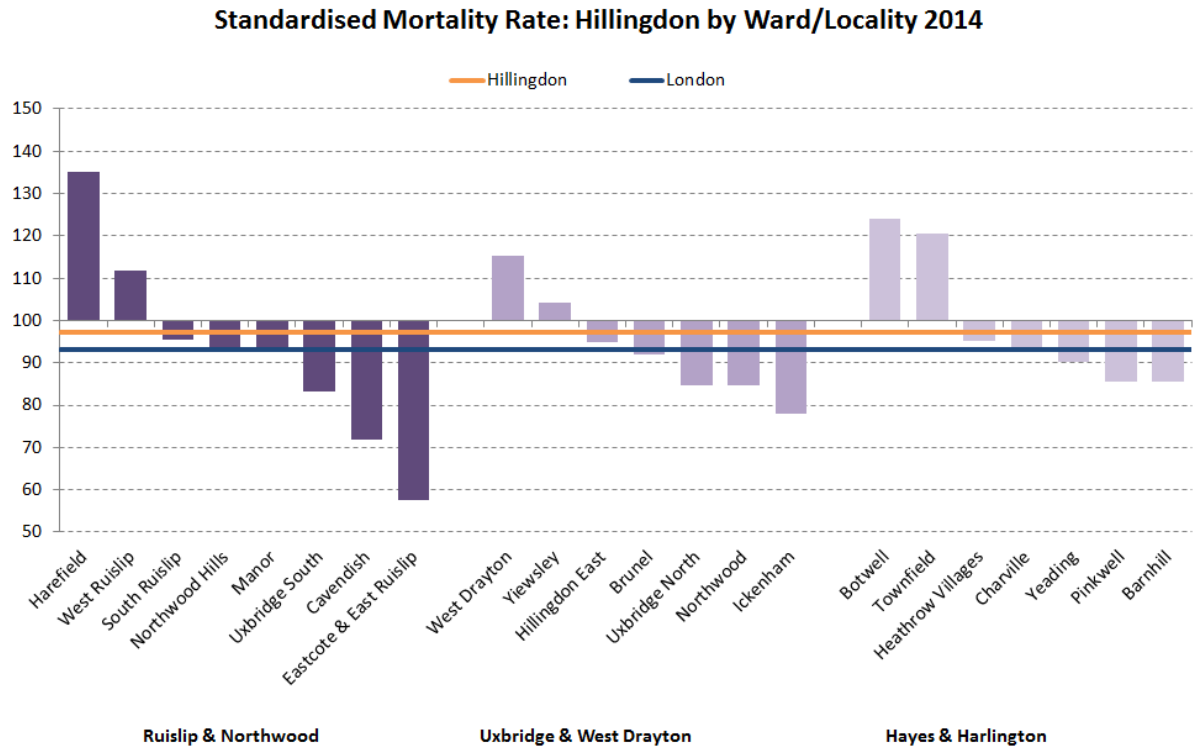
Out of the 44 infant deaths in the 3-year period 2012-14, the majority occur in the first 4 weeks after the live birth. 2012-2014 pooled data shows that for infants aged less than 28 days the mortality rate in Hillingdon is 2.2 per 1,000 live births. The England rate for the same age is 3 deaths per 1,000 live births and London rate 2.9 per 1,000 live births. For infants aged 28 days to 1 year the mortality rate in Hillingdon is 1.5 deaths per 1,000 live births, close to the England and London averages of 1.3 deaths per 1,000 live births (Source: HSCIC). Death in infancy is a rare event, and even one additional death, or life saved can make a large difference to calculations. Some of the variations in the Borough may be the result of chance rather than a cause / problem.

All-age all-cause mortality

The standardised mortality ratio (SMR) is constructed by applying the England age-specific rates to the age structure of the subject population to give an expected number of deaths. The observed (actual) number of deaths is then compared with the expected number and is expressed as a ratio (100x observed/expected). SMRs equal to 100 imply that the mortality rate is the same as the standard (in this case, England) mortality rate. A number higher than 100 implies an excess mortality rate whereas a number below 100 implies below average mortality. The variation in the

mortality rates for different wards in Hillingdon are shown in the next figure.

Standardised Mortality Rate (all causes) for Hillingdon wards, 2014



Source: GLA 2014

Major causes of deaths in Hillingdon

The average number of deaths per year in the period 2011-15 in Hillingdon is 1,873. Circulatory diseases and cancers are the two major causes of death in Hillingdon. Deaths as a consequence of circulatory diseases accounted for an annual average of 559 deaths (30% of all deaths) in the 5-year period 2011-2015. Deaths from all cancers accounted for an annual average of 547 deaths (29% of total) in the 5-year period 2011-2015.

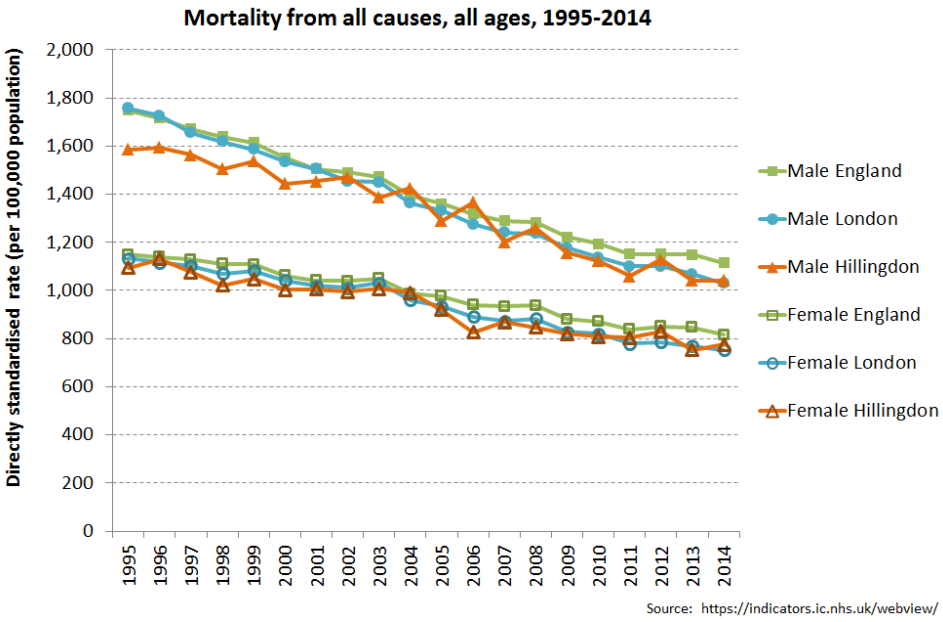
An annual average of 274 deaths, (15% of total) was as a consequence of respiratory diseases; the remaining 493 deaths (26% of total) were as a result of other causes.

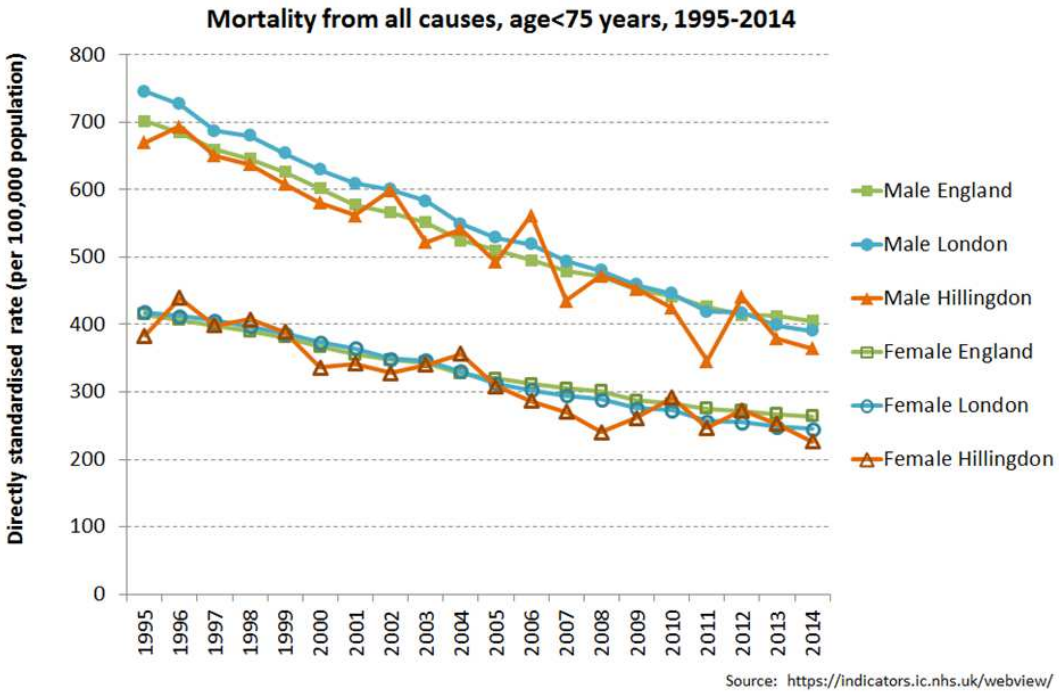
Source: National Statistics, Vital Statistics Tables VS4d

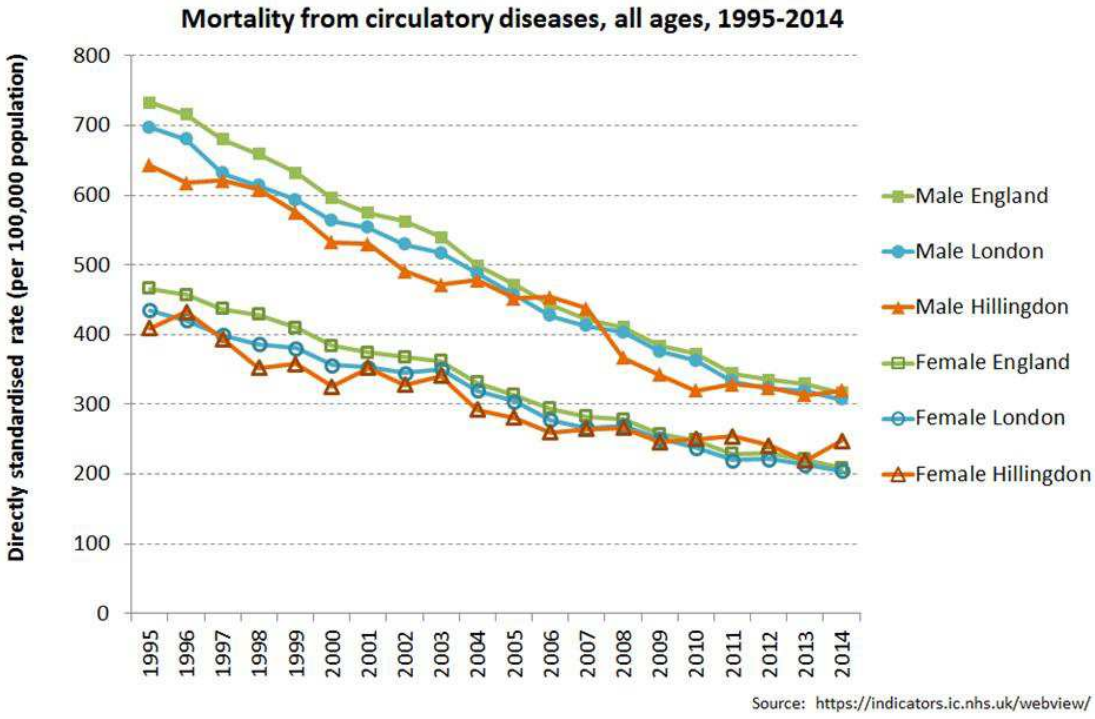
The overall number of deaths varies on the basis of age structure of the population. Therefore, younger populations as in Hayes & Harlington and Uxbridge & West Drayton localities have lower number of deaths when compared with Ruislip & Northwood, where the proportion of older people is higher in the population. Populations with higher proportion of older people would have higher crude death rates, even as the health conditions are improving. On the other hand, younger populations will have low crude death rates even when health conditions are poorer. Therefore, to depict the health status more accurately, we also consider early deaths, or premature mortality.

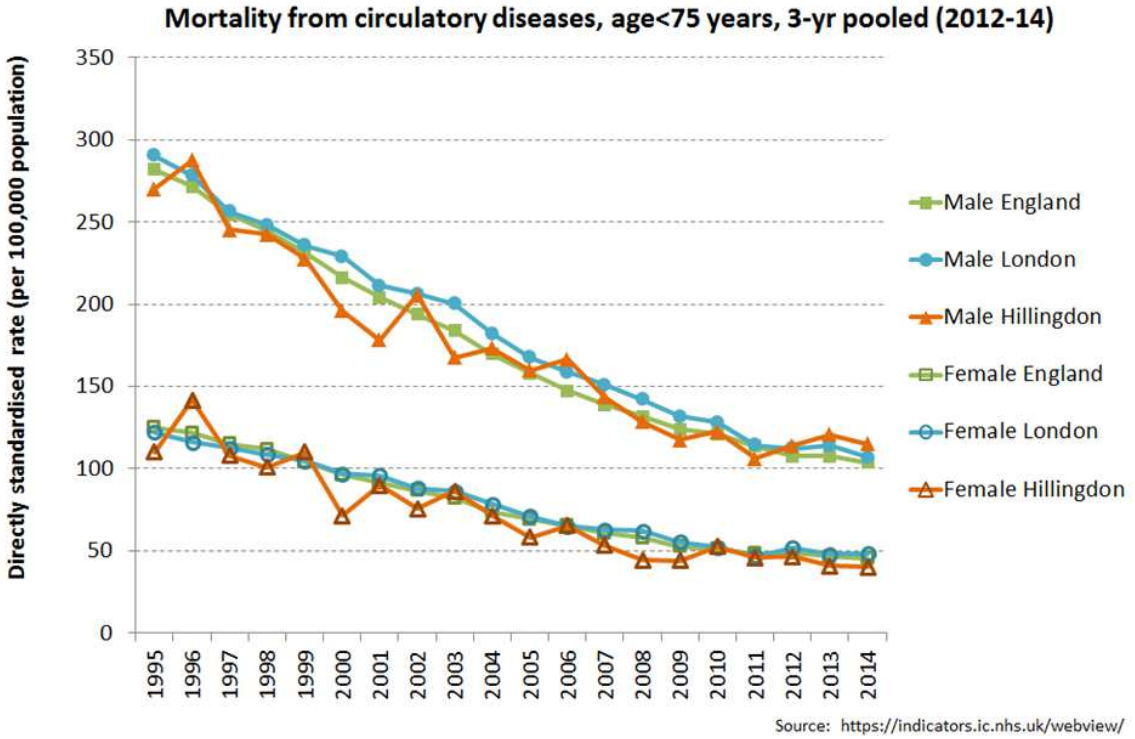
Many of the causes of premature mortality are correlated with the levels of deprivation.

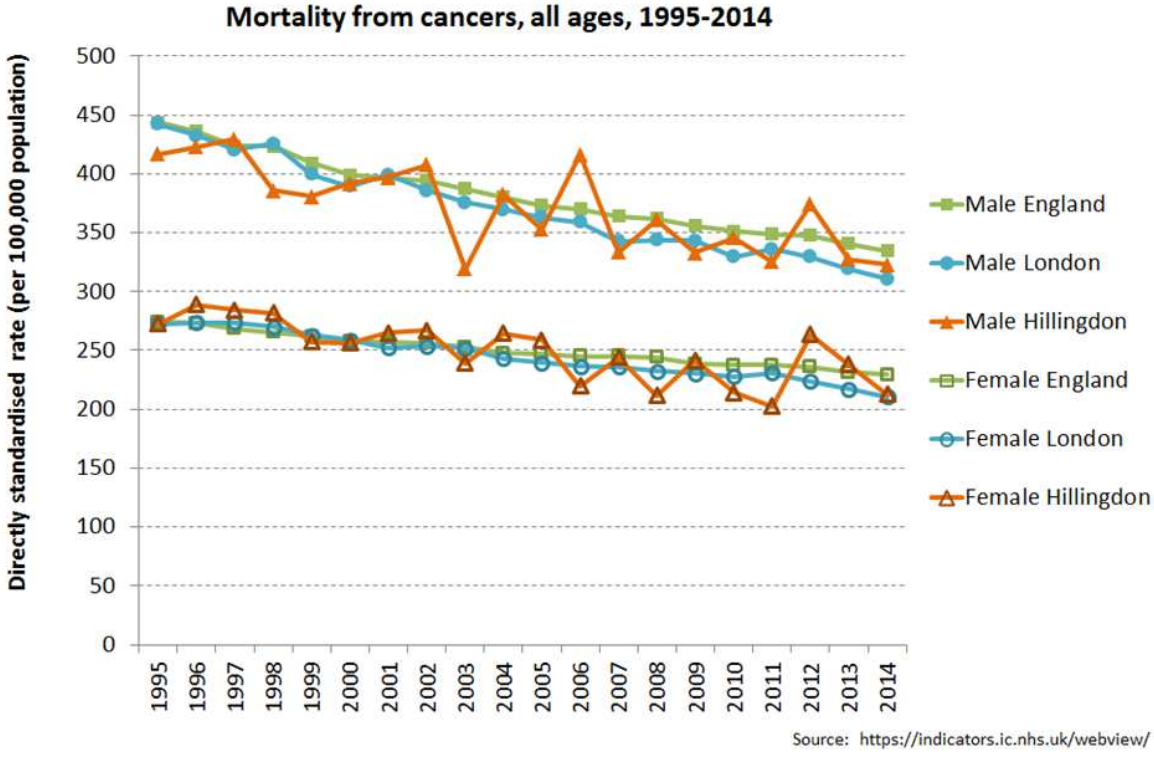
The locality of Ruislip & Northwood has an annual average number of deaths of 720, the locality of Uxbridge & West Drayton has an annual average number of deaths of 600 and the locality of Hayes & Harlington has an annual average number of deaths of 540 (all figures are rounded to the nearest 10). Mortality from all causes has been falling in Hillingdon in line with the national decreases.

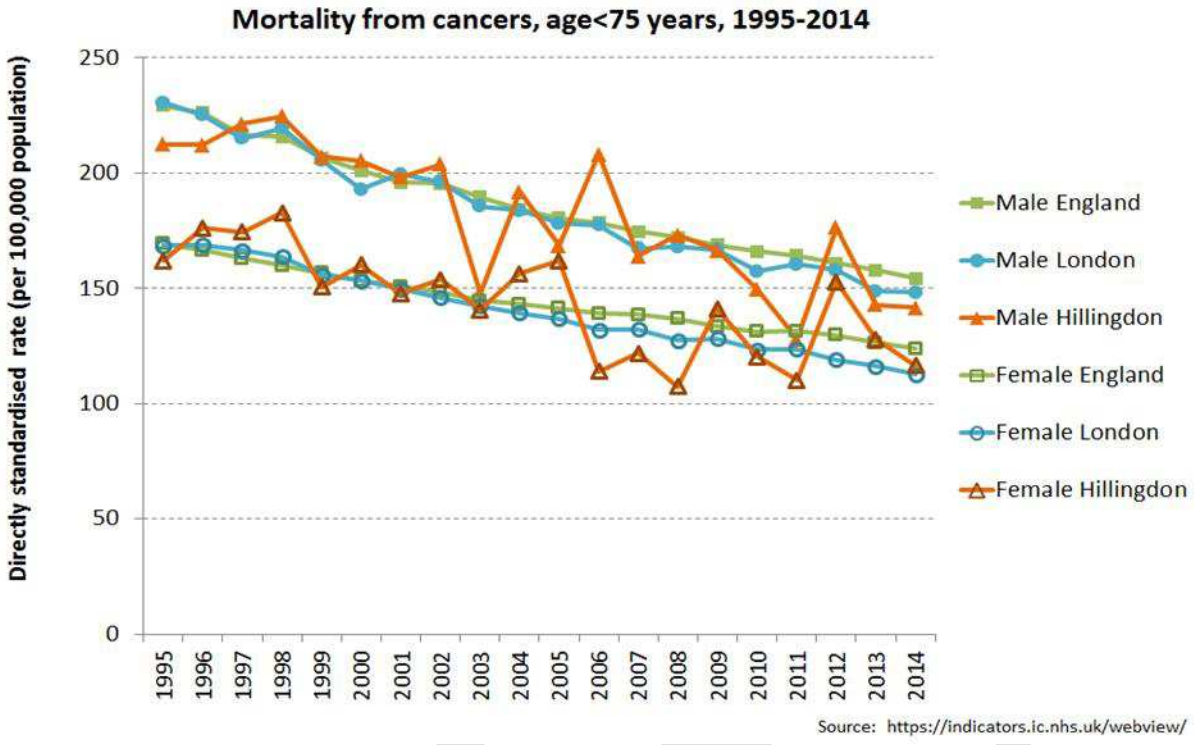


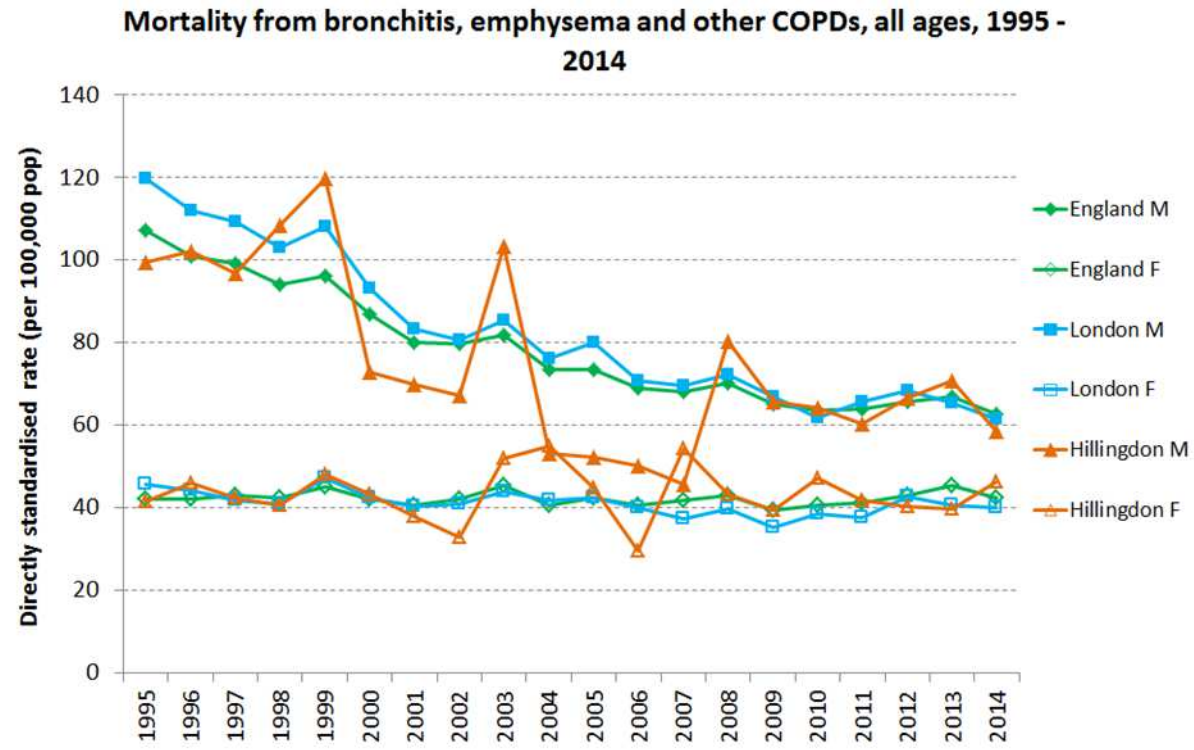

Mortality from all causes, age<75 years, 1995-2014
Directly standardised rate (per 100,000 population)
800
700
600
500
400
300
200
100
0
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
Male England
Male London
Male Hillingdon
Female England
Female London
Female Hillingdon
Source: https://indicators.ic.nhs.uk/webview/


Mortality from circulatory diseases, all ages, 1995-2014
Directly standardised rate (per 100,000 population)
800
700
600
500
400
300
200
100
0
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
Male England
Male London
Male Hillingdon
Female England
Female London
Female Hillingdon
Source: https://indicators.ic.nhs.uk/webview/


Mortality from circulatory diseases, age<75 years, 3-yr pooled (2012-14)
Directly standardised rate (per 100,000 population)
350
300
250
200
150
100
50
0
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
Male England
Male London
Male Hillingdon
Female England
Female London
Female Hillingdon
Source: https://indicators.ic.nhs.uk/webview/


Mortality from cancers, all ages, 1995-2014
Directly standardised rate (per 100,000 population)
500
450
400
350
300
250
200
150
100
50
0
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
Male England
Male London
Male Hillingdon
Female England
Female London
Female Hillingdon
Source: https://indicators.ic.nhs.uk/webview/


Mortality from cancers, age<75 years, 1995-2014
Directly standardised rate (per 100,000 population)
250
200
150
100
50
0
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
Male England
Male London
Male Hillingdon
Female England
Female London
Female Hillingdon
Source: https://indicators.ic.nhs.uk/webview/


Mortality from bronchitis, emphysema and other COPDs, all ages, 1995 - 2014
Directly standardised rate (per 100,000 pop)
140
120
100
80
60
40
20
0
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
England M
England F
London M
London F
Hillingdon M
Hillingdon F

Analysis of mortality rates in Hillingdon shows that premature death rates (for people aged under 75) from all causes in Hillingdon (1995-2014) were lower than England and London. In 2014, the wards of Townfield, Brunel and West Drayton had a higher number of male premature deaths; for females, the wards with the higher number of premature deaths were South Ruislip, West Drayton, Brunel and Yiewsley. Source: Vital Statistics Table 4, 2014.

The main cause of early deaths was cancer which accounted for 33% of all early deaths followed by cardiovascular disease (25%). Together, these two causes accounted for 58% of all early deaths in 2014.

Identifying individuals and families at high risk of cardiovascular disease and cancer ensures timely start of treatment and reduces risk of complications and early death. Early management and secondary prevention of disease reduces the need of more costly and complicated NHS treatment or social care. It therefore has positive impact on individual's quality of life and features strongly in the national strategies for cardiovascular disease and cancer.

3. Prevalence of non-communicable diseases and major risk factors

The figures on the next few pages take data from NHS Digital (2015/16): Observed Prevalence from GP register population. The observed prevalence is the actual number of patients on a GP register that are recorded by their GP as having a given condition. The expected prevalence is the number that could be expected (estimated) in the population calculated by mathematical models, hence includes people who might have the illness but have not been identified / diagnosed as having that illness.

The treatment of long term conditions is estimated to account for £7 in every £10 of total health and social care spending in England and the number affected is set to rise by 25% by 2035. It is becoming more common to have multiple conditions; by 2018 the number of people with 3 or more long term conditions is predicted to grow from 1.9 million in 2008 to 2.9 million.

(source: www.kingsfund.org.uk)

Increasing attendances at GP surgeries and other health settings such as A&E call for looking at alternatives to the traditional models of how health and social care work. Four driving principles outlined in a recent paper by a collaboration for primary care:

- Self-care
- Care outside hospital

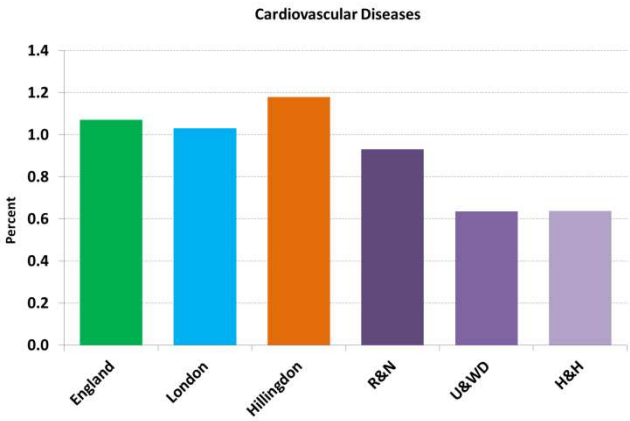
- Professional collaboration around improved patient pathways
- Preventing illness by tackling public health issues such as smoking and obesity.

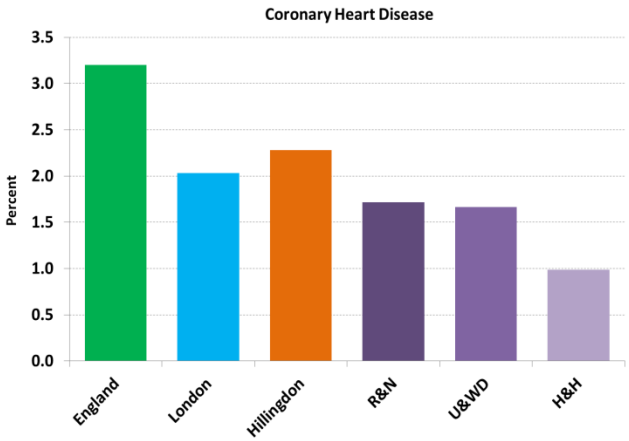
Elements of the above are already a part of Hillingdon's Health and Wellbeing Strategy signifying strategic fit. Steps are also being taken in Hillingdon as part of the Better Care Fund to integrate health and social care and to promote independent living.

Cardiovascular disease (CVD)

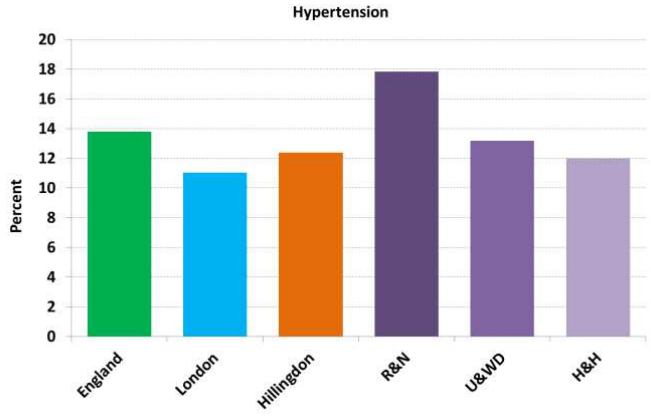
The observed prevalence of cardiovascular diseases in Hillingdon (1.2% of GP registered population) is above the England average (1.12%) and London average (1.1%).

Ruislip & Northwood (R&N) shows a higher observed prevalence than Uxbridge & West Drayton (U&WD) and Hayes & Harlington (H&H).





The observed prevalence of Coronary Heart Disease is 2.3% within Hillingdon, higher than London but lower than England. Hayes & Harlington is showing a lower rate of all localities.

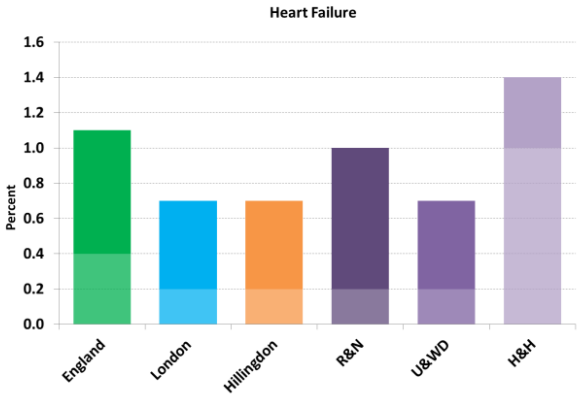


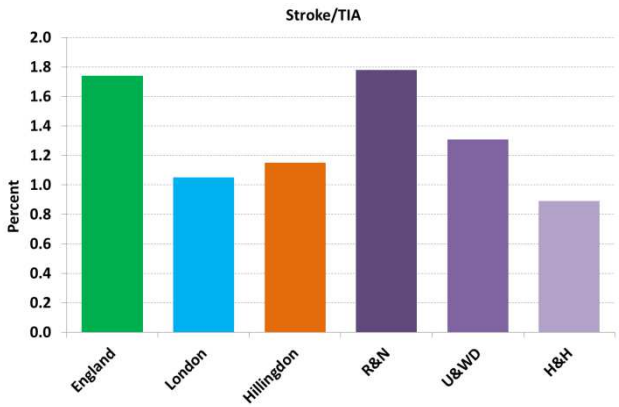
Hypertension was recorded as the highest CVD risk factor in Hillingdon – affecting 12.4% of the Hillingdon GP registered population. This is higher than the London average (11%) but lower than the rates for England (13.8%) as a whole.

Ruislip & Northwood have the highest prevalence among the Hillingdon localities.

The prevalence of all heart failure in Hillingdon (0.7%) of GP registered patients is below the England average (1.1%). Of the Hillingdon localities Hayes and Harlington shows the highest prevalence (1.4%).

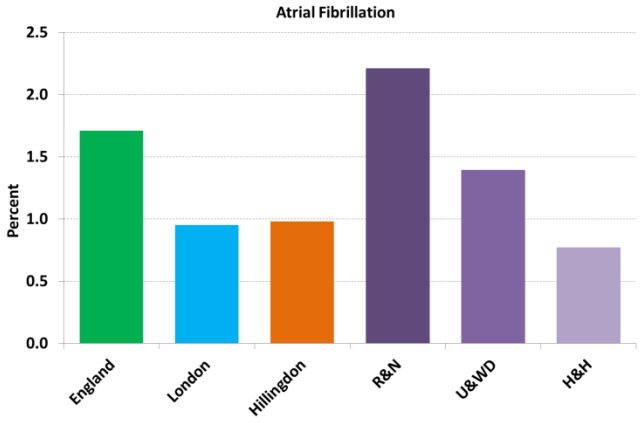
The lighter shades at the bottom of the chart show the prevalence of heart failure due to left ventricular dysfunction and the darker shades higher on the chart show the prevalence of other heart failure.

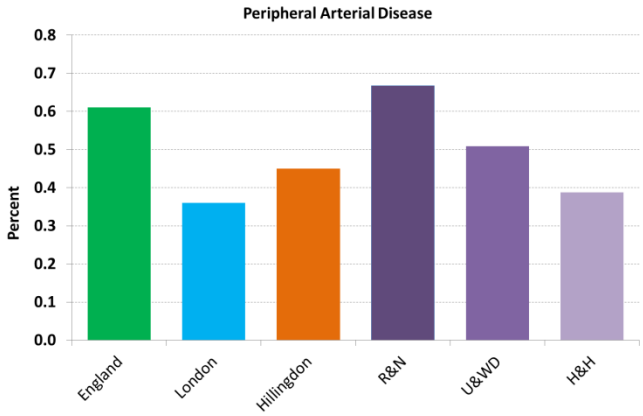




The overall prevalence of stroke in Hillingdon (1.2%) is lower than the England average (1.7%). Of the Hillingdon localities Ruislip & Northwood shows the highest observed prevalence.

The prevalence of Atrial Fibrillation is lower in Hillingdon than in England, but Ruislip & Northwood shows a higher prevalence than Hillingdon and the England average.





The prevalence of Peripheral Arterial Disease (PAD) is lower in Hillingdon (0.45% of the GP registered population) than the England average (0.6% of the GP registered population).

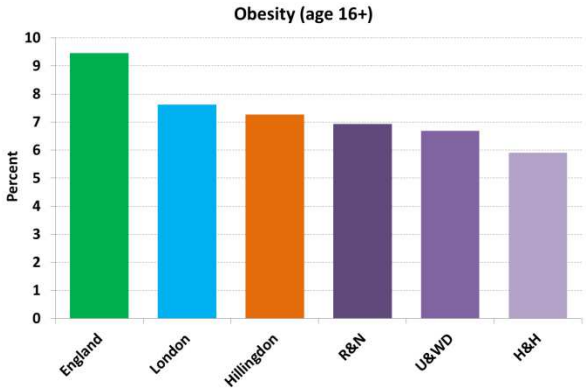
Of the Hillingdon localities Ruislip & Northwood show the highest prevalence of PAD although the numbers and rates are low.

Excess weight and obesity

Obesity is an established risk factor for many chronic conditions including diabetes, arthritis and heart failure.

In Hillingdon 7.3% of adults (aged over 16 years) on the GP register population are noted to be obese. This is slightly lower than the England average (9.5%).

Of the Hillingdon localities Ruislip & Northwood reported higher levels of obesity compared to Hayes & Harlington who had slightly lower levels

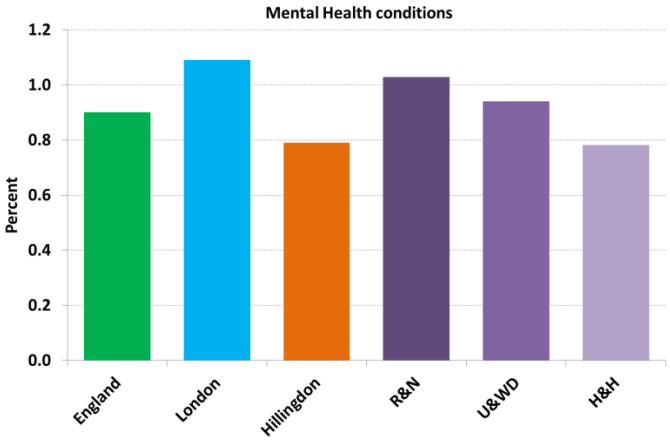


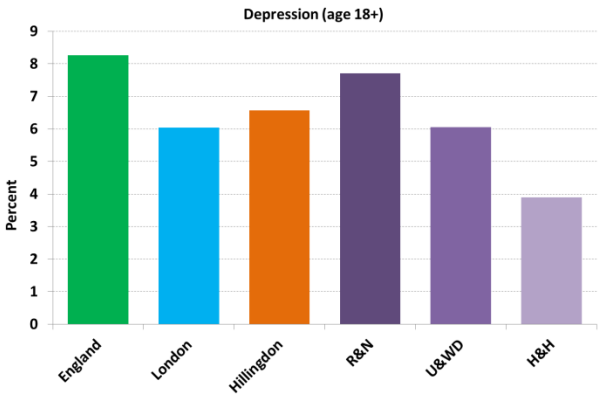
Data from Public Health Outcomes Framework (indicator 2.12) shows that 62% of adults within Hillingdon are carrying excess weight in the period of 2013-2015, which is below England (64.8%) but above London (58.8%); this has decreased from

63.4% in the period of 2012-2014. However, it should be noted that the data is taken from The Sport England Active People Survey which is based on self-reported height and weight from a small sample of residents.

Mental illness

The prevalence of mental health conditions is recorded as 0.8% of the GP register population in Hillingdon. This is lower than the England average (0.9% of the GP register population), and also lower than the London average (1.1% of the GP register population).



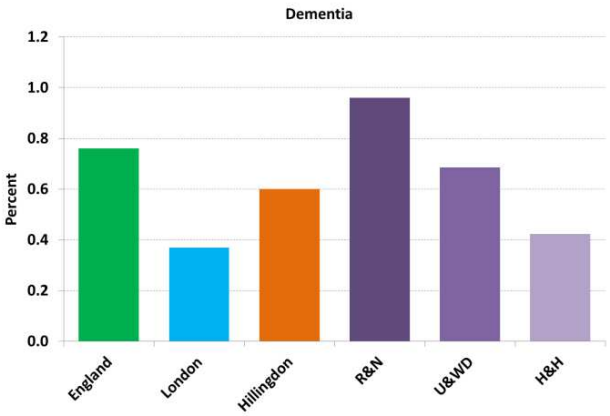


The prevalence of depression in Hillingdon is 6.6% of the GP register population. This is lower than the England average of 8.2% of the GP register population and slightly higher than London.

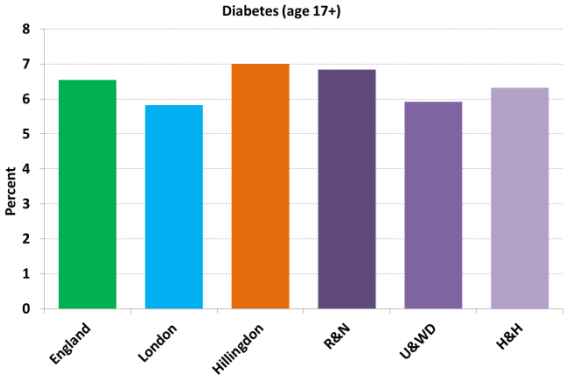
Of the Hillingdon localities there is a higher observed prevalence of depression in Ruislip & Northwood and slightly lower in Uxbridge & West Drayton and Hayes & Harlington.

The prevalence of dementia in Hillingdon is 0.6% of the GP register population, lower than the England average.

Of the Hillingdon localities Ruislip & Northwood record a higher prevalence compared with the other areas.



Diabetes mellitus



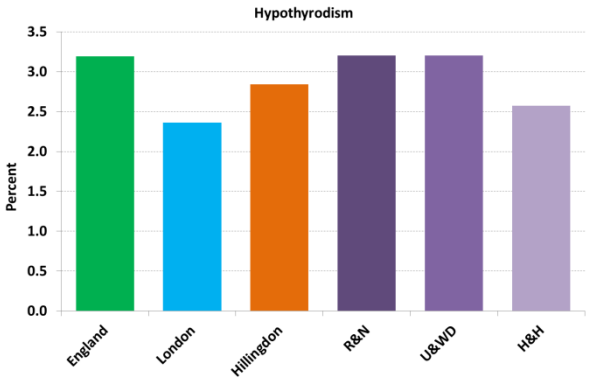
The prevalence of diabetes in Hillingdon (7.0% of the GP register population) is slightly higher than the averages for England (6.6 %) and London (5.9%).

In terms of localities Ruislip & Northwood has the highest prevalence of diabetes (6.9%).

Hypothyroidism

The prevalence of hypothyroidism is lower in Hillingdon (2.8% of the GP register population) than the England average (3.2% of the GP register population).

Of the Hillingdon localities Ruislip & Northwood and Uxbridge & West Drayton show a higher prevalence than Hayes & Harlington.

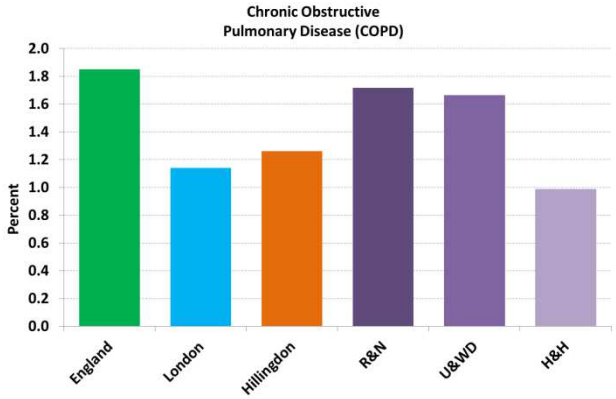


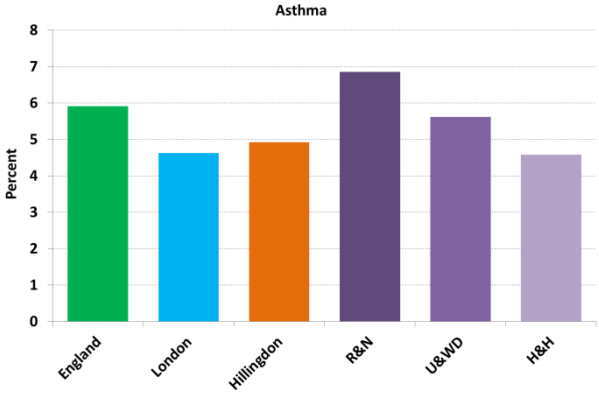
Respiratory diseases

The major causes of respiratory dysfunctions are asthma and chronic obstructive pulmonary diseases (COPD).

The prevalence of COPD in Hillingdon is 1.25% of the GP register population, compared with 1.8% in England.

Within the Borough there is a higher prevalence in Ruislip & Northwood and Uxbridge & West Drayton than in Hayes & Harlington.



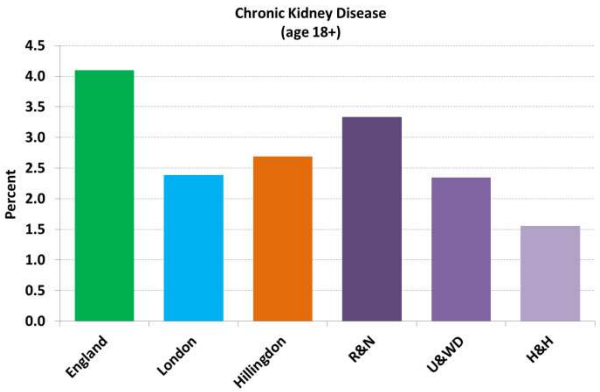


The prevalence of asthma patients is in Hillingdon is 4.9% of the GP register population, slightly lower in Hillingdon than the England average of 6%. Within Hillingdon there is a higher prevalence of asthma patients in Ruislip & Northwood than in the other localities.

Chronic kidney disease

The overall prevalence of Chronic Kidney disease in Hillingdon is 2.6%, lower than the England average of 4.1%.

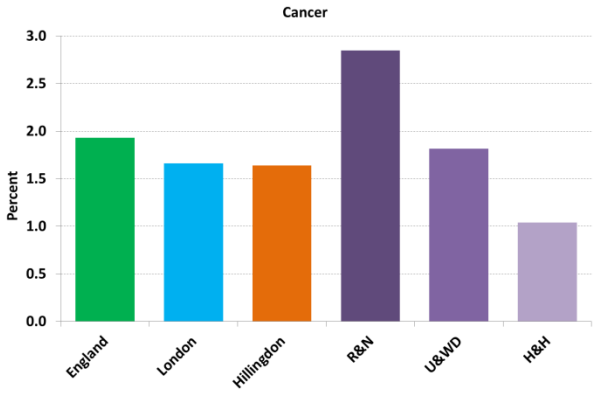
However Ruislip & Northwood shows a higher prevalence (3.4% of the GP register population) than the Borough average.



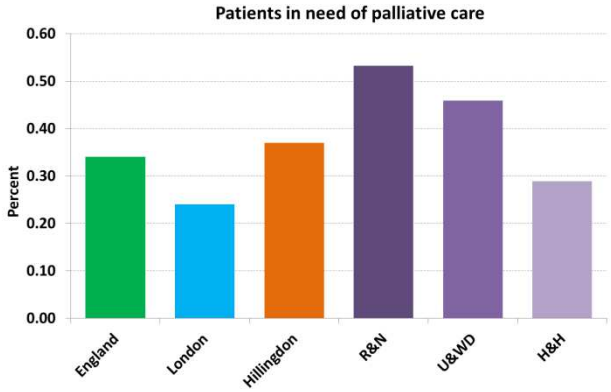
Cancer

In Hillingdon the prevalence of cancer patients was 1.6% of the GP register population, lower than the England average of 1.9%.

Within the Hillingdon localities there is a higher prevalence in Ruislip & Northwood (2.8% of the GP register population) and a lower prevalence in Uxbridge & West Drayton and Hayes & Harlington.



Palliative care (or end of life care)



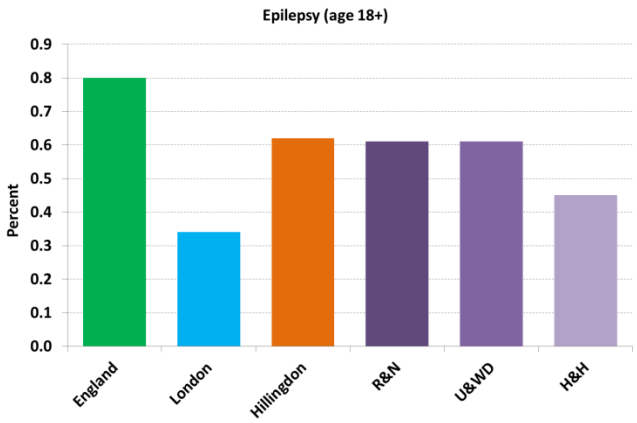
The number of patients on GP registers in need of palliative care is higher in Hillingdon than the England and London averages.

Within the Borough there are more patients in need of palliative care in Ruislip & Northwood than in the other localities, although the numbers and percentages are low overall.

Epilepsy

The prevalence of epilepsy in Hillingdon is 0.6% of the GP register population, lower than the England average of 0.8% of the GP register population.

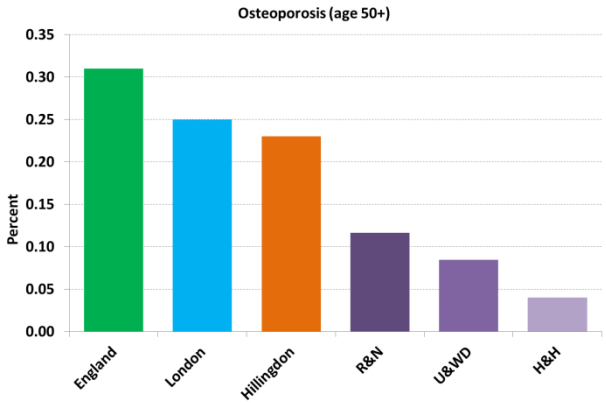
The prevalence is broadly consistent throughout the Hillingdon localities with Uxbridge & West Drayton recording a slightly higher prevalence than the other localities.



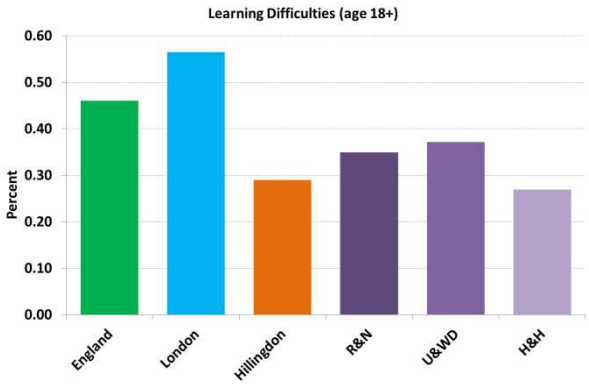
Osteoporosis (age 50+)

The prevalence of osteoporosis in Hillingdon is 0.23% of the GP register population (age over 50). This is lower than the England average.

Within the Borough Ruislip & Northwood showed a higher prevalence of osteoporosis than the other localities.



Learning difficulties



The prevalence of learning difficulties is lower in Hillingdon than the England and London averages.

Within the Borough Uxbridge & West Drayton has a higher prevalence of adults with learning difficulties than the other localities although the numbers and percentages are low overall.

The health care needs of a population vary with age, with the elderly and the young having different needs. For example, the need for chronic disease management will be greater in the elderly population while the need for sexual health and maternity services will be greater in the younger population.

Smoking

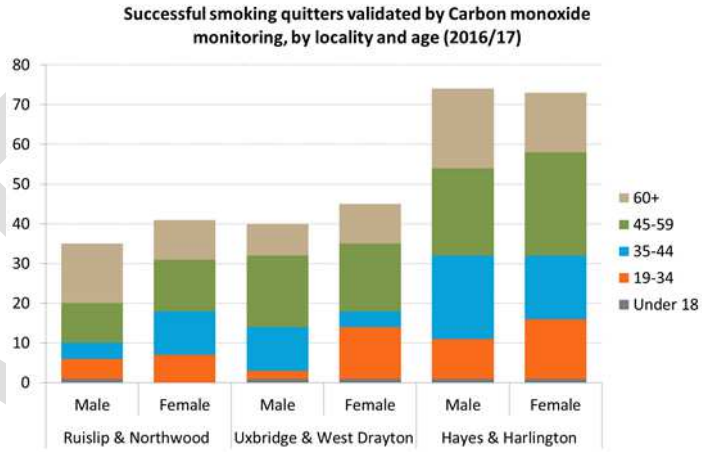
Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers including lip, mouth, throat, bladder, kidney, stomach, liver and cervix. In Hillingdon the estimated prevalence of smoking is 16.9% of the population aged over 18. This is the same as England (16.9%) and slightly higher than London at 16.3%. In surveys of manual workers and workers in routine occupations the prevalence of smoking is higher, assessed as 22.2% of the population in Hillingdon

(24.2% in London and 26.5% in England).

Source: PHOF Indicator 2.14, 2015

Smoking attributable hospital admissions are also measured to support smoking prevalence data. In Hillingdon in 2015/16 the rates of smoking attributable hospital admissions were 1,528 per 100,000 population aged over 35. This is lower than England rate of 1,726 per 100,000 population aged over 35 and slightly lower than the London rate of 1,597.

Source: Public Health England, Local Tobacco Control Profile 2015/16.



Source: LBH Public Health data, Pharmoutcomes Standard Service Report

4. Prevalence of communicable diseases

Tuberculosis (TB)

Between 2013-2015 in the UK an average of 6,497 cases of TB were reported, a rate of 12.0 cases per 100,000 population. London has the main burden, with almost 40% of these cases. The majority of cases were in people born in high burden countries and concentrated in urban centres. Hillingdon reports much higher rates – the three year average tuberculosis case reports is an average of 107 cases annually, a rate of 36.5 per 100,000 population. Treatment completion rates (2014 data) in Hillingdon are 83.8%, below both London (87.2%) and England (87.2%).

Source: Public Health Outcomes Framework, Indicator 3.05i

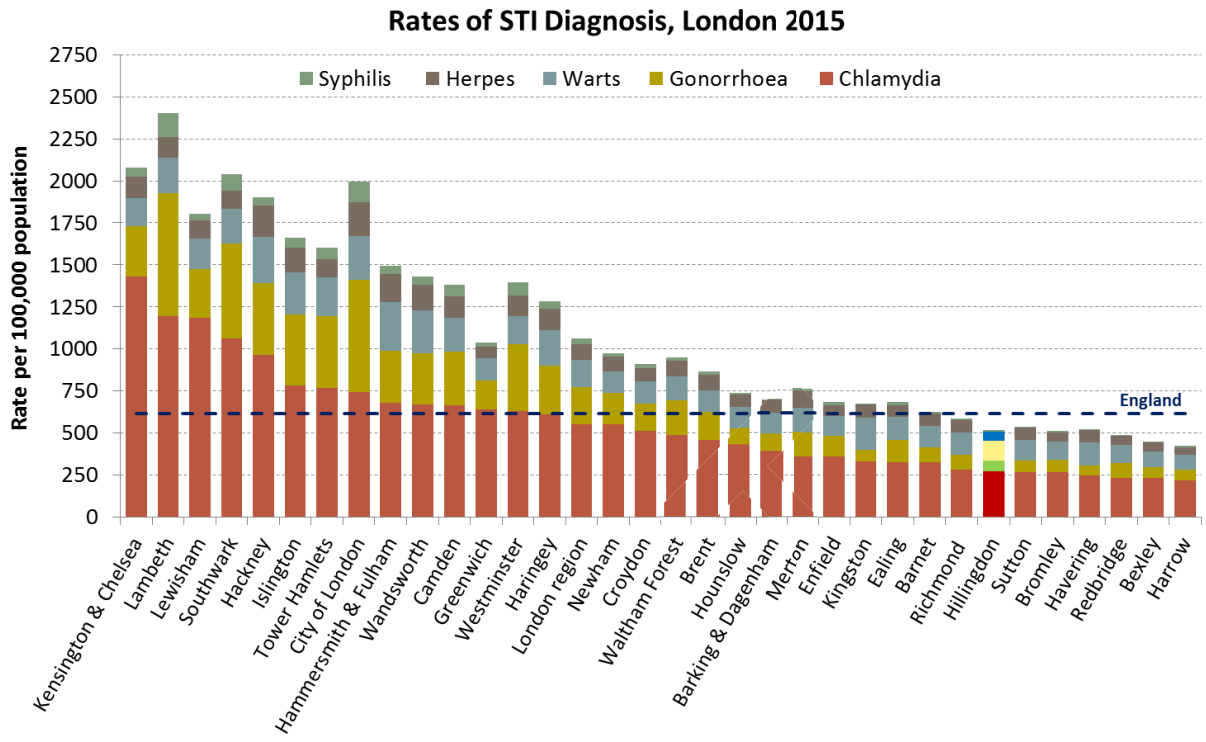
Seasonal influenza

Influenza is a highly infectious illness caused by the influenza (flu) virus. It spreads rapidly through small droplets coughed or sneezed into the air by an infected person. Influenza vaccines are shown to provide effective protection against influenza. Influenza immunisation is offered to people in at-risk groups such as pregnant women and elderly people. These people are at greater risk of developing serious complications, such as bronchitis and pneumonia if they catch flu. Immunisation coverage is a good indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely related to levels of disease.

Population vaccination coverage 2015/16 flu vaccination aged 65+ in Hillingdon is 68.3% of the population, below England and above London averages (71% and 66.4% respectively. Source: PHOF 3.03xiv). This is just below the Chief Medical Officer's target of 75% coverage for this population group. Vaccination of at risk individuals (those under the age of 65, who suffer from certain chronic conditions) is 47.8% of the at risk groups in Hillingdon, which is higher than the London and England averages (43.7% and 45.1% respectively), and working towards the Chief Medical Officer's 55% target of at risk groups vaccinated. Pharmacy continues to play an important role in the distribution of antiviral and the overall clinical management of patients. Since 2013, community pharmacies have been commissioned by NHSE (via patient group direction) to vaccinate eligible individuals.

Sexually transmitted infections

Sexually transmitted infections (STI) represent an important public health issue in London which has the highest rate of acute STIs in England, 66% higher than England as a whole. Sexually transmitted infections have been on a general increase over the past 10 years. In comparison with other London boroughs, however, Hillingdon has a relatively low rate of sexually transmitted infections.



Source: fingertips.phe

The table shows the main STIs diagnosed in Hillingdon.

STI / year	2009	2010	2011	2012	2013	2014	2015
Chlamydia	745	800	760	810	895	860	800
Gonorrhoea	85	95	80	110	130	200	185
Herpes	115	130	150	150	180	195	170
Syphilis	<10	<10	<10	30	10	25	30
Genital Warts	370	350	365	360	380	315	345

Source: Public Health England, Sexual & Reproductive Health Profiles

The total number of all new STIs diagnosed in Hillingdon in 2015 is 811 per 100,000 of the population; this is lower than the London rate of 1,391 per 100,000 and higher than the England rate (768 per 100,000).

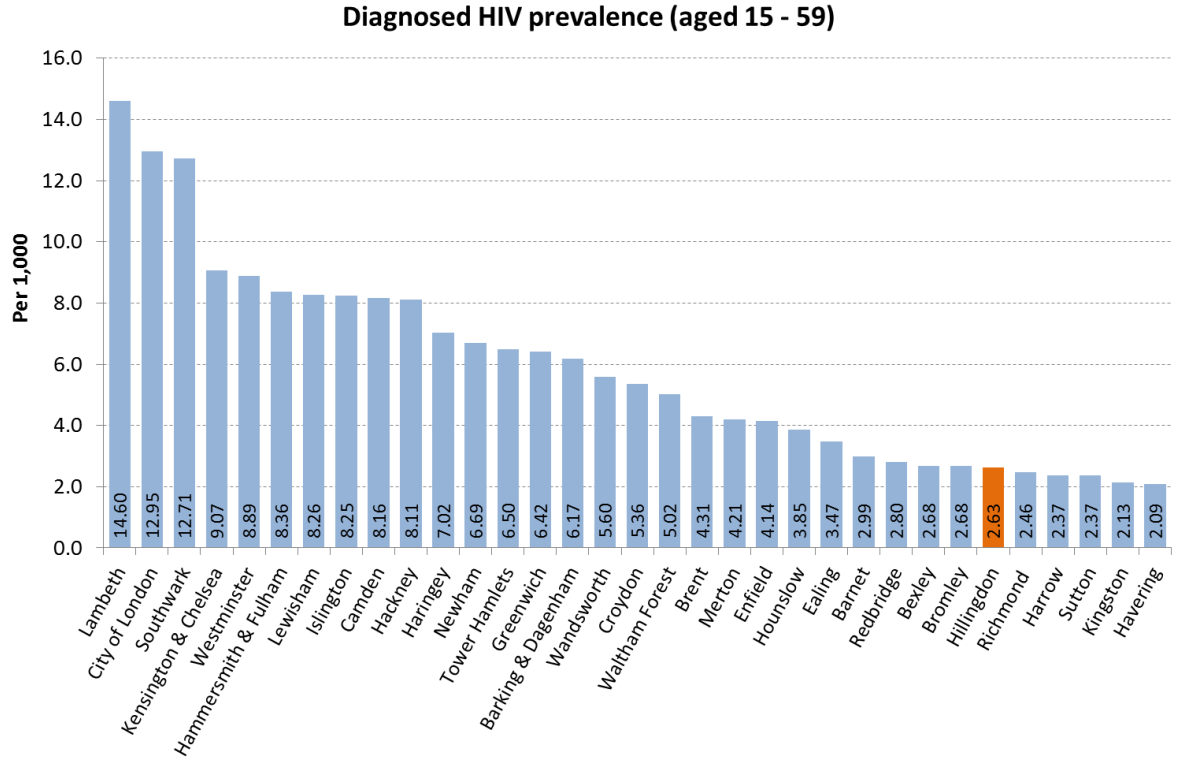
Age data shows that young people experience higher rates of infection and account for higher proportions of treatments. In England in 2016, STI diagnosis rates in 15-24 year olds are twice as high in men and seven times as high in women when compared to those aged 25-59 years.

Source: Sexually transmitted infections (STIs): annual data tables, 2016 (infographic)
https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables

HIV

The rate of HIV diagnosed in Hillingdon in 2015 was 2.63 per 1,000 of the population aged 15-59. Hillingdon ranked 27th lowest out of the 32 London Boroughs submitting data for diagnosed HIV prevalence. When those aged under 15 years and those aged over 59 years were included then the number of people in Hillingdon known to have the virus in 2015 was 500 (to the nearest 10).

Source: HIV in the United Kingdom 2016 report, PHE report.

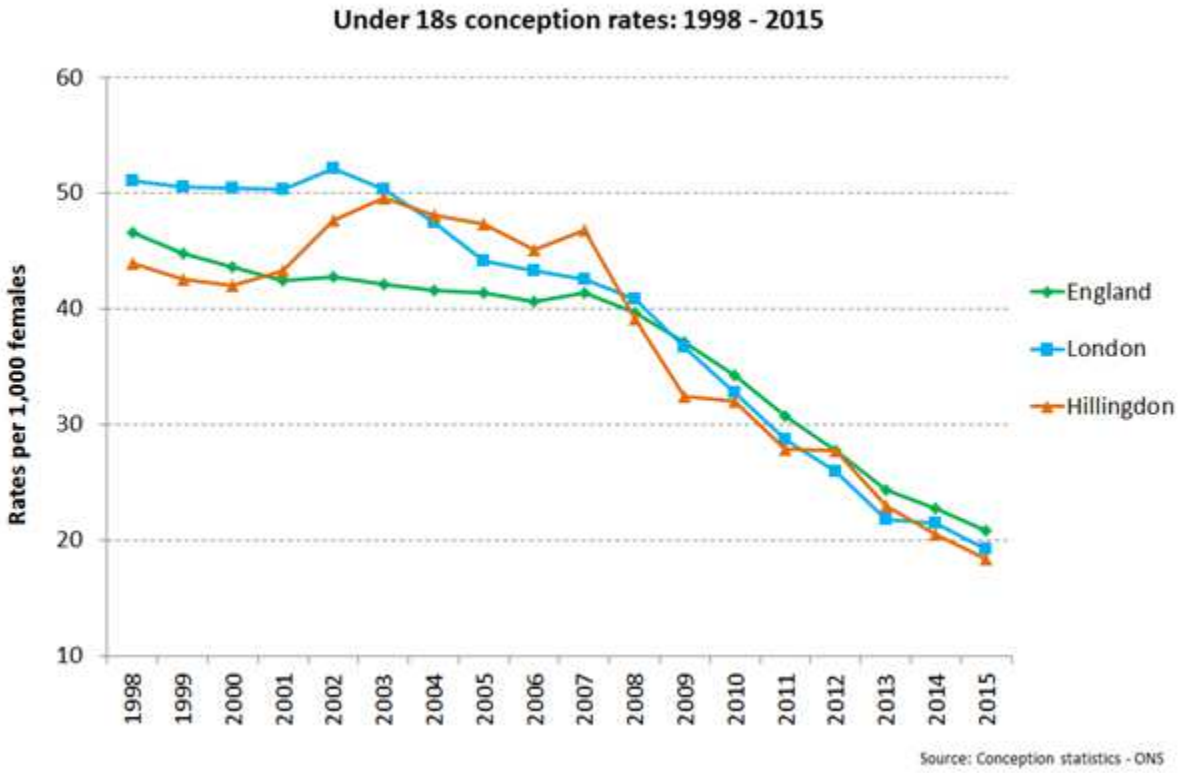


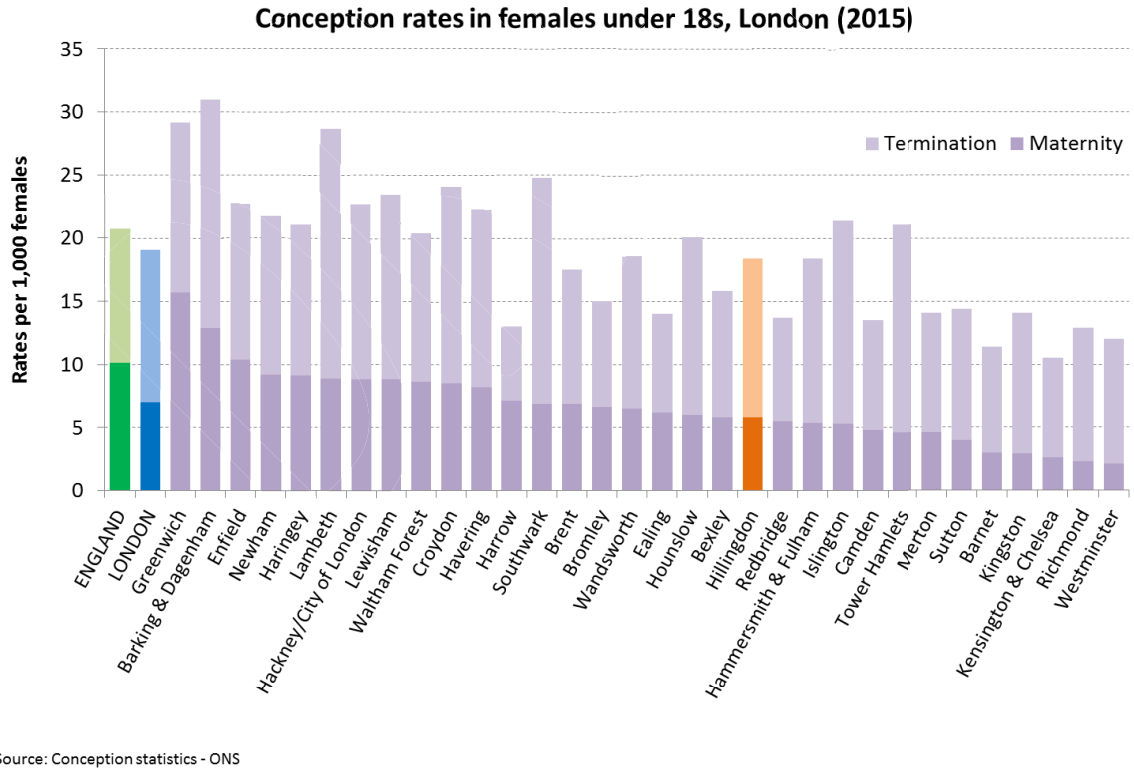
5. Risk taking behaviours

Teenage conceptions

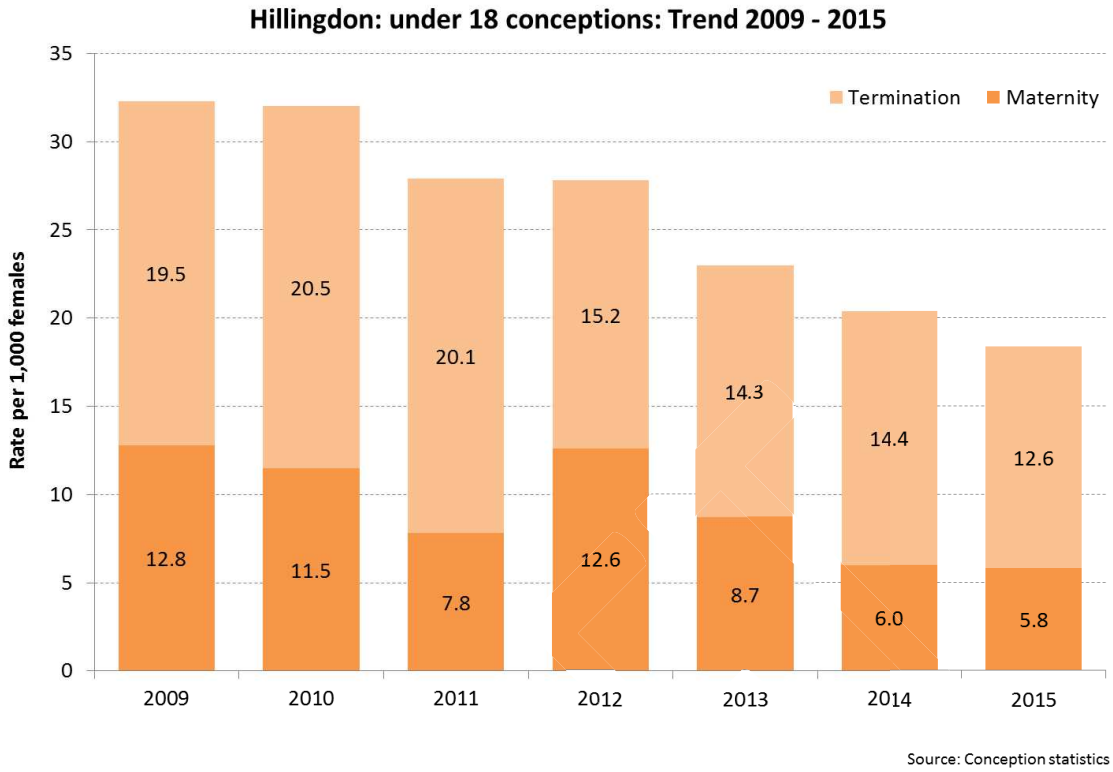
The 2015 teenage conception rate for Hillingdon was 18.4 per 1000 (aged 15-17), which was lower than both the England rate (20.8 per 1000) and London rate (19.2 per 1,000). The trend in teenage conceptions shows reductions in rates for England, London and Hillingdon since 1998. However, the rate of conceptions (age <18 years) in the wards of Yiewsley, West Drayton, Townfield, Botwell and Brunel was significantly higher than the England rate for 2012-14.

(Source: PHOF indicator 2.04, 2015)





Source: Conception statistics - ONS



Source: Conception statistics - ONS

There were 95 teenage conceptions in 2015, of which 68% resulted in terminations. Wards with the highest teenage conception rates within Hillingdon are in the south of the borough.

Substance misuse – Drugs

Data on drug treatment outcomes report successful completion of drug treatment (defined as leaving treatment free of drugs and not re-presenting within 6 months) for opiate users in Hillingdon as 8.4% of those in treatment, compared with 7.6% for London and 6.7% for England (2015/16).

Successful drug treatment for non-opiate users (defined as above) for Hillingdon, is 43.9% of those in treatment compared with 40.1% for London and 37.3% for England (2015/16).
Source: PHOF, Indicator 2.15i, 2015/16

Substance misuse – Alcohol

Consumption of excess alcohol has an impact on health, crime and use of local services.

Alcohol specific hospital admissions in Hillingdon are recorded as 507 per 100,000 population for males, slightly below the England and London averages of 583 and 547 per 100,000 population respectively. For females the rates are much

lower, 279 per 100,000 population in Hillingdon, close to the London average of 283 per 100,000 population and below the England average of 367 per 100,000 population.
Source: Public Health England, Local Alcohol Profiles for England - Indicator 6.02, 2015/16

Under 18 hospital admission rates for alcohol specific admissions for Hillingdon are close to the England average. The crude rate for Hillingdon is 35.7 per 100,000 population and the England average is 37.4 per 100,000. The Hillingdon rate is significantly higher than the London rate which is 22.4 per 100,000 population.
Source: Public Health England, Local Alcohol Profiles for England - Indicator 5.02, 2013/15-2015/16

6. Pharmacy Services

Community pharmacies can play a crucial role in supporting young families by providing advice and support before, during and after pregnancy. Through patient choice, community pharmacy is now the main route of access for emergency hormonal contraception (EHC) and has been successful in delivering the Chlamydia screening and treatment programme. Currently 49 pharmacies in Hillingdon provide EHC, 28 pharmacies provide Chlamydia screening and 19 provide treatment.

The need for the provision of out of hours services for both reproductive and sexual health in the Borough is evident. Those wards where the population of young people is higher or wards demonstrating higher need (high rates of teenage conceptions) have been targeted by commissioners in Public Health and the provision of emergency hormonal contraception. Since 2015, 12 more pharmacies are offering 72 hour EHC option and 28 additional pharmacies are offering the 120 hour EHC option. As part of this approach, particular attention has been paid to those pharmacies which are open for longer periods and during weekends.

Through the use of the Making Every Contact Count (MECC) approach, pharmacists can target individuals at higher risk for promoting public health programmes such as Healthy Start, and smoking cessation during and after pregnancy, EHC, Chlamydia screening and oral health promotion. MECC is the recommended approach for improving health and reducing variation; community pharmacists could use the Making Every Contact Count (MECC) approach while dispensing medicines in order to target individuals with public health messages and provide holistic care.

Hillingdon Pharmaceutical Needs Assessment 2018

Appendix 3: Community Pharmacy Provision

March 2018

1. Provision within Hillingdon

The skills and expertise of community pharmacy teams should be utilised to alleviate some of the pressures and ever increasing demands on the NHS and social care services. Community pharmacies are well positioned to support independent living, the promotion of self-care and contribute to a reduction in A&E attendances and hospital admissions. Locally, the Minor Ailment Service is provided by community pharmacists, since 2015 a further 4 pharmacies are now offering the Minor Ailment service. There are now 29 pharmacies with a larger proportion of pharmacies offering the service are in the south of the borough. Integration with the NHS 111 service would also be of benefit.

The current level of essential services in Hillingdon is considered necessary and good based on the existing needs and choices of residents. The level of advanced services, eg medicines use reviews (MURs), new medicines services (NMS), appliance use reviews (AURs) and stoma appliance customization services (SACS) are relevant to local needs and the provision of these services has increased in recent years with MURs and NMS being provided by all pharmacies within the borough. The north of the Borough has a higher proportion of those aged 65 years and over, hence utilisation of health services, including community pharmacy is higher, as evidenced through the higher utilization of prescription items in Ruislip & Northwood locality.

The proportion of ethnic minority older people is high and increasing in Hayes & Harlington locality, which is likely, over time, to reflect the pattern of service utilisation which currently typifies the north of the Borough. Community pharmacies have been providing an increasing number of MURs over the years, as well as a growing number of NMS. However, there is potential for the provision of more directed MURs for patients with long term conditions who may benefit from services nearer home, and from the diverse language skills of community pharmacy staff. By developing better understanding of their condition, patients will be able to manage their conditions more effectively, which in turn will reduce the likelihood of escalations and the need for urgent treatment.

There are many examples both locally and nationally where community pharmacies have contributed to meeting priorities and achieving outcomes. Smoking cessation service delivery, influenza immunisations and Chlamydia screening are good examples of such work. Providing health and social care services closer to home is a key local Health and Wellbeing Board priority. Community pharmacies are an ideal setting for the provision of services closer to home, especially given the very good accessibility to pharmaceutical services across Hillingdon.

Hillingdon CCG plans to provide more services in the community with the transition of diabetes and cardiology services from secondary to primary care. The 2018 PNA has seen an increase in the number of pharmacies providing disease specific service. There has been an increase in services for Diabetes Type 1 and Type 2 and Diabetes screening management. There is a sustained service providing CHD support. Community pharmacies can make a useful contribution in the redesign of care pathways during remodelling and decommissioning of services.

The Joint Health and Wellbeing Strategy prioritised maternity and child health, due to the number of births in Hillingdon and the need to enhance the quality of maternal and child

health services. Community pharmacies situated at the heart of local communities where pregnant women, young people and young families shop, play and work, are the most accessible primary care professionals, available without appointment (in some areas for 100+ hours a week). Their skills and experience make them ideally placed to meet the needs of young families and older people alike. Patients with long term conditions such as dementia (an important local priority) can benefit from services accessible near home.

In 2013 NHS England commissioned community pharmacies across London and Hillingdon to provide influenza immunisations, which increased the accessibility of immunisation services especially for the working age population and achieved high immunisation rates. Pharmacy provision of flu vaccine has increased from 35 pharmacies to 53 since 2015, and the intranasal vaccine for children has increased from 10 to 16 pharmacies offering this service, 29 pharmacies provide the pneumococcal immunisation service.

There is growing emphasis on developing the public health role of community pharmacies. The Public Health Professional Standards for community pharmacy is an important step towards strengthening this relationship. Public health teams are responsible for commissioning public health programmes to improve health status of the local population. The delivery of national programmes such as NHS health checks, smoking cessation and tackling obesity contribute to improving the health of residents and tackling inequalities in health outcomes. Community pharmacies experience of providing these services for Hillingdon residents in the past is a key strength upon which future programmes could be based.

2. Current provision of pharmaceutical services

NHS England North West London Area Team commissions 65 community pharmacies in Hillingdon to provide pharmaceutical services.

Table 1: Provision of community pharmacies in Hillingdon by ward and locality

Locality / ward	**Population in 2018 (GLA demographic projections, 2015)** published 2016	**Number of pharmacies**
Ruislip & Northwood	**Total = 96,200**	**Total = 23**
Cavendish	12,442	
Eastcote & East Ruislip	14,182	
Harefield	7,964	
Manor	12,129	
Northwood	11,231	
Northwood Hills	12,427	
South Ruislip	13,418	
West Ruislip	12,407	
Uxbridge & West Drayton	**Total = 103,100**	**Total = 21**
Brunel	14,510	
Hillingdon East	13,648	
Ickenham	10,933	
Uxbridge North	15,303	
Uxbridge South	15,396	
West Drayton	18,390	
Yiewsley	14,945	
Hayes & Harlington	**Total = 108,100**	**Total = 21**
Barnhill	14,147	
Botwell	19,672	
Charville	13,131	
Heathrow Villages	13,442	
Pinkwell	16,152	
Townfield	16,859	
Yeading	14,685	
22 wards	**307,400 population**	**65 pharmacies**

Benchmarking with England and London

Table 2: Number of pharmacies per 100,000 population (based on 2018 population)

Area	Rate per 100,000 based on GLA Demographic Projections, 2015	Rate per 100,000 based on SNPP, 2014 (released May 2016)
Ruislip & Northwood	**23.9** population = 96,200 number of pharmacies = 23	Population not available at ward level from this source
Uxbridge & West Drayton	**20.3** population = 103,100 number of pharmacies = 21	Population not available at ward level from this source
Hayes & Harlington	**19.4** population = 108,100 number of pharmacies = 21	Population not available at ward level from this source
Hillingdon	**21.1** population = 307,400 number of pharmacies = 65	**20.7** population = 314,300 number of pharmacies = 65
London	**20.6** population = 8,980,071 number of pharmacies = 1,853**	**20.4** population = 9,081,300 number of pharmacies = 1,853**
England	Population not available at national level from this source	**20.8** population = 56,061,500 number of pharmacies = 11,688**

** source = General Pharmaceutical Services in England 2015/16, NHS Digital
http://content.digital.nhs.uk/searchcatalogue?productid=23420&q=pharmacy&sort=Relevance&size=10&page=1#top

Information on the distribution of community pharmacies across Hillingdon shows that the locality of Ruislip & Northwood has a marginally higher provision with 23 pharmacies than either Uxbridge & West Drayton or Hayes & Harlington that have 21 pharmacies each. The proportion of community pharmacies per 100,000 population, is also higher in Ruislip & Northwood (23.9) when compared with Uxbridge & West Drayton (20.3), Hayes & Harlingon (19.4), London (20.4) and England (20.8).

Pharmacy provision is good across all three localities in Hillingdon. Pharmaceutical services in Hillingdon are also well resourced. In the pharmacy service survey pharmacists stated their willingness to provide services that may be required in the future. This suggests the number of pharmacies is sufficient to manage the need of the population over the next 3-5 years. However, given population increases predicted for both Hayes & Harlington (Housing

Zone) and Uxbridge & West Drayton (St Andrews Park) localities, there will be a need to monitor provision of pharmaceutical services over the medium to longer term (ie 3-5 years).

While the population size does not vary much between localities; there are differences in factors such as: demographic features, health status and distribution of risk factors which make the overall picture on health status more complex. Based on the narrative regarding age and ethnicity distribution and mortality and morbidity, the health needs of the older population in the north of the Borough are different from the relatively younger and less affluent south. Community pharmacies based at the heart of these communities can play a vital role in meeting some of the specific needs.

The Local Government Association has urged commissioning organisations to recognise and harness the expertise and experience of community pharmacies in optimising medicines use, supporting patients and the public's health and wellbeing, as well as improving patient safety. The potential role of community pharmacy in prevention and early identification of diseases is being evaluated under what has been termed the Healthy Living Pharmacies model.

In Hillingdon, community pharmacies actively contribute to national programmes like NHS health check, influenza immunisation, smoking cessation and Chlamydia screening and treatment. The uptake of such public health programmes could be increased by raising awareness about their availability within the community pharmacy setting through improved communication to patients and residents. The new Local Authority Public Health Primary Care Contract provides an opportunity for more community pharmacists to provide preventative services with better outcomes for all.

There is an even spread of pharmacies across Hillingdon especially in areas of deprivation in the south, and in areas with a higher proportion of older people and people with long term conditions (Ruislip & Northwood). These pharmacies are open early, late and at weekends. The results of the survey of community pharmacists detailed in Appendix 4, highlights that over 80% of pharmacies have disabled car parking nearby and over 70% have free car parking in close proximity to their premises. During certain days and times of the week, community pharmacies are the only healthcare facility available.

Pharmacy opening hours

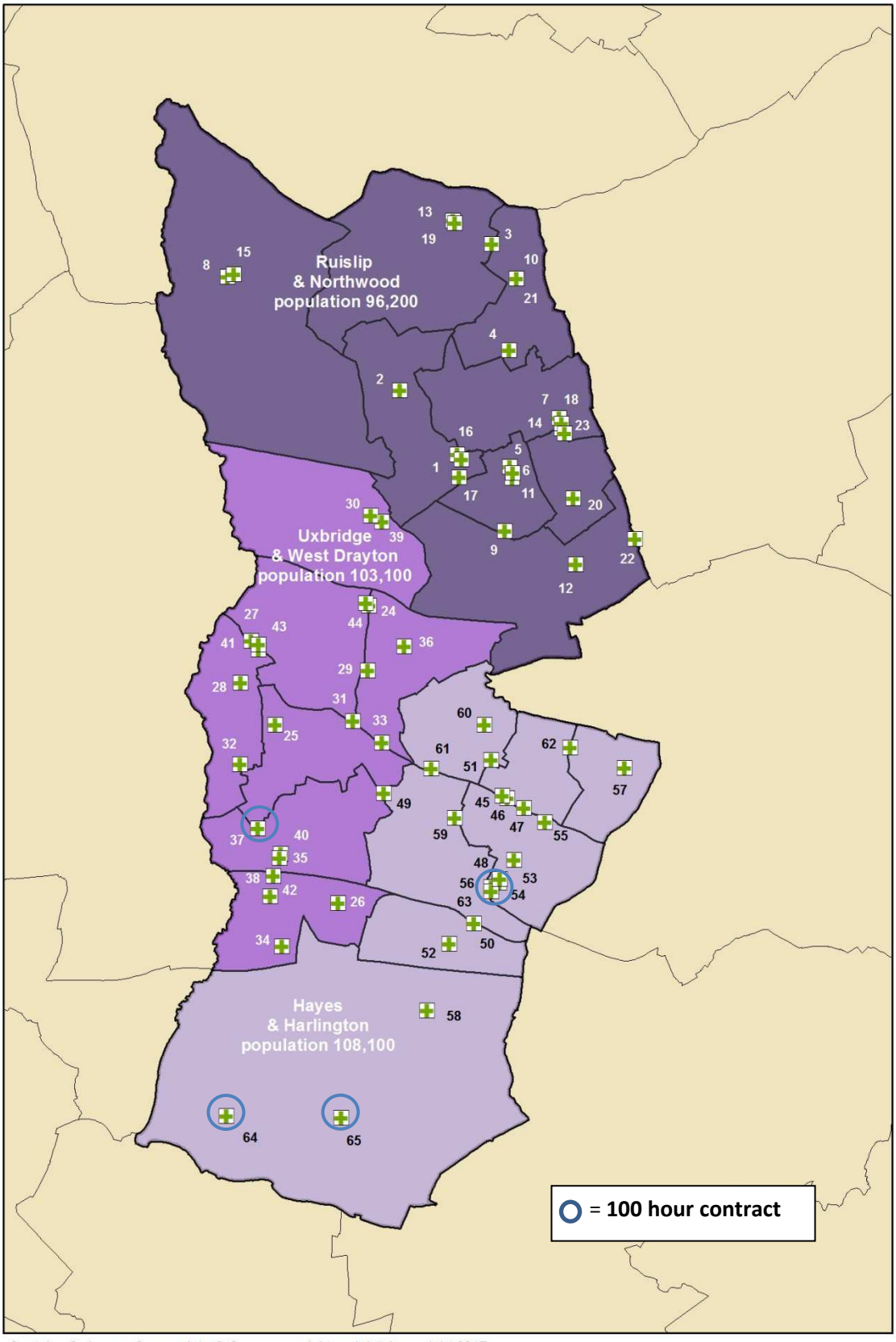
The national framework for pharmaceutical services requires every pharmacy to open for 40 hours minimum and provide essential services which are necessary services. Maps on the following pages show the distribution of pharmacies that are open less than 100 hours per week and those that are contracted to open 100 hours a week. Pharmacies 64 and 65 (Boots) located in Heathrow terminals might not be as accessible to local residents due to parking charges for airport car parks even though these are open for 100+ hours.

Compliance with the Equalities Act

Community pharmacies must make reasonable provision for access by patients who have disabilities. Out of 65 community pharmacists, 64 stated they had wheelchair access and were compliant with the Equalities Act. In 27 pharmacies (42%) patients have access to

toilet facilities and 52 (80%) had consultations room / area accessible via wheelchair. 26 pharmacies reported that they provide consultations in patients' homes or other suitable sites for greater accessibility.

Map 1: Pharmacies by locality and type



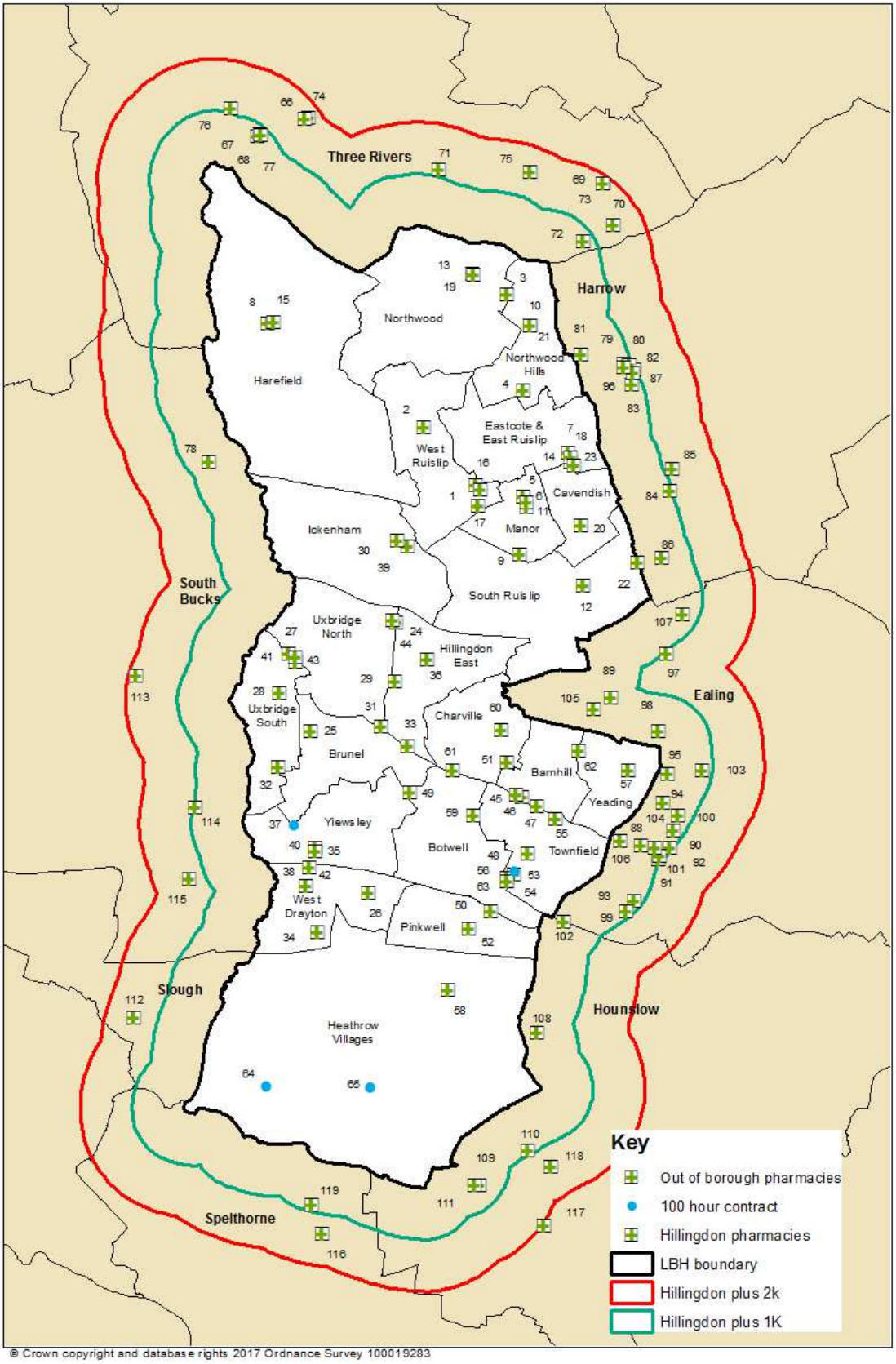
Key	Pharmacy name	Location
1	Ashworths Pharmacy	Ruislip
2	Howletts Pharmacy	Ruislip
3	Carter Chemist & Ability	Northwood
4	Carters Pharmacy	Eastcote
5	Chimsons Ltd	Ruislip Manor
6	Dana Pharmacy	Ruislip Manor
7	Eastcote Pharmacy	Eastcote
8	Harefield Pharmacy	Harefield
9	Nu-Ways Pharmacy	Ruislip
10	Ross Pharmacy	Northwood
11	Ruislip Manor Pharmacy	Ruislip Manor
12	Lloyds Pharmacy in Sainsbury's	South Ruislip
13	Sharman's Chemist	Northwood
14	Superdrug	Eastcote
15	The Malthouse Pharmacy	Harefield
16	Boots, 67 High Street	Ruislip
17	Boots, Wood Lane Medical Centre	Ruislip
18	Boots	Eastcote
19	Boots	Northwood
20	Boots, Whitby Road	Ruislip
21	Boots	Northwood Hills
22	Boots, 716 Field End Road	South Ruislip
23	Boots, 171 Field End Road	Eastcote
24	Adell Pharmacy	Hillingdon
25	Brunel Pharmacy	Uxbridge
26	Carewell Chemists	West Drayton
27	Flora Fountain Ltd	Uxbridge
28	H A McParland Ltd	Uxbridge
29	Hillingdon Pharmacy	Hillingdon
30	Anglebond Pharmacy	Ickenham
31	Lawtons Pharmacy	Hillingdon
32	Mango Pharmacy	Cowley
33	Oakleigh Pharmacy	Hillingdon
34	Orchards Pharmacy	West Drayton

Key	Pharmacy name	Location
35	Phillips Pharmacy	Yiewsley
36	Puri Pharmacy	Hillingdon
37	Tesco In-Store Pharmacy ●	West Drayton
38	Winchester Pharmacy	West Drayton
39	Winchester Pharmacy	Ickenham
40	Yiewsley Pharmacy	Yiewsley
41	Boots, High Street	Uxbridge
42	Boots	West Drayton
43	Boots, Intu Shopping Centre	Uxbridge
44	Boots, 380 Long Lane	Hillingdon
45	Daya Ltd	Hayes
46	Grosvenor Pharmacy	Hayes
47	H.A. McParland Ltd	Hayes
48	Hayes Town Pharmacy ●	Hayes
49	Joshi Pharmacy	Hayes
50	Kasmani Pharmacy	Hayes
51	Lansbury Pharmacy	Hayes
52	Medics Pharmacy	Hayes
53	Nuchem Pharmacy	Hayes
54	Pickups Chemist	Hayes
55	Lloyds Pharmacy in Sainsburys	Hayes
56	Superdrug	Hayes
57	Tesco In-Store Pharmacy	Yeading
58	The Village Pharmacy	Harlington
59	Vantage Chemists	Hayes
60	Vantage Pharmacy	Hayes
61	Boots, 1266 Uxbridge Road	Hayes
62	Boots, 236 Yeading Lane	Hayes
63	Boots, 28-30 Station Road	Hayes
64	Boots, Terminal 5 ●	Heathrow Airport
65	Boots, Terminal 3 ●	Heathrow Airport

● = 100 hour contract

Access to pharmaceutical services: in Borough and out of Borough

Map 2: Pharmacies in Hillingdon, and those within 2km of the boundary (Three Rivers, South Bucks, Slough and Spelthorne) and 1km of the boundary (London Boroughs of Harrow, Ealing and Hounslow):

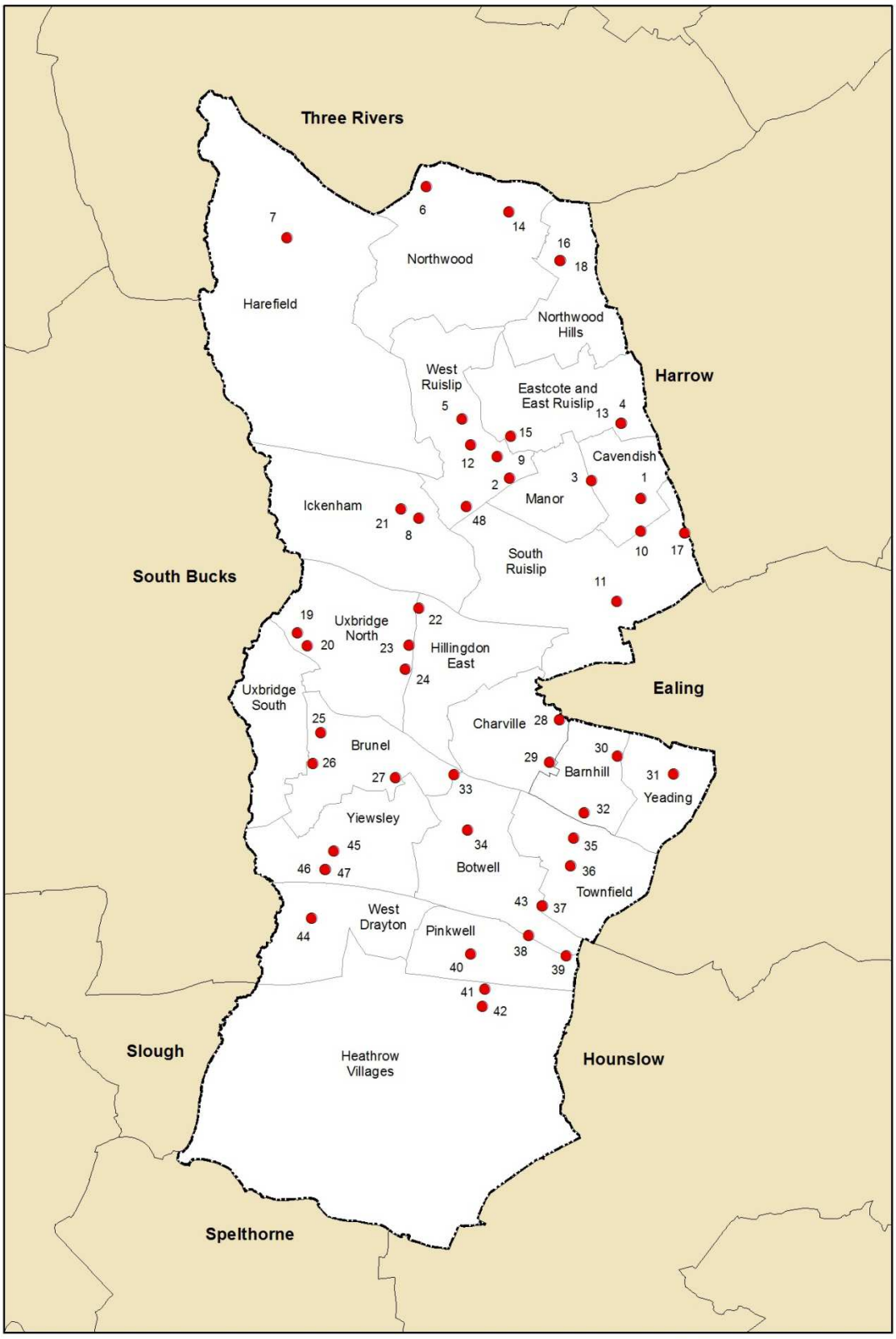


Out of Borough pharmacies:

Key	Pharmacy name	Location
66	Boots, 78 High Street	Rickmansworth
67	Dave Pharmacy	Rickmansworth
68	Delite Chemist	Rickmansworth
69	Esom Chemist	South Oxhey
70	Lex Pharmacy	South Oxhey
71	Loomrose Pharmacy	Moor Park
72	Prestwick Pharmacy	South Oxhey
73	Viks Pharmacy	South Oxhey
74	Riverside Pharmacy	Rickmansworth
75	Medco Pharmacy	South Oxhey
76	Tudor Pharmacy	Rickmansworth
77	The Chief Cornerstone	Rickmansworth
78	Boots	Denham
79	Angie's Chemist	Pinner
80	Carters Chemist	Pinner
81	Tesco In-Store Pharmacy	Pinner
82	Gor Pharmacy, Pinn Medical Centre	Pinner
83	Gor Pharmacy	Pinner
84	Jade Pharmacy	Harrow
85	Jade Pharmacy	Harrow
86	Kings Pharmacy	South Harrow
87	Lloyds Pharmacy in Sainsburys	Pinner
88	Alchem Pharmacy	Southall
89	Alpha Chemist	Northolt
90	Anmol Pharmacy	Southall
91	Chana Chemist	Southall
92	Chana Chemist	Southall
93	Fountain Pharmacy	Southall
94	H.J. Dixon Chemist	Southall
95	Lady Margaret Pharmacy	Southall
96	Boots	Pinner
97	M Gokani Chemist	Northolt

Key	Pharmacy name	Location
98	Northolt Pharmacy	Northolt
99	Puri Pharmacy	Southall
100	Shah Pharmacy	Southall
101	Sherrys Chemist	Southall
102	Tesco In-Store Pharmacy, Bulls Bridge	Southall
103	Chana Chemist	Southall
104	Boots	Southall
105	Touchwood Pharmacy	Northolt
106	Woodland Pharmacy	Southall
107	Boots	Northolt
108	Dunns Chemist	Cranford
109	Edwards & Taylor	Bedfont
110	Tesco In-Store Pharmacy	Feltham
111	Boots	Bedfont
112	Colnbrook Pharmacy	Colnbrook
113	Jeeves Pharmacy	Iver Heath
114	Lloyds Pharmacy	Iver
115	Saleys Chemist	Iver
116	Tesco	Stanwell
117	Boots	Feltham
118	Boots	Feltham
119	Hermans	Stanwell

Map 3: GP practices in Hillingdon



List of GP practices in Hillingdon

Key	Practice name
1	Oxford Drive Medical Centre
2	Wood Lane Medical Centre
3	Cedars Medical Centre
4	The Abbotsbury Practice
5	Dr Karim's Practice, Ladygate Lane
6	The Mountwood Surgery
7	The Harefield Practice
8	Swakeleys Medical Centre
9	King Edwards Medical Centre
10	Medical Centre, Queenswalk
11	Dr Siddiqui's, Walnut Way
12	Southcote Clinic
13	Devonshire Lodge
14	Eastbury Surgery
15	St Martin's Medical Centre
16	Acre Surgery
17	Acrefield Surgery
18	Carepoint Practice
19	Belmont Medical Centre
20	Uxbridge Health Centre
21	Wallasey Medical Centre
22	Hillingdon Health Centre
23	Oakland Medical Centre
24	Acorn Medical Centre

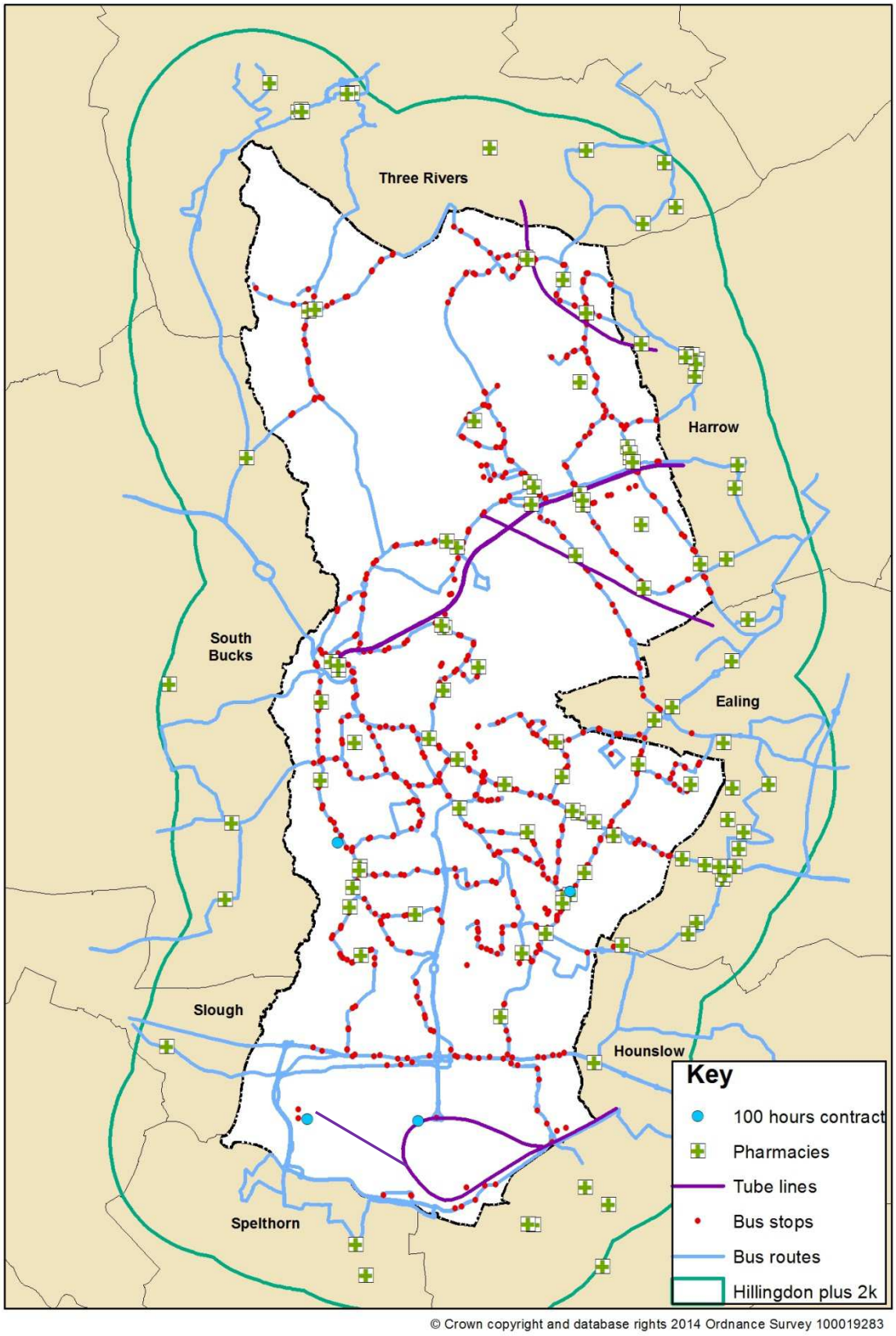
Key	Practice name
25	Brunel Medical Centre
26	Church Road Surgery
27	West London Medical Centre
28	Cedar Brook Practice
29	Pine Medical Centre
30	Yeading Court Surgery
31	Willow Tree Surgery
32	The Warren Practice
33	Parkview Surgery
34	Kingsway Surgery
35	Townfield Doctors Surgery
36	Kincora Doctor's Surgery
37	Hayes Town Medical Centre
38	Hayes Medical Centre
39	North Hyde Practice
40	Shakespeare Surgery
41	Heathrow Medical Centre
42	Glendale House Surgery
43	Orchard Practice
44	Medical Centre, The Green
45	Otterfield Medical Centre
46	Yiewsley Family Practice
47	The High Street Practice
48	St Martin's Medical Centre

Hospital services

NHS hospital trusts and private hospitals do not provide pharmaceutical services as defined for the purposes of the PNA however, as part of the integrated services for patients being discharged from acute and secondary care into community, liaison between hospital pharmacy and community pharmacies is important for providing seamless discharge of patients.

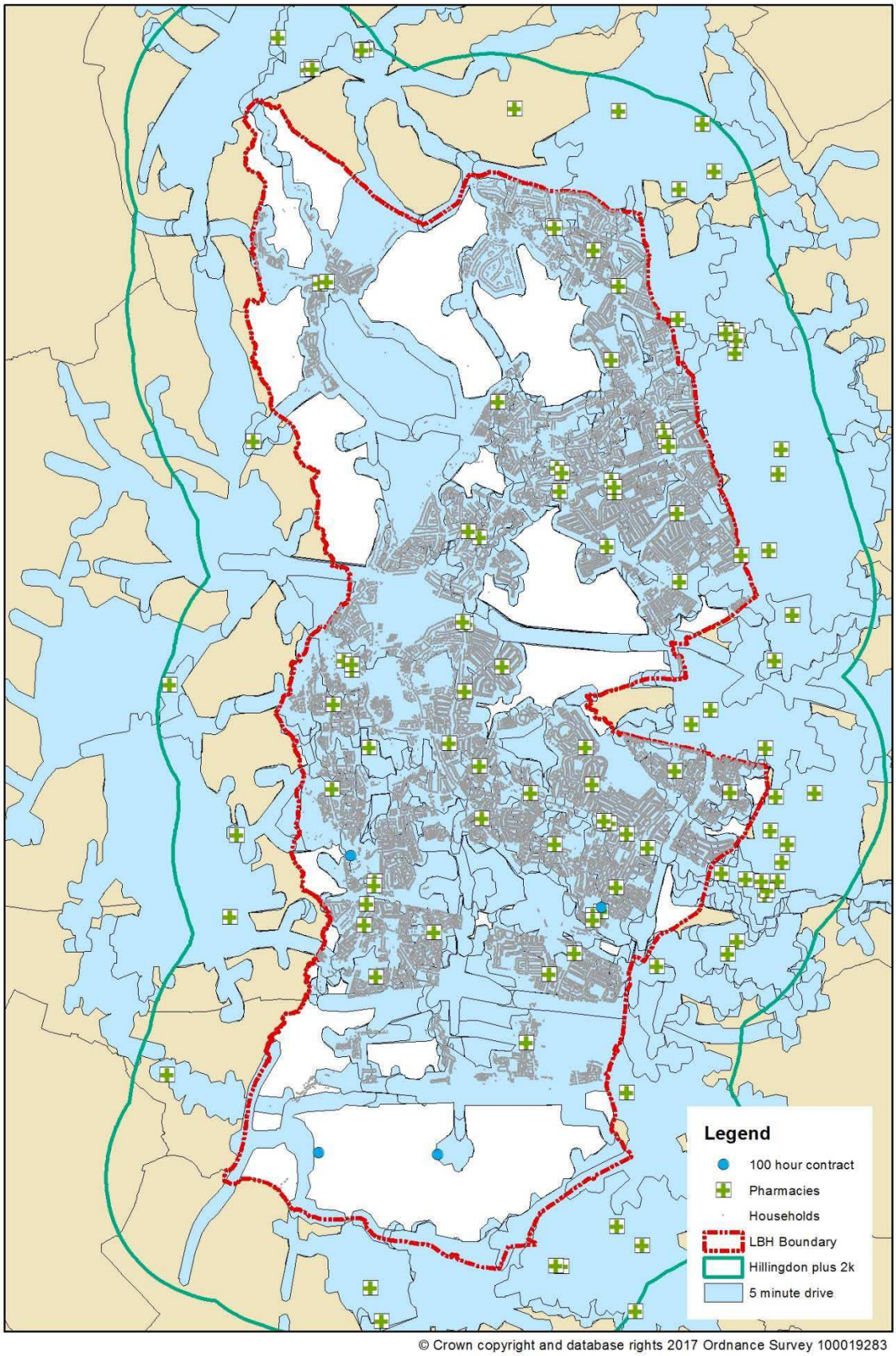
Map 4: Accessibility via public transport

Bus routes and bus stops in relation to Hillingdon and out of Borough pharmacies



Map 5: Access by car

Pharmacies within a 5 minute drive time, by residential postcodes

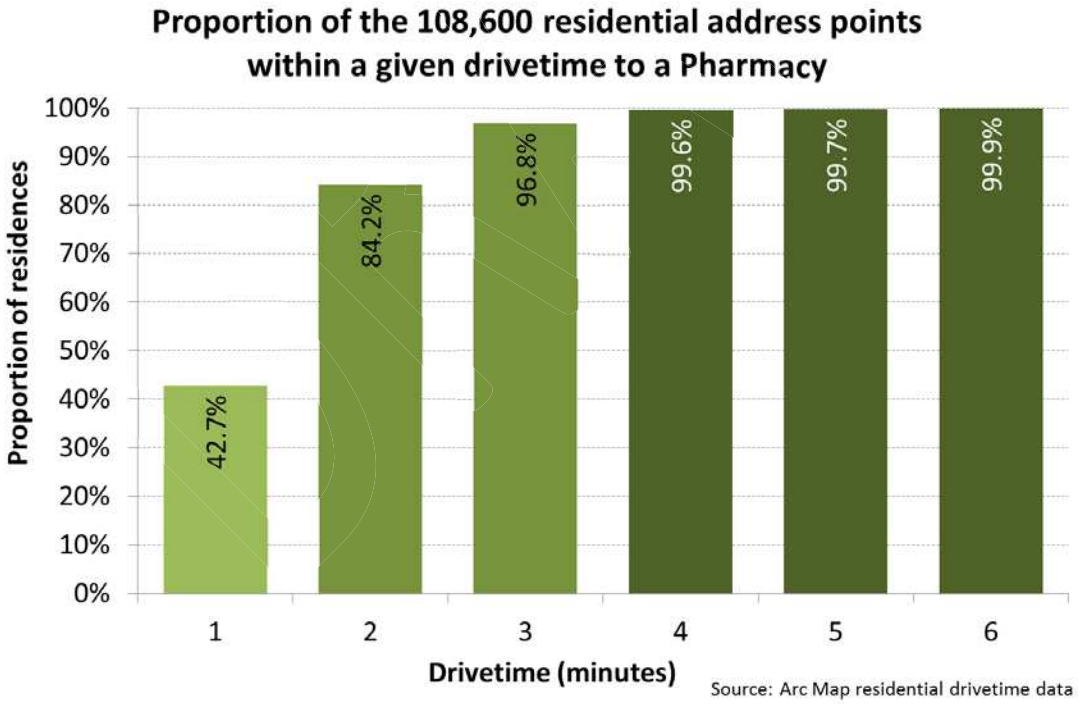


Geographic Information System (GIS) drive time layers at 1 minute intervals were analysed; the number of Borough households found to be within and not within the following drive times to pharmacies are:

Drive time	Within drive time:		Outside drive time:	
	Number of households	Percentage	Number of households	Percentage
1 minute	46,404	42.7%	62,203	57.3%
2 minutes	91,485	84.2%	17,122	15.8%
3 minutes	105,142	96.8%	3,465	3.2%
4 minutes	108,171	99.6%	436	0.4%
5 minutes	108,335	99.7%	272	0.3%
6 minutes	108,592	99.9%	15	<0.1%

*based on 108,607 households

Driving in light urban traffic and keeping within the posted speed limits, 97% of households are within a 3 minute drive or within a 30 minute walk away from a community pharmacy.

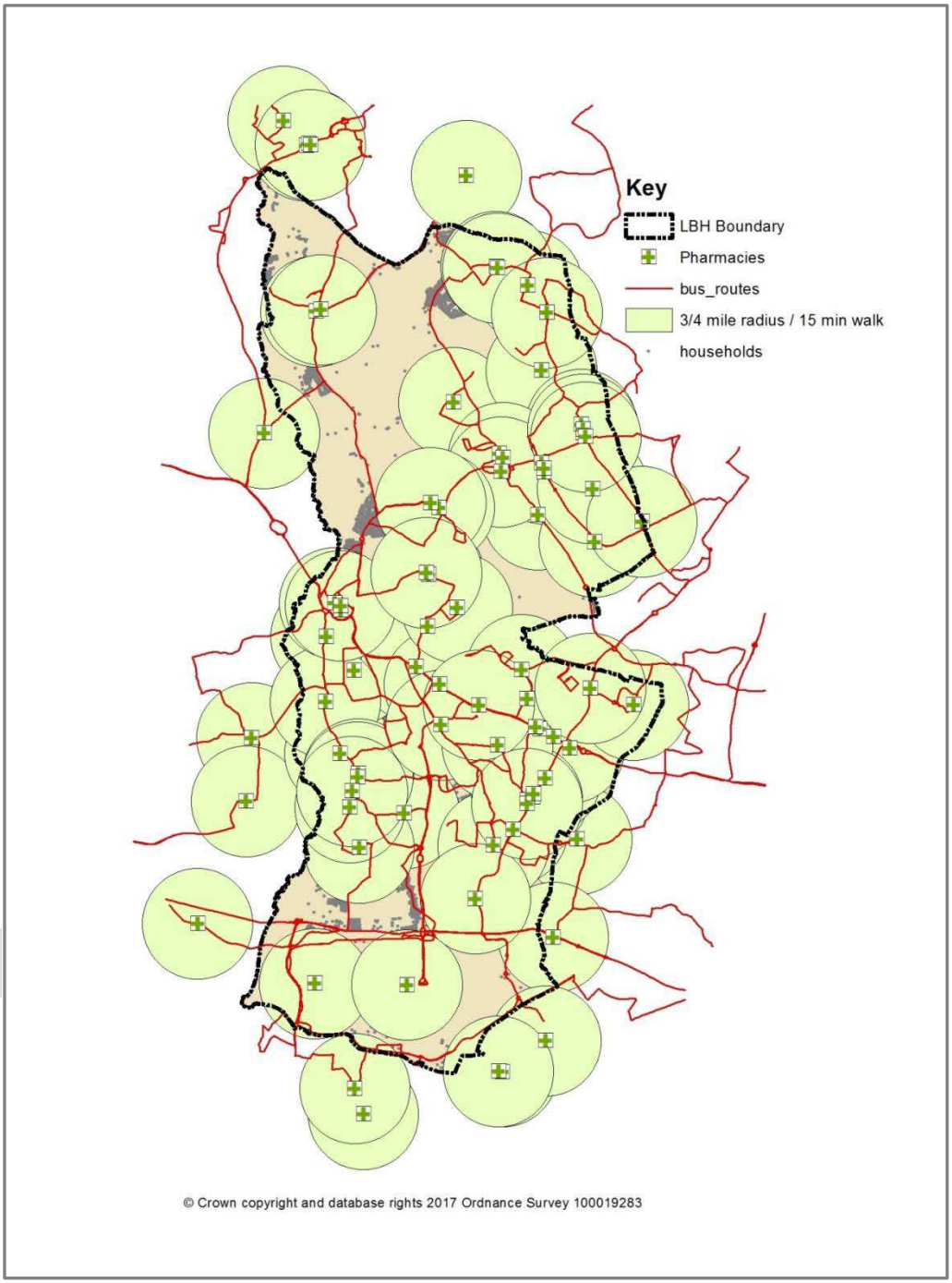


Types of pharmacies

Out of the 65 pharmacies in Hillingdon, 28 are provided by large multiples like Boots, Superdrug, Lloyds (within Sainsbury's), Vantage Pharmacy and Tesco, and 30 are independent. The other 7 belong to small groups with 2-10 pharmacies.

Map 6: ¾ mile radius around the pharmacies

Pharmacies with a ¾ mile radius (15 minute walk), by residential postcodes (with bus routes):

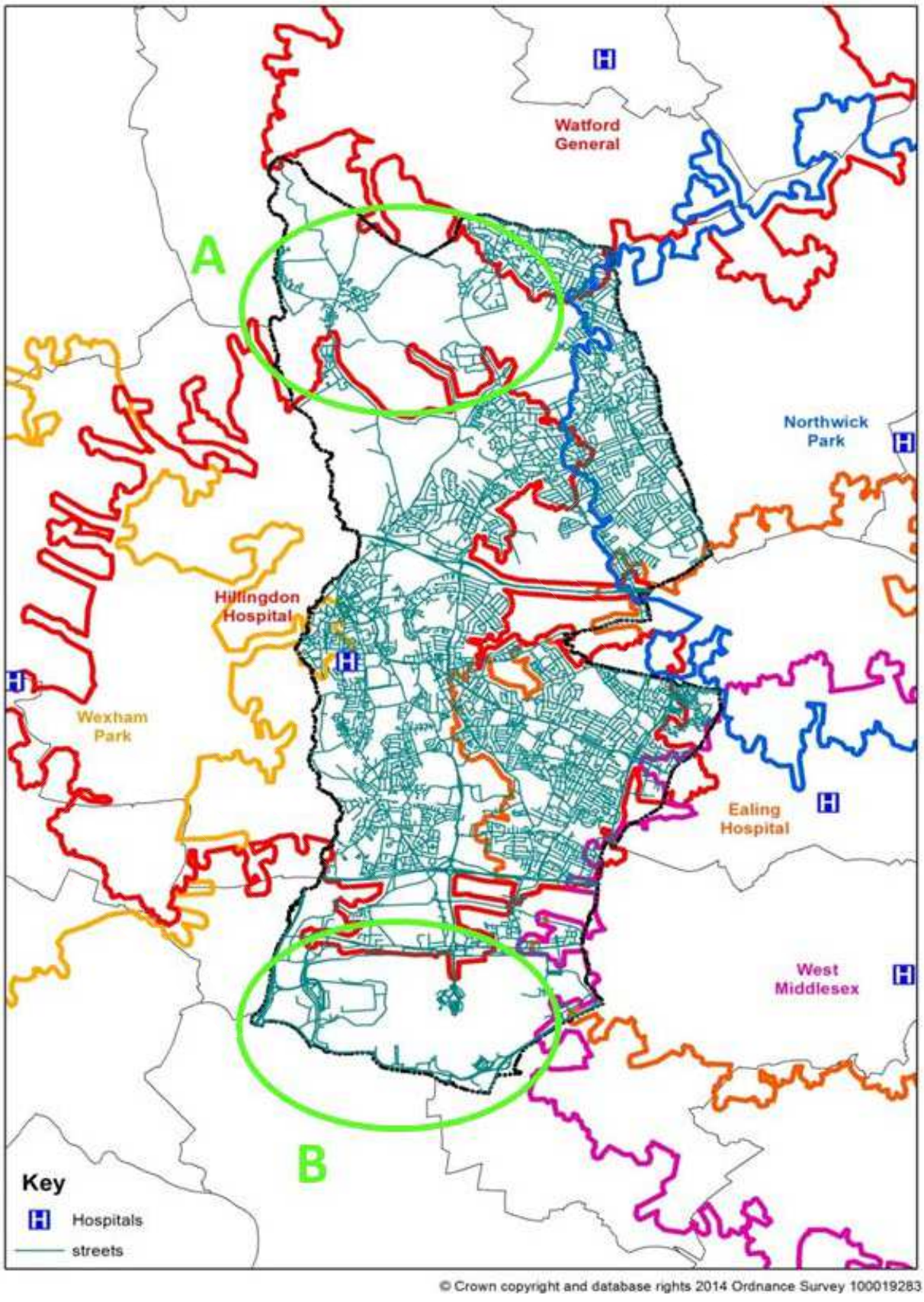


The map shows (from the overlapping ¾ mile circles), a 15 minute walking distance around each pharmacy.

It is acknowledged that there are some areas of the community where a pharmacy is more than 15 minute walk away. Where this is the case pharmacies are readily accessible by bus and road with parking close to the premises. The majority of borough pharmacies are within a 15 minute walk of another pharmacy which is currently serving their geographical location.

Map 7: Access to acute and emergency care - hospitals with a 5 mile radius

The coloured lines show the extent of 5 miles road travel from each hospital.

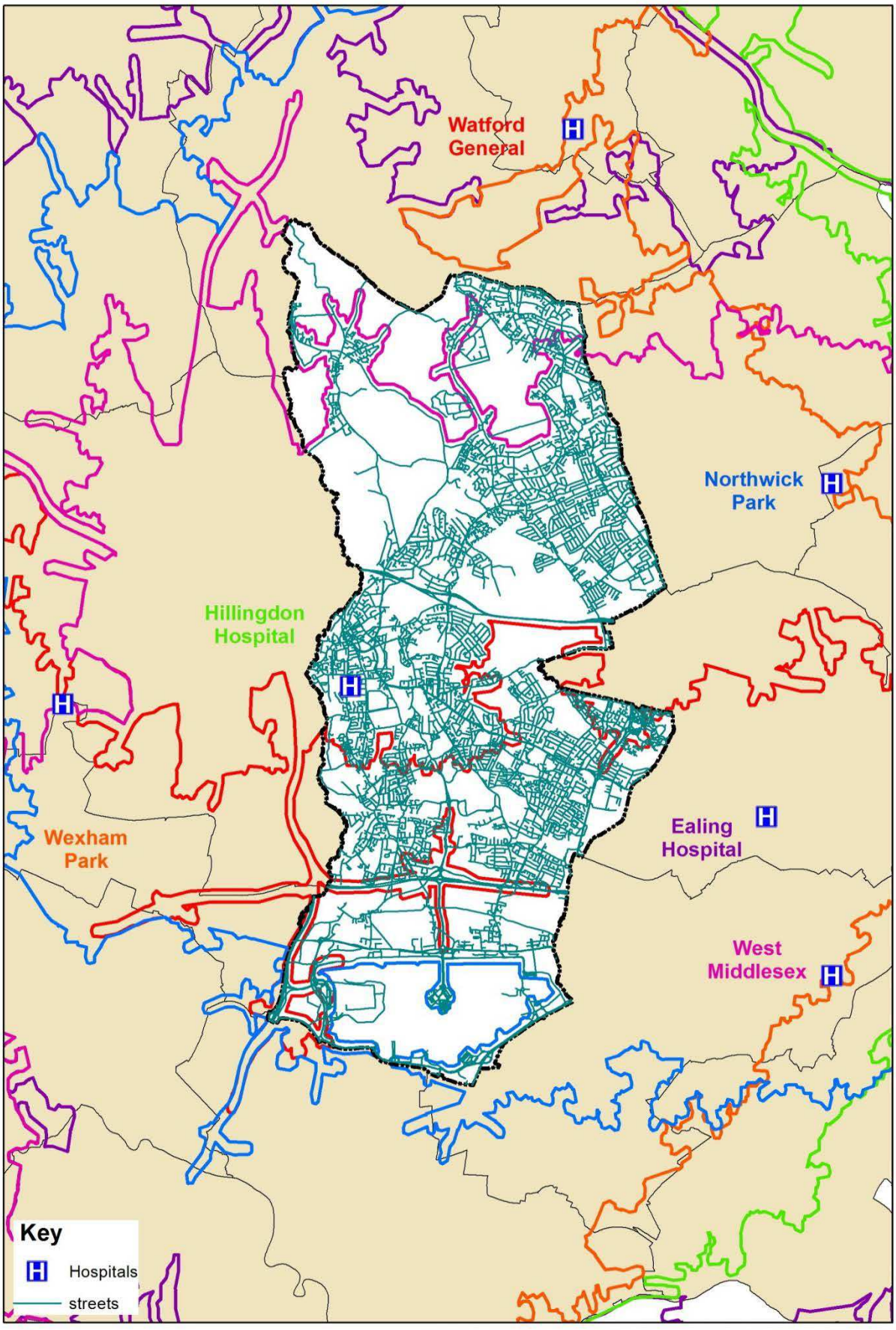


Note - there are areas of low population density in Harefield and Northwood in the north of the borough ('A'), and in Heathrow Villages in the south ('B'). Whilst there are very few residential roads within 'B', Ashford Hospital is approximately 1.5k from the Borough boundary, and has a GP/nurse walk-in centre operating 8am – 8pm 365 days a year; their A&E sister hospital is St Peter's in Chertsey, approximately 15k outside Hillingdon's Borough boundary.

In the north of the Borough at 'A', Mount Vernon Minor Injuries Unit operates from 9am to 8pm seven days a week, offering the following services:

- Minor wounds (including those that may need stitches)
- Minor burns and scalds
- Minor head injury where there has been no loss of consciousness or vomiting, and there are no residual symptoms (ie headache, nausea, dizziness or any other symptoms of concussion)
- Minor injuries to legs below the knee and arms below the shoulder
- Minor nose bleeds
- Emergency contraception

Map: A&E hospitals within a 30 minute drive time



3. Services provided by community pharmacies

Community pharmacies provide three tiers of pharmaceutical services:

- Essential services: These services are required from all community pharmacies
- Advanced services: To support patients with safe use of medicines
- Enhanced services: These services can be commissioned locally by NHS England

Hillingdon community pharmacies listed here are known to be compliant with their contracts at the time of this report.

Essential services

Every community pharmacy providing NHS pharmaceutical services dispenses medicines & appliances and does repeat dispensing, disposal of unwanted medicines, promotion of healthy lifestyles and support for self-care. Based on the previous PNA and the current analysis, the current level of provision of essential services is considered necessary.

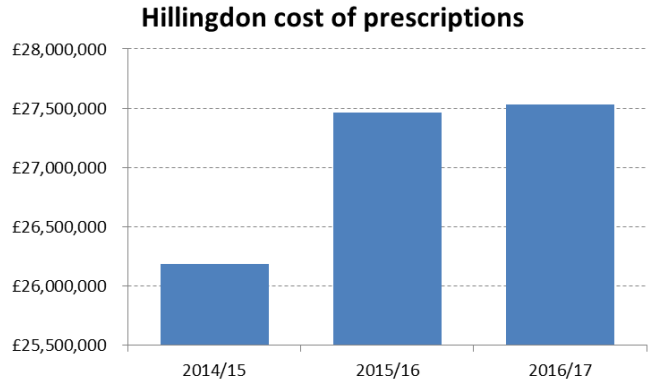
Prescriptions by volume and cost

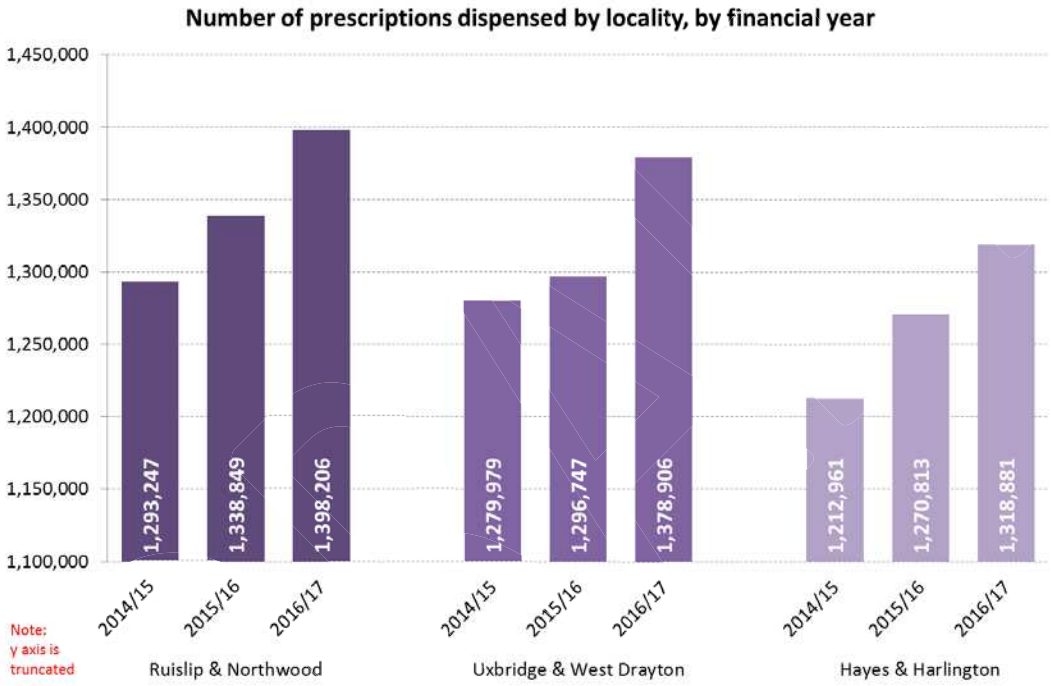
Statistics on prescriptions dispensed in the community by community pharmacists, appliance contractors, and dispensing doctors in England comes from Prescription Cost Analysis (PCA) data. NHS Digital publishes the Prescription Cost Analysis National Statistics annually in April. Data for the most recent calendar year (2016) shows that nationally:

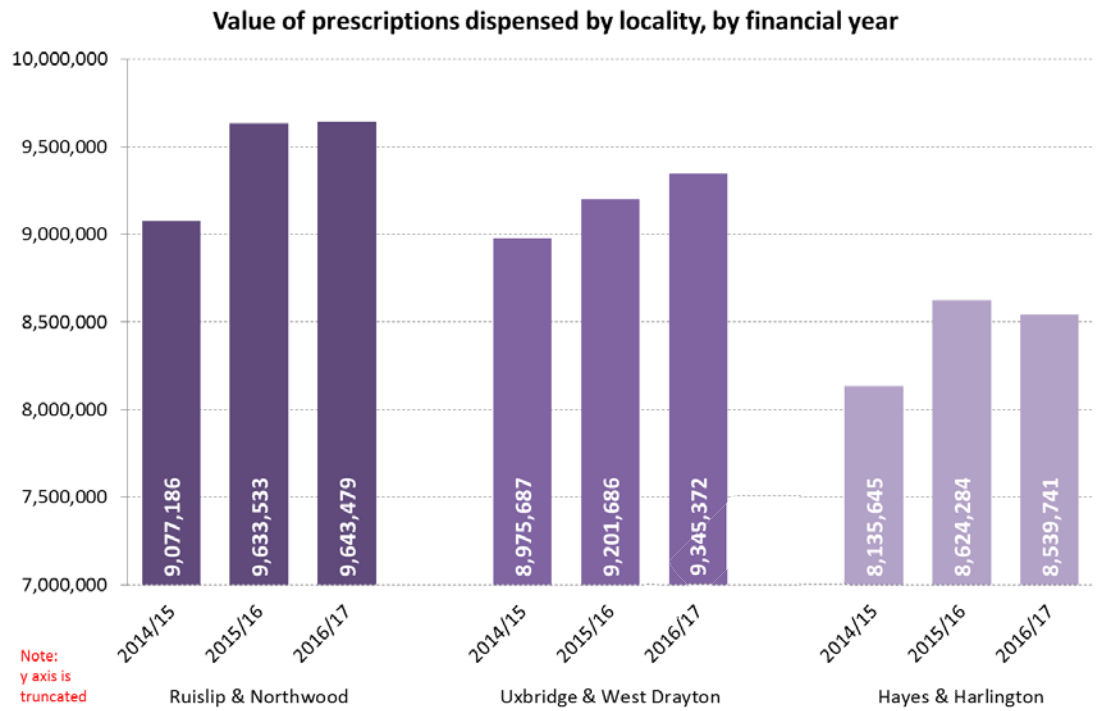
- 1.10 billion prescription items were dispensed in the community. An increase of 1.89% from 1.08 billion in 2015
- £9.20 billion was the cost of prescriptions dispensed in the community.
- The leading BNF (British National Formulary) Section in terms of NIC (Net Ingredient Cost), is BNF 6.1 drugs used in diabetes at £984m
- The BNF Section with the largest number of items is 2.5, Hypertension & Heart Failure with 71.4 million items
- 89.7% of all prescription items are dispensed free of charge (2015, published 6/7/16).

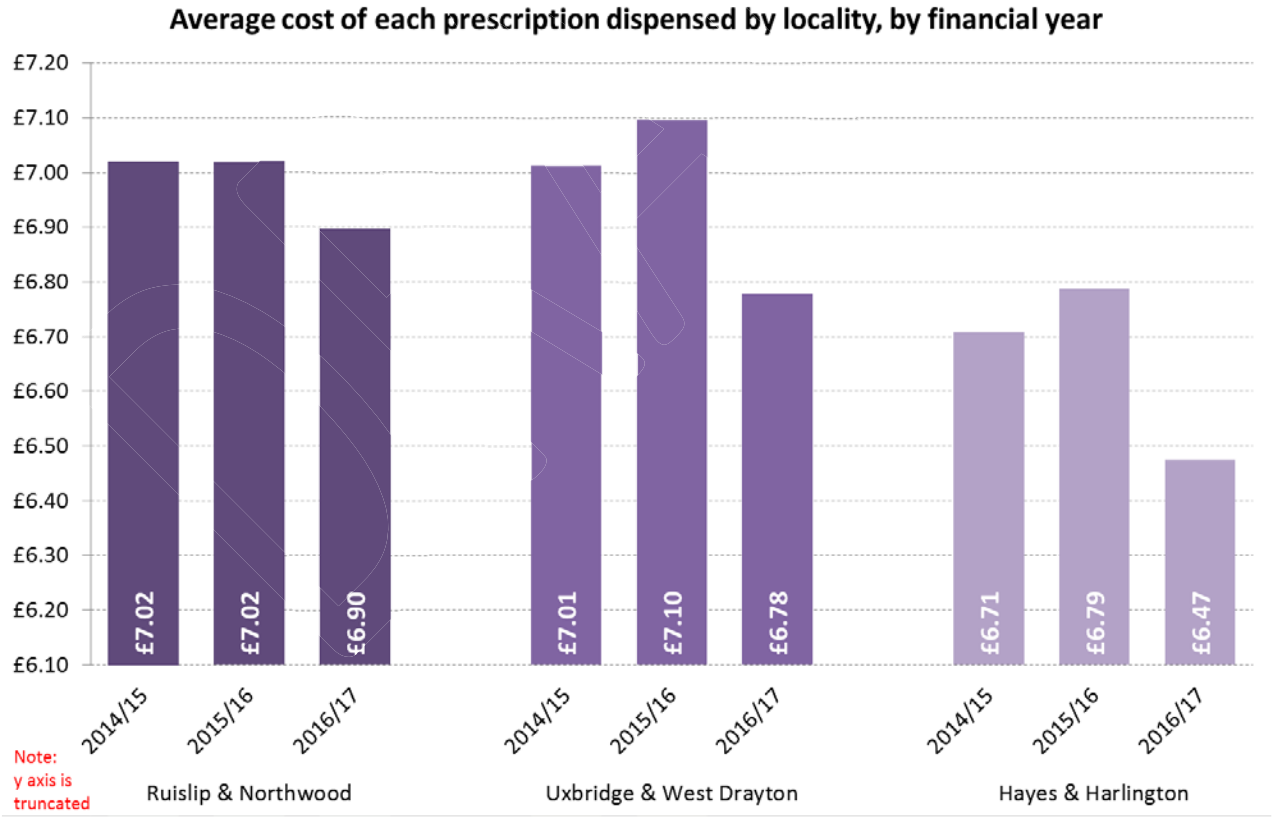
Within Hillingdon, the volume of prescriptions has increased across all localities since 2014/15. The overall cost of dispensed prescriptions in Hillingdon has increased year on year; the costs in each locality has increased, apart from a small drop in Hayes & Harlington between 2015/16 and 2016/17. Although the overall costs of prescriptions has increased, the average cost of a prescription has fallen in each locality, and is now (on average) under £7.00; this may be due to the type of generic medicines prescribed.

The charts on the following pages show that the volume and cost of prescriptions is higher for Ruislip & Northwood in comparison with Uxbridge & West Drayton and Hayes & Harlington. This is consistent with the higher observed prevalence of various chronic illnesses and an older age profile of Ruislip & Northwood locality, based on current need. In future, an ageing ethnic population in wards within Hayes & Harlington locality is likely to balance some of the demand.


Hillingdon cost of prescriptions
£28,000,000
£27,500,000
£27,000,000
£26,500,000
£26,000,000
£25,500,000
2014/15
2015/16
2016/17

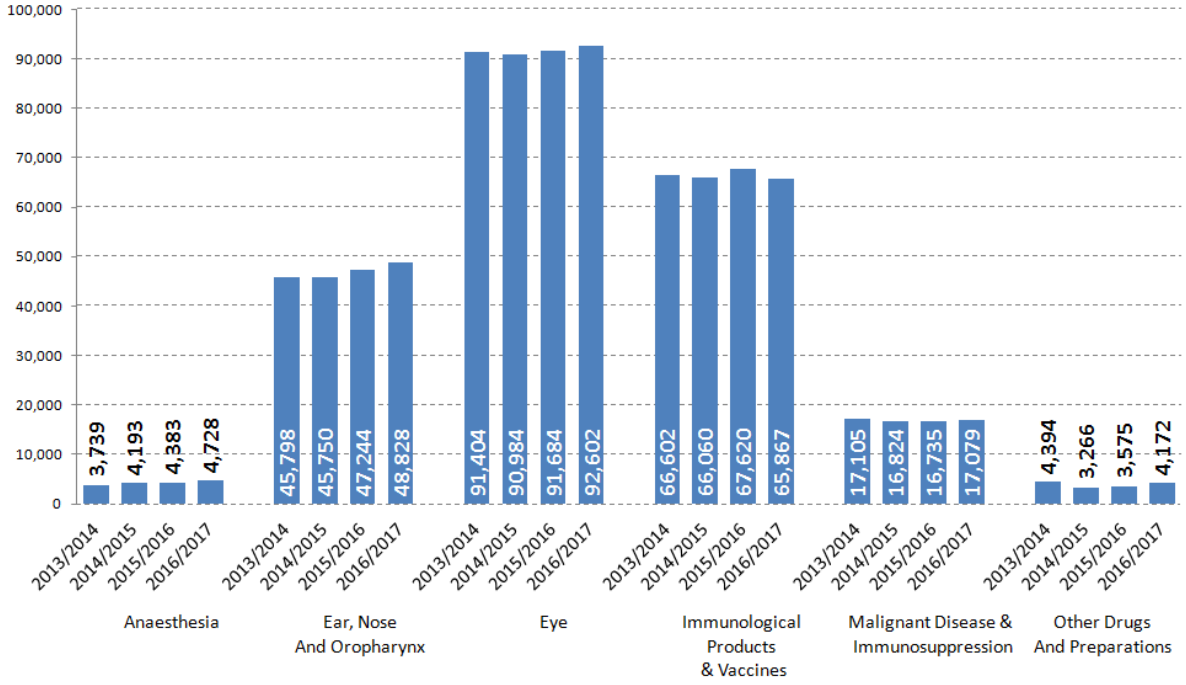

Number of prescriptions dispensed by locality, by financial year
1,450,000
1,400,000
1,350,000
1,300,000
1,250,000
1,200,000
1,150,000
1,100,000
1,293,247
1,338,849
1,398,206
1,279,979
1,296,747
1,378,906
1,212,961
1,270,813
1,318,881
2014/15
2015/16
2016/17
2014/15
2015/16
2016/17
2014/15
2015/16
2016/17
Note: y axis is truncated
Ruislip & Northwood
Uxbridge & West Drayton
Hayes & Harlington



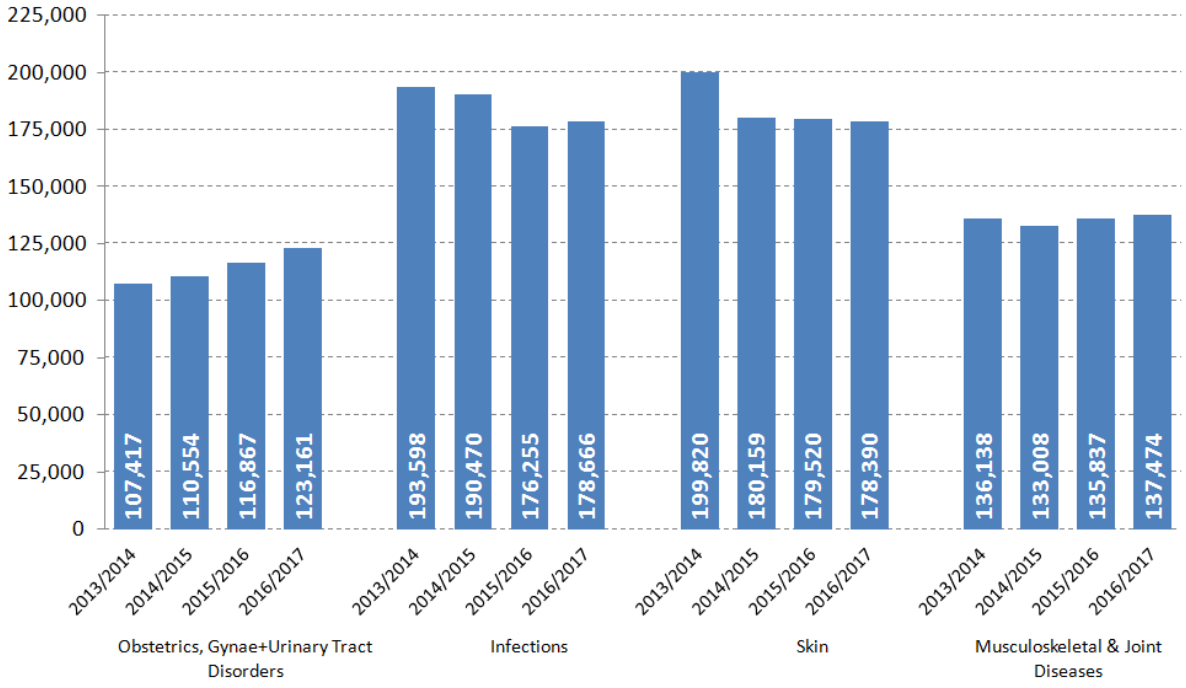


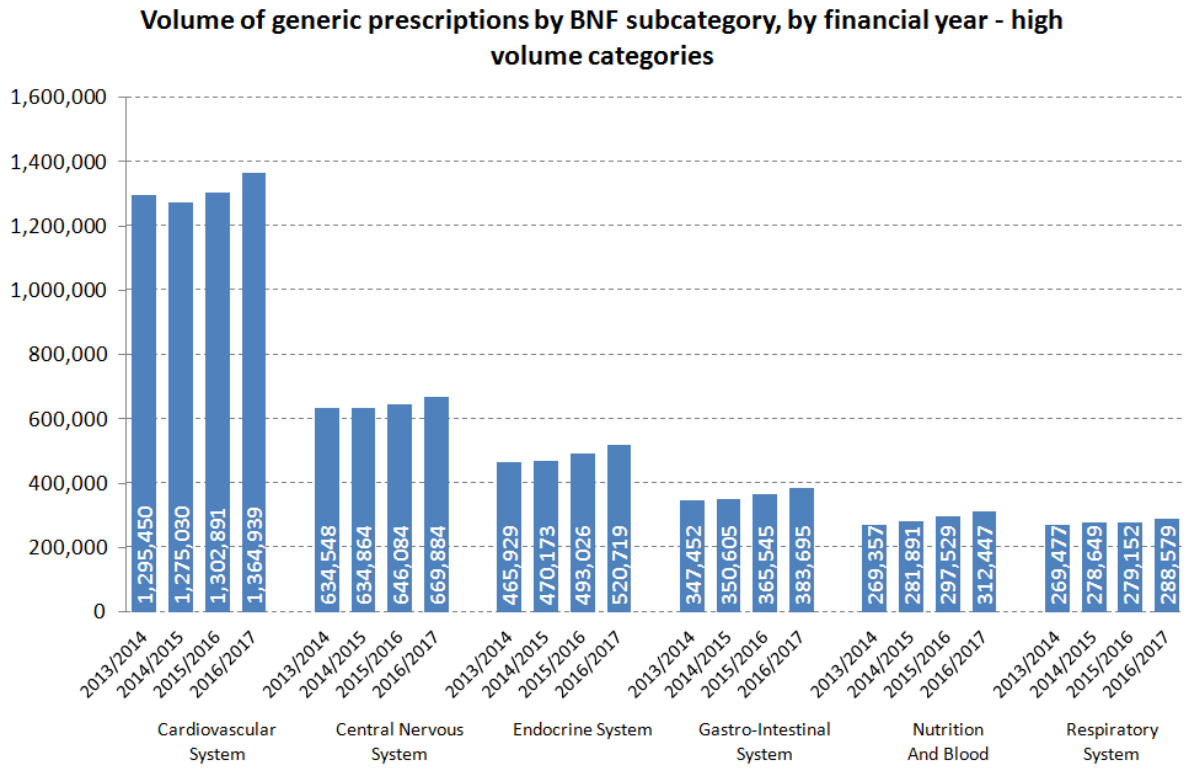
The following charts show low, medium and high BNF sub category volume of prescriptions; the highest volume is prescriptions for the cardiovascular group of illnesses, which is consistent with the increasing prevalence and mortality reductions.

Volume of generic prescriptions by BNF subcategory, by financial year - low volume categories



Volume of generic prescriptions by BNF subcategory, by financial year - medium volume categories





Locality	Financial Year	Items dispensed	Total Cost	Cost per item	population	rates per 1,000 of the population	cost per head
Ruislip & Northwood	2014/15	1,293,247	£9,077,186	**£7.02**	**93,200**	**72.1**	**£97.39**
Ruislip & Northwood	2015/16	1,338,849	£9,633,533	**£7.20**	**94,600**	**70.7**	**£101.83**
Ruislip & Northwood	2016/17	1,398,206	£9,643,479	**£6.90**	**95,500**	**68.3**	**£100.98**
Uxbridge & West Drayton	2014/15	1,279,979	£8,975,687	**£7.01**	**96,000**	**75.0**	**£93.50**
Uxbridge & West Drayton	2015/16	1,296,747	£9,201,686	**£7.10**	**98,000**	**75.6**	**£93.89**
Uxbridge & West Drayton	2016/17	1,378,906	£9,345,372	**£6.78**	**99,500**	**72.2**	**£93.92**
Hayes & Harlington	2014/15	1,212,961	£8,135,645	**£6.71**	**104,200**	**85.9**	**£78.08**
Hayes & Harlington	2015/16	1,270,813	£8,624,284	**£6.79**	**105,700**	**83.2**	**£81.59**
Hayes & Harlington	2016/17	1,318,881	£8,539,741	**£6.47**	**107,000**	**81.1**	**£79.81**

4. Public health campaigns (Promotion of Healthy Lifestyles)

NHS Pharmacists are required to participate in up to six campaigns each year to promote public health messages to their users as part of their NHS contract. When requested to do so by NHS England the NHS pharmacist records the number of people to whom they have provided information as part of those campaigns.

- Urinary tract infections
- Influenza
- COPD

5. Advanced services

The level of provision of Advanced, Enhanced and other locally commissioned services within Hillingdon and in neighbouring areas was assessed via a local survey, which was validated with further commissioner information for Hillingdon community pharmacies. Advanced services are services which are *relevant*, but do not constitute as *necessary*.

Necessary and Relevant Services

SCHEDULE 1 Regulation 4(1)

Information to be contained in pharmaceutical needs assessments

Necessary services are services that

(a) need to be provided (whether or not they are located in the area of the HWB) in order to meet a current need for pharmaceutical services, or pharmaceutical services of a specified type, in its area;

(b) will, in specified future circumstances, need to be provided (whether or not they are located in the area of the HWB) in order to meet a future need for pharmaceutical services, or pharmaceutical services of a specified type, in its area.

Other relevant services:

A **relevant service** is a service that is provided:

(a) in the area of the HWB and which, although they are not necessary to meet the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area;

(b) outside the area of the HWB and which, although they do not contribute towards meeting the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area.

Services categorised as necessary or relevant:

Services	Necessary or Relevant
Supervised consumption	Necessary
Needle and syringe programme	Necessary
NHS Health Check	Relevant
EHC and contraceptive services	Necessary
Stop smoking	Relevant

Services	Necessary or Relevant
COPD Screening (as part of stop smoking service)	Relevant
Asthma Support Service	Relevant
Chlamydia testing and treatment	Relevant
Minor Ailments Service	Relevant but necessary at certain times, e.g. Sunday and Public Holidays
Out of Hours Palliative Care Medicines Service	Necessary
Advanced services e.g. MUR, NMS	Relevant
Essential Services e.g. dispensing	Necessary

6. The Pharmaceutical Needs Assessment Questionnaire

All community pharmacists in Hillingdon (65 in total) and a total of 54 community pharmacies outside Hillingdon (within 2 kilometre geographic boundary) were requested to outline information about services provided in each pharmacy, from essential services around dispensing, advanced, enhanced and other locally relevant services like minor ailment scheme, disease specific services, vaccinations, screening and monitoring and a range of other commissioned and non-commissioned services.

The full text of the Pharmacy Questionnaire can be seen under Appendix 5. Based on responses received and the local commissioning knowledge, analysis was undertaken to show opening hours and the range of essential services.

In addition to the essential services, there are four Advanced Services within the NHS community pharmacy contractual framework (the *pharmacy contract*), which community pharmacies can choose to provide; as long as they meet the requirements set out in the Secretary of State Directions. Each one of these services is intended to support and empower patients to manage their medicines and appliances better and reduce wastage. These are:

A. Medicines Use Reviews (MURs)

Currently 100% of Hillingdon's community pharmacies are able to provide MURs. During 2016/17, 21,500 MURs were conducted in Hillingdon by an average of 59 pharmacies (90%) each month. Nationally, the number of Medicine Use Reviews provided by pharmacies has increased; between 2006/07 to 2016/17 the volume grew from around half a million to just over 3 million (March 2017).

The table below shows the Medicine Use Reviews conducted and claimed by Hillingdon pharmacies from April 2016 – March 2017.

Medicines Use Reviews					
Date	**Items dispensed**	**Total no. of pharmacies**	**MURs conducted**	**No. claiming MURs**	**% claiming MURs**
Apr-16	392,095	64	1,662	61	95%
May-16	387,069	64	1,610	58	91%
Jun-16	391,500	64	1,436	61	95%
Jul-16	392,721	64	1,556	59	92%
Aug-16	382,673	64	1,525	60	94%
Sep-16	394,140	64	1,513	60	94%
Oct-16	381,957	64	1,739	61	95%
Nov-16	401,357	64	1,812	59	92%
Dec-16	400,261	65	1,628	57	88%
Jan-17	381,697	65	1,977	59	91%
Feb-17	361,670	64	2,784	56	88%
Mar-17	404,937*	64	2,272	52	81%

B. New Medicine Service (NMS)

New Medicine Service is offered by all of the community pharmacies within Hillingdon. During 2016/17, 64 out of Hillingdon's 65 pharmacies claimed NMS with an average of 46 (71%) pharmacies claiming each month.

The table below shows the numbers of pharmacies claiming the New Medicines Service in Hillingdon from April 2016 – March 2017.

New Medicines Service (NMS)				
Date	**Items dispensed**	**Total number of pharmacies**	**Number claiming NMS**	**% claiming NMS (higher is better)**
Apr-16	329,095	64	46	72%
May-16	387,069	64	45	70%
Jun-16	391,500	64	43	67%
Jul-16	392,721	64	46	72%
Aug-16	382,673	64	46	72%
Sep-16	394,140	64	43	67%
Oct-16	381,957	64	45	70%
Nov-16	401,357	64	48	75%
Dec-16	400,261	64	47	72%
Jan-17	381,697	64	45	69%
Feb-17	361,670	64	51	80%
Mar-17	404,937	64	49	77%

Source: Pharmaceutical Services Negotiating Committee (PSNC) Website
http://psnc.org.uk/funding-and-statistics/nhs-statistics/mur-statistics
http://psnc.org.uk/funding-and-statistics/nhs-statistics/nms-statistics/

C. Appliance Use Reviews (AURs)

There are 7 pharmacies in total which provide Appliance Use Review (AUR) service, and these are spread across the three localities: 1 in Ruislip & Northwood, 4 in Uxbridge & West Drayton and 2 in Hayes & Harlington.

D. Stoma Appliance Customisation Service (SACS)

Stoma Appliance Customisation (SACS) Service is also provided by 6 pharmacies in total across the 3 localities (2 in each).

7. Enhanced services

The NHSE is authorised to arrange for the provision of the following additional pharmaceutical services with a pharmacy contractor:

A) **Anticoagulant monitoring service**, the underlying purpose of which is for pharmacist to test the patient's blood clotting time, review the results and adjust (or recommend adjustment to) the anticoagulant dose accordingly

B) **Care home service**, the underlying purpose of which is for pharmacist to provide advice and support to residents and staff in a care home relating to the proper and effective ordering of drugs and appliances for the benefit of residents in the care home the clinical and cost effective use of drugs, the proper and effective administration of drugs and appliances in the care home, the safe and appropriate storage and handling of drugs and appliances, and the recording of drugs and appliances ordered, handled, administered, stored or disposed of

C) **Disease specific medicines management service**, the underlying purpose of which is for a registered pharmacist to advise on, support and monitor the treatment of patients with specified conditions, and where appropriate to refer the patient to another health care professional

D) **Gluten free food supply service**, the underlying purpose of which is for pharmacist to supply gluten free foods to patients

E) **Independent prescribing service**, the underlying purpose of which is to provide a framework within which pharmacist independent prescribers may act as such under arrangements to provide additional pharmaceutical services with the NHSCB

F) **Home delivery service**, the underlying purpose of which is for pharmacist to deliver to the patient's home—drugs, and appliances other than specified appliances

G) **Language access service**, the underlying purpose of which is for a registered pharmacist to provide, either orally or in writing, advice and support to patients in a language understood by them relating to—drugs which they are using, their health, and general health matters relevant to them

H) **Medication review service**, the underlying purpose of which is for a registered pharmacist to conduct a review of the drugs used by a patient, including on the basis of information and test results included in the patient's care record held by the provider of primary medical services that holds the registered patient list on which the patient is a registered patient, with the objective of considering the continued appropriateness and effectiveness of the drugs for the patient, to advise and support the patient regarding their use of drugs, including encouraging the active participation of the patient in decision making relating to their use of drugs, and where appropriate, to refer the patient to another health care professional

I) **Medicines assessment and compliance support service**, the underlying purpose of which is for pharmacist to assess the knowledge of drugs, the use of drugs by and the compliance with drug regimens of vulnerable patients and patients with special needs, and to offer advice, support and assistance to vulnerable patients and patients with special needs regarding the use of drugs, with a view to improving their knowledge and use of the drugs, and their compliance with drug regimens

J) **Minor ailment scheme**, the underlying purpose of which is for pharmacist to provide advice and support to eligible patients presenting with a minor ailment, and where appropriate to supply drugs to the patient for the treatment of the minor ailment

K) **Needle and syringe exchange service**, the underlying purpose of which is for a registered pharmacist to provide sterile needles, syringes and associated materials to

drug misusers, to receive from drug misusers used needles, syringes and associated materials, and to offer advice to drug misusers and where appropriate refer them to another health care professional or a specialist drug treatment centre

L) **On demand availability of specialist drugs service**, the underlying purpose of which is for pharmacist to ensure that patients or health care professionals have prompt access to specialist drugs

M) **Out of hours services**, the underlying purpose of which is for pharmacist to dispense drugs and appliances in the out of hours period (whether or not for the whole of the out of hours period)

N) **Patient group direction service**, the underlying purpose of which is for pharmacist to supply or administer prescription only medicines to patients under patient group directions

O) **Prescriber support service**, the underlying purpose of which is for pharmacist to support health care professionals who prescribe drugs, and in particular to offer advice on the clinical and cost effective use of drugs, prescribing policies and guidelines, and repeat prescribing

P) **Schools service**, the underlying purpose of which is for pharmacist to provide advice and support to children and staff in schools relating to the clinical and cost effective use of drugs in the school, the proper and effective administration and use of drugs and appliances in the school, the safe and appropriate storage and handling of drugs and appliances, and the recording of drugs and appliances ordered, handled, administered, stored or disposed of

Q) **Screening service**, the underlying purpose of which is for a registered pharmacist to identify patients at risk of developing a specified disease or condition, to offer advice regarding testing for a specified disease or condition, to carry out such a test with the patient's consent, and to offer advice following a test and refer to another health care professional as appropriate

R) **Stop smoking service**, the underlying purpose of which is for pharmacist to advise and support patients wishing to give up smoking, and where appropriate, to supply appropriate drugs and aids

S) **Supervised administration service**, the underlying purpose of which is for a registered pharmacist to supervise the administration of prescribed medicines at Pharmacists premises, and a Supplementary Prescribing Service, the underlying purpose of which is for a registered pharmacist who is a supplementary prescriber, and with a doctor or a dentist is party to a clinical management plan, to implement that plan, with the patient's agreement.

8. Locally commissioned services

Community pharmacists sit right at the heart of our communities and are trusted, professional and competent partners in supporting individual and community health. They have a significant and increasingly important role to play in improving the health of local people. In Hillingdon, we have a strong history of successful partnership work exemplified by Hillingdon Stop Smoking Service, Emergency Hormonal Contraception Scheme and other such work which the local authority commissions via community pharmacists.

Local authorities have responsibility for commissioning a wide range of services, including most public health services and social care services. The following public health services provided by community pharmacies can be commissioned by local authorities:

- Supervised consumption

- Needle and syringe programme
- NHS Health Check (including Atrial Fibrillation Screening in 9 pharmacies)
- EHC and contraceptive services
- Sexual health screening services
- Stop smoking
- Chlamydia testing and treatment
- Weight management
- Alcohol screening and brief interventions
- COPD screening

There are a small number of circumstances where a public health service is commissioned by another organisation, egg NHS England commission vaccination services from GPs, community pharmacies and other providers. There may also be circumstances where Clinical Commissioning Groups may wish to be involved in commissioning a public health service, due to the impact the service may have on the development or management of long-term conditions. Hillingdon Council commissions the following services:

A. NHS Health Check

Launched in April 2009, the NHS Health Check is a national prevention programme which aims to identify people at risk of developing heart disease, stroke, diabetes, kidney disease or vascular dementia. Everyone between the ages of 40 and 74 in England who has not been diagnosed with vascular disease or already being managed for certain risk factors should be offered an NHS Health Check once every five years to assess their risk.

An NHS Health Check assessment involves a 20-30 minute appointment with a healthcare professional (usually a practice nurse or community pharmacist) where height, weight, waist circumference and blood pressure measurements are taken. Personal details, including age, ethnicity, postcode, smoking, drinking, dietary and exercise habits are recorded alongside any family history of vascular disease. In community pharmacies, a finger-prick blood test for cholesterol and glucose is also carried out. The assessor will then calculate the person's risk of developing a vascular disease over the next 10 years. This risk will be explained to the person and they will be given healthy lifestyle advice to help them reduce/maintain their risk level and signposted to local services such as leisure centres and health walks. If necessary, the person will be referred to their GP for further investigations.

Currently, 18 Hillingdon pharmacies are contracted to provide an NHS Health Check service to cover three localities (commissioning information). However, based on the Pharmacy Survey, 20 pharmacies (31% of Borough pharmacies) actively offer this service – 8 of these are located in Uxbridge & West Drayton with 6 pharmacies each in Ruislip & Northwood and Hayes & Harlington.

B. NHS stop smoking service

The Stop Smoking Service is the most widely offered service with 91% of pharmacies offering it across the three localities in Hillingdon (59 out of 65); 48 pharmacies also offer smoking cessation as part of PGD. Community pharmacy remains the main provider of this service for smokers in Hillingdon.

In 2016/17, the Hillingdon Stop Smoking Service (HSSS) helped 1,001 people to set a quit date and 463 to quit smoking. Hillingdon's pharmacy providers saw the majority of these, and helped 587 (59%) persons to set a quit date and 202 to quit. HSSS offers the

opportunity for pharmacy staff to attend an approved Level 2 advisor training program free of charge, which pharmacies in Hillingdon take up to provide stop smoking services for Hillingdon residents, through a contract with Hillingdon Council. Pharmacy staff are responsible for marketing their individual services and generating referrals.

The Level 2 service consists of supporting patients to a 4 week quit as defined by DH and NICE guidance. This involves counselling patients, helping them to set a quit date and offering weekly 1-1 support for a maximum of 6-8 sessions. Level 2 advisors offer behavioural therapy delivered to a high standard, as outlined in the NCSCT Standard Treatment Programme and provide pharmacological support to aid cessation. All the different stop smoking treatment options (NRT and stop smoking medication), unless there are any contra-indications, are offered equally as first line of treatment to patients. Furthermore, 47 Hillingdon pharmacists are trained to deliver the stop smoking medication Champed® directly to patients via a Patient Group Direction (PGD).

Stop Smoking advisors are required to record client information using specified monitoring forms and return completed monitoring forms by the 10th of each month or at least quarterly to ensure regular and timely performance reporting and remuneration. All accredited advisers are encouraged to attend a refresher course twice a year.

Innovations in the service also include pharmacy providers being trained by the HSSS in a COPD screening tool to screen the population for early detection of COPD and a referral pathway to the GP's once COPD has been detected. The majority of the activity is focused in Hayes & Harlington and Uxbridge & West Drayton localities which show higher levels of deprivation and higher estimated prevalence of chronic conditions like circulatory diseases, cancers.

C. COPD screening for smokers accessing community pharmacy

This locally enhanced service is aimed at providing help and support for dependant smokers in Hillingdon, who wish to give up through provision of a Level 2 Stop Smoking Service by primary care professionals.

Level 2 Stop Smoking Advisors can screen smokers for COPD as part of their assessment routine. This is via a brief questionnaire and a lung age monitor. A COPD-6 screening monitor is provided on loan to the participants free of charge for the duration of their participation in the Local Enhanced Service. Key aspects of the service include:

- Smokers accessing the service will be offered a brief screening questionnaire
- If score over 3 then the smoker offered a lung age function screen
- If abnormal results are identified, this will trigger a referral to the patients GP
- All staff should be aware of the service and be able to advise patients how to access it

Hillingdon has 60 pharmacies accredited to use the Vital graph COPD-6 screening tools. However, based on the Pharmacy Survey, 20 pharmacies actively provide COPD specific services, split equally across all three localities: Ruislip & Northwood (9), Uxbridge & West Drayton (11), Hayes & Harlington (10). The prevalence of COPD in Hillingdon is 1.2% of the GP register population, compared with 1.7% in England. Within the Borough there is a higher prevalence in Ruislip & Northwood (1.2%) and Uxbridge & West Drayton (1.3%) than in Hayes & Harlington (1%).

D. Supervised consumption of methadone via community pharmacies

This service has the following elements:

- Stabilise and maintain engagement in prescribing regime - as part of a comprehensive treatment package, the daily supervision of diversional opioids can ensure that therapeutic plasma levels are maintained and help ensure that the service user's opiate dependency is stabilised, which reduces the need for illicit opiates. The successful stabilisation of illicit drug use can reduce the risk of blood-borne virus transmission and overdose and positively impact on public and individual health.
- Reduce diversion of medication (leakage) - supervised consumption also assists in ensuring that diversional opioids are taken in accordance with prescribers' instructions therefore reducing medication misuse. This also limits the likelihood of medication being diverted onto illicit drug markets, termed *leakage*. Supervised consumption may have a significant effect in reducing overdose deaths attributed to illicit consumption.
- Support effective communications whilst a person becomes established in their treatment regime - community pharmacy staff have daily contact with individuals receiving treatment via supervised consumption. As such, community pharmacies play a valuable role, both in supporting individuals and monitoring their day to day progress in drug treatment. The supervised consumption scheme also enables the community pharmacy, prescriber and/or the treatment provider's keyworker to effectively communicate any relevant comments or concerns regarding the individual's progress or wellbeing.
- Opioid supervised consumption scheme - 47 pharmacies provide this scheme. Coverage across the Borough optimises patient choice. Pharmacists play a key role in providing treatment to opiate dependent patients. Pharm Outcomes is now the platform used to record supervised consumption activity.
- Needle exchange provided by community pharmacies - this scheme provides a harm reduction intervention which aims to reduce drug related morbidity/mortality and positively impact upon anti-social behaviour and drug-related crime. All needle and syringe provision pharmacies participating in the scheme must develop operating procedures which underpin health and safety of both staff and clients. Operating procedures should reflect available national advice and locally produced needle exchange service guidelines.

The community pharmacy must:

- offer a user-friendly, non-judgmental, client-centred and confidential service at all times
- provide access to approved injection materials and paraphernalia, together with sharps containers for return of used equipment and appropriate health promotion materials
- provide safe disposal for used equipment returned by service users
- offer support and advice to service users, including referral to other health and social care professionals and specialist drug and alcohol treatment services where appropriate
- assist service users to remain healthy until they are ready to cease injecting and ultimately achieve a drug-free life with appropriate support.

The following are not *pharmacy musts*:

- Low commissioning priority with government policy shift away from harm minimisation and financial constraints
- HDAS continues to operate a large *pick and mix* needle exchange, supported by community pharmacies
- Daniels provides equipment to the scheme but sharps collection from pharmacy sites is from PHS.

Prevention of drug related deaths and blood-borne viruses

The scheme aims to protect health and reduce the rate of blood-borne infections and drug related deaths among service users by:

- promoting safe practice to service users, including advice on sexual health and sexually transmitted infections, HIV and Hepatitis C transmission and Hepatitis B immunisation
- reducing the rate of sharing and other high risk injecting behaviours
- providing sterile injecting equipment and other support
- promoting safer injecting practices
- providing and reinforcing harm reduction messages including safe sex advice and advice on overdose prevention (e.g. risks of poly-drug use and alcohol use).

Improve the health of local communities by preventing the spread of blood-borne infections

The scheme aims to improve the health of local communities by preventing the spread of blood-borne infections by:

- ensuring the safe disposal of used injecting equipment
- referral to specialist drug and alcohol treatment centres and health and social care professionals where appropriate.

Improve access to services

- The scheme aims to maximise the access and retention of all injectors, especially the highly socially excluded
- The scheme will help service users access other health and social care and act as a gateway/signpost to other services such as treatment planning/recovery, prescribing, hepatitis B immunisation, hepatitis and HIV screening and primary care services.

E. Minor ailments service

A minor ailment service is available in 29 pharmacies across Hillingdon (R&N =3, U&WD = 10, H&H =16). In brief, it aims to provide greater choice for parents, carers of older people and patients to utilise the expertise of community pharmacists as NHS professionals. They can become the first port of call for conditions such as cough, cold, temperature, infant gripes, and nappy rash, though no treatment is provided for babies under the age of 3 months.

Pharmacies have a crucial role in supporting young families through advice and support before, during and after pregnancy, and promoting programmes like healthy start, smoking cessation and contraception. The following conditions are included:

- Constipation
- Diarrhoea
- Headache, sore throat, earache
- Hay fever, conjunctivitis, indigestion and infant gripes, thread worms
- Cough, temperature, nasal congestion
- Fungal skin infections
- Thrush, cold sores, nappy rash, headache

The uptake of this service has been low in the past but is improving. This service has the potential for reducing the pressure of the traditional urgent care and needs to be an integral part of the local NHS and social care capacity planning. Closure of the Urgent Care Centre in Hayes is being balanced to some degree with developing the role of community pharmacy in that area, which is a great example of how pharmacy services can be effectively used to their full potential. A larger proportion of pharmacies that provide the service are based in the Hayes & Harlington locality.

F. Emergency hormonal contraception (EHC)

Almost all (49, 75%) of the Hillingdon Pharmacies provide EHC over the counter at a cost, and the remainder have said they would provide if commissioned. In addition, 29 Hillingdon pharmacies, as well as providing over the counter EHC, also supply it free of charge to clients up to the age of 25 through a Patient Group Direction (which means they are trained, assessed and directed to provide the medicine to the specified client group). Residents below the age of 25 are specifically targeted under this scheme due to the high rate of terminations of pregnancy, and to prevent unwanted conceptions, especially amongst younger age groups.

G. Chlamydia screening and treatment

Due to the informal nature of community pharmacy premises, they can provide ideal non-threatening environment for targeting young people, and hence can play an important role in helping to control the spread of sexually transmitted infections (STIs). 28 pharmacies provide Chlamydia screening and 15 pharmacies are trained to provide Chlamydia treatment via a Patient Group Direction (PGD).

H. Identification and management of various diseases

In addition to their important existing role of supplying medicines to patients and optimising medicine use, community pharmacies provide further services to the local population where they may screen people for various conditions, train to provide services under patient group direction or support patients in managing their condition. Some examples are:

- 12 pharmacies offer asthma support services. 4 of these are in Ruislip & Northwood which has a higher prevalence of asthma patients than the other Hillingdon localities

- 16 pharmacies in the Borough offer hypertension support. 4 of these are in Ruislip & Northwood which has the highest prevalence of the condition among the Hillingdon localities
- 11 pharmacies (17% of pharmacies in the Borough) offer services for Diabetes Type I. 16 pharmacies offer services for Diabetes Type II (4 in Hayes & Harlington). 16 pharmacies (6 in Hayes & Harlington) offer diabetes management services (screening and monitoring)
- 6 pharmacies (4 pharmacies in Uxbridge & West Drayton and 2 in Hayes & Harlington, 9% of the pharmacies in the Borough) offer obesity management services for adults, and 2 offer this for children
- 55 pharmacies (85% of pharmacies in the Borough) provide some form of home delivery service to residents. 21 of these are in Ruislip & Northwood which has a slightly older population.

Utilisation of health services is higher by older populations. Therefore the higher proportion of older residents in Ruislip & Northwood matches well with the high prescription items and costs. The higher proportion of younger university age population in Uxbridge & West Drayton is consistent with utilisation of young people's services eg immunisations, Chlamydia screening and treatment.

The younger ethnic mix in Hayes & Harlington reflects a need for similar services for young people but also due to a maturing ethnic population, a higher need for services like NHS Health Check to identify vascular conditions early to prevent exacerbations. The majority of the growth predicted for the ethnic population could be in Hayes & Harlington locality, and some across the other two localities.

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Hillingdon Pharmaceutical Needs Assessment 2018

Appendix 4: Pharmacy Survey Results

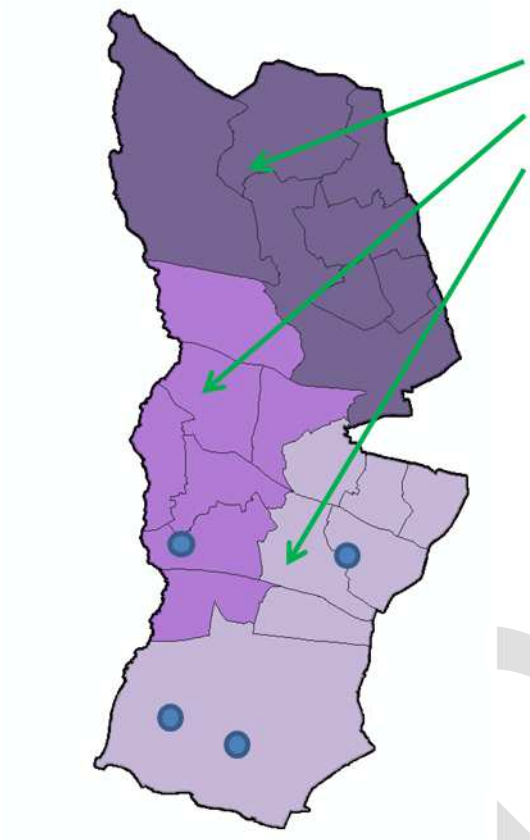
March 2018

Pharmacy Survey

An electronic survey was agreed by the LPC and sent out via email to all 65 borough pharmacies and 54 pharmacies around Hillingdon's boundary. The survey contained questions on services offered to the community (ie advanced, enhanced and essential, disease specific, screening and vaccinations) along with questions about staffing, access, parking, opening hours and consultation rooms. The survey was sent out on the 9th June for 2 weeks, and was completed by 100% of borough pharmacies and 20% of out of borough pharmacies. A copy of the survey be found in Appendix 5.

Not all of the answers to the survey questions are reproduced in full here as much of this data is reported in the main body of the PNA. Full survey results are available on request.

Hillingdon's Pharmacies, 2017



● 100 hour contract

65 pharmacies in total:
- 23 in Ruislip & Northwood
- 21 in Uxbridge & West Drayton
- 21 in Hayes & Harlington

Healthy Living Pharmacy Status
- 14 have achieved HLP status
- 44 working towards

In 2015, 58 pharmacies indicated an interest in becoming HLP accredited

28 are part of large chains (Boots, Lloyds etc)
7 are in groups containing 2-10 pharmacies
30 are independent
0 distance selling pharmacies or private pharmacies

Opening times:
56 open between the core hours of 9.30am–5pm (Mon-Fri),
8 close at lunch times
1 closes at 1pm on Wednesday
61 are open on Saturdays
15 are open on Sundays

* see Appendix 4 for full opening times

Pharmacy Staffing, 2017

62 pharmacies have a **Dementia Friend** working onsite

58 pharmacies have staff who **speak languages** other than English

29 have a **Health Champion** working onsite

14 have a **Health Trainer** working onsite

10 have a **Pharmacist with Special Interest**

74% totally agree their clinical skills are well utilised, and **26% partly agree**

Pharmacy IT, 2017

64

Have release 2 enabled

63

Have summary of care records enabled

60

Have an up to date NHS choice entry

56

Have access to IT in the consultation room/area

2

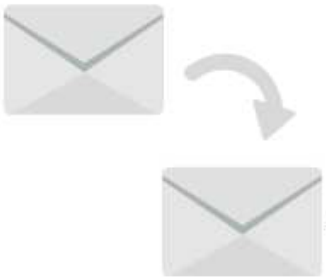
Intend to do so within 12 months

50 of the 56

Have access to patient records

44

Have access to NHS.net email



35

Actively use it

Hillingdon's pharmacy consultation areas / rooms, 2018

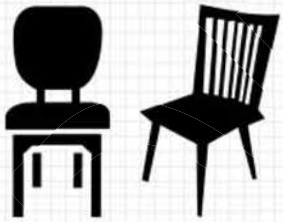
Pharmacies were asked about their consultation areas / rooms. Out of the 65 pharmacies in Hillingdon:

All are compliant with MURs / NMS

26 say consultations can be carried out in patients homes, 32 said at another site

Facilities available within the consultation areas / rooms:

64 have seating



60 have hand washing close by; 2 more have this planned

27 have access to a toilet

Wheelchair access:

49
access with wide door, 3 have this planned

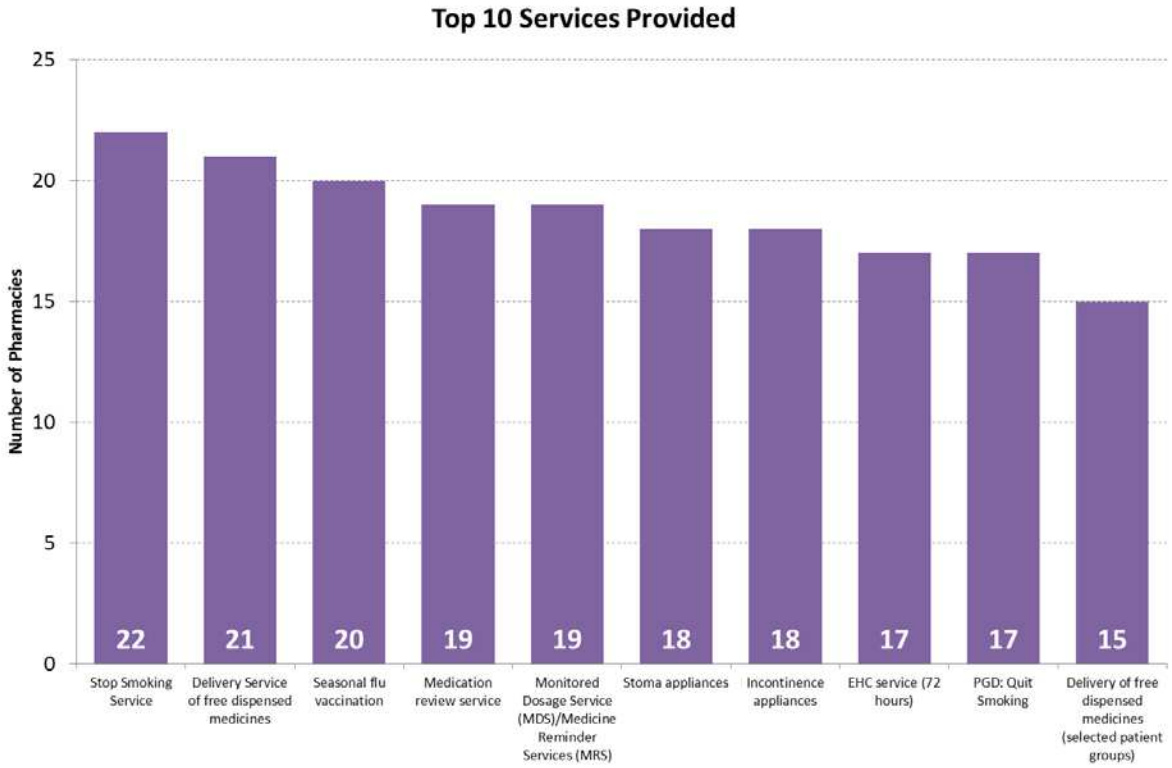
41
ramped access, 2 have this planned

5
access with electric door, 1 has this planned

Services by locality

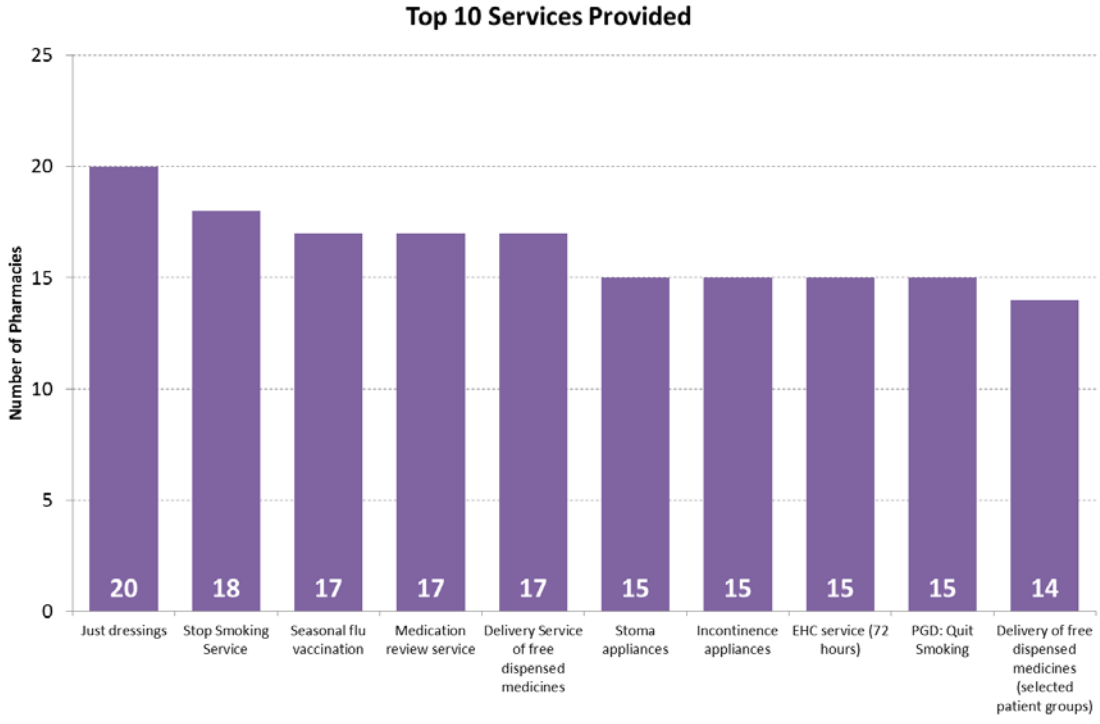
Ruislip & Northwood – 23 pharmacies

All of the pharmacies within R&N provide Just Dressing (Appliances), Medicines Use Review, New Medicines Service, collection of prescriptions from GP surgeries and a repeat prescription service. Of the remaining services, the top 10 are:



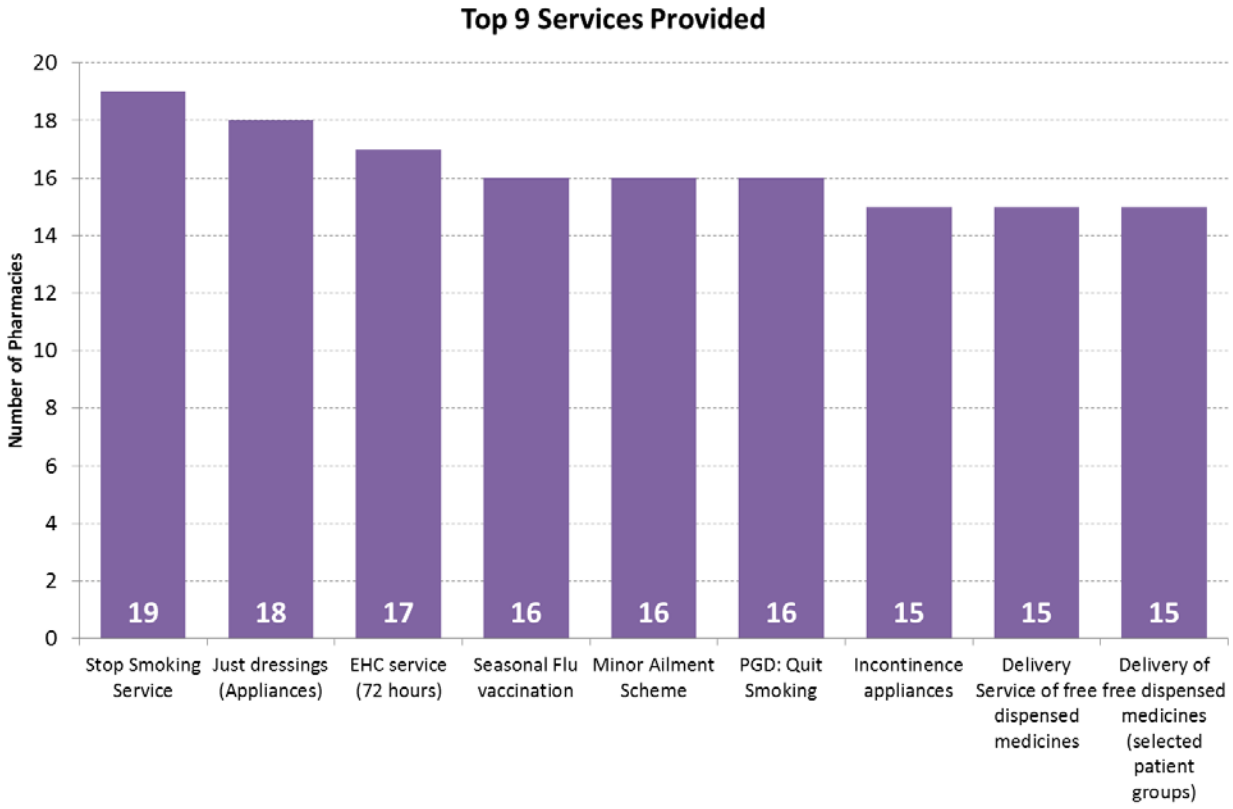
Uxbridge & West Drayton – 21 pharmacies

All of the pharmacies within U&WD provide Medicine Use Reviews, New Medicines Service, collection of prescriptions from GP surgeries and a repeat prescription service. Of the reamining services, the top 10 are:



Hayes & Harlington – 21 pharmacies

All of the pharmacies within H&H provide Medicine Use Reviews, New Medicines Service, collection of prescriptions from GP surgeries and a repeat prescription service. Of the remaining services, the top 9 are:



Borough Provision

All pharmacies now offer Medicines Use Review (MURs) and New Medicines Services (NMS) – an increase in service provision since 2015.

Disease specific services are available at a small number of pharmacies across the Borough, with the exception of COPD services which are provided more widely. Most pharmacies would be willing to provide these services if they were commissioned to do so. Provision has **increased** since the 2015 PNA in the following areas:

Diabetes Type 1
Diabetes Type 2
Depression and Parkinson's
Asthma
Hypertension

Screening and monitoring services are available at a small number of pharmacies across the Borough, with the exception of Chlamydia screening and cholesterol services which are provided more widely. Almost all pharmacies have indicated their willingness to provide these services if they were commissioned to do so. Provision has increased since the 2015 PNA in the following areas:

Asthma management
Cholesterol
Diabetes management

Gonorrhoea

However, provision of Chlamydia screen has reduced since 2015. One pharmacy is a pilot for Atrial Fibulation with Harefield Hospital.

Vaccination services are available at a range of pharmacies across the Borough, with the flu vaccination provided widely (and has seen an increase in provision from 35 pharmacies in 2015 to 53 in 2018). Another large increase since 2015 is the provision of the PCV jab (4 pharmacies in 2015, now 29); travel vaccinations have also seen an increase in provision (mainly provided privately), and MMR provision has increased from 2 to 10 pharmacies. Most pharmacies would be willing to provide vaccinations if they were commissioned to do so.

Pharmacies offer a wide range of other services. Those that have seen a large increase since 2015 are:
- PGD: Quit Smoking (an increase of 13 pharmacies)
- PGD: Malaria (an increase of 12 pharmacies)
- Substance Misuse Service (an increase of 6 pharmacies)
- Emergency Hormone Contraception

Conclusion
Since 2015, although there is one less pharmacy (in Ruislip & Northwood) and the population has increased, provision of overall services has increased.

Pharmacy opening hours

Pharmacy Name	Address	Postcode	Monday - Friday	Saturday	Sunday
Ruislip & Northwood					
Ashworths Pharmacy	64 High Street, Ruislip	HA4 7AA	09:00 - 18:00	09:00 - 13:00	Closed
Howletts Pharmacy	81 Howletts Lane, Ruislip	HA4 7YG	09:00 - 18:00	09:00 - 13:00	Closed
Carter Chemist & Ability	112-114 High Street, Northwood	HA6 1BJ	09:00 - 19:00	09:00 - 13:00	Closed
Carters Pharmacy	41 Salisbury Road, Eastcote	HA5 2NJ	09:00 - 17:00	Closed	Closed
Chimsons Ltd	29 Victoria Road, Ruislip Manor	HA4 9AB	09:00 - 18:30	09:00 - 17:30	Closed
Dana Pharmacy	100 Victoria Road, Ruislip Manor	HA4 0AL	09:00 - 18:00	09:00 - 13:00	Closed
Eastcote Pharmacy	111 Field End Road, Eastcote	HA5 1QG	09:00 - 18:30	09:00 - 17:00	Closed
Harefield Pharmacy	12e High Street, Harefield	UB9 6BU	09:00 - 18:30	09:00 - 14:00	Closed
Nu-Ways Pharmacy	292 West End Road, Ruislip Gardens	HA4 6LS	09:00 - 18:00	09:00 - 14:00	Closed
Ross Pharmacy	28 Joel Street, Northwood	HA6 1PF	09:00 - 18:30	09:00 - 17:30	Closed
Ruislip Manor Pharmacy	53 Victoria Road, Ruislip Manor	HA4 9BH	09:00 - 18:00	09:00 - 17:00	Closed
Lloyds Pharmacy in Sainsburys	Sainsburys, 11 Long Drive, South Ruislip	HA4 0HQ	08:00 - 22:00	08:00 - 22:00	10:00 - 16:00
Sharman's	3 Clive Parade, Maxwell Road, Northwood	HA6 2QF	09:00 - 19:00	09:00 - 17:30	10:00 - 14:00

Pharmacy Name	Address	Postcode	Monday - Friday	Saturday	Sunday
Ruislip & Northwood					
Superdrug	143 Field End Road, Eastcote	HA5 1QL	09:00 - 18:30	09:00 - 17:30	Closed
The Malthouse Pharmacy	The Malthouse, Breakspear Road North Harefield	UB9 6NF	09:00 - 18:30	09:00 - 13:00	Closed
Boots	67 High Street, Ruislip	HA4 8LS	09:00 - 18:00	09:00 - 18:00	11:00 - 17:00
Boots	Wood Lane Medical Centre, 2A Wood Lane, Ruislip	HA4 6ER	M, F 08:30 - 19:00 Tu, W 08:30-20:00 Th 08:30 - 16:00	08:30 - 13:30	Closed
Boots	123 Field End Road, Eastcote	HA5 1QH	09:00 - 19:00	09:00 - 17:30	Closed
Boots	11 Maxwell Road, Northwood	HA6 2XY	09:00 - 18:00	09:00 - 18:00	10:15 - 16:00
Boots	212 Whitby Road, Ruislip	HA4 9DY	09:00 - 18:00	09:00 - 17:30	Closed
Boots	32 Joel Street, Northwood Hills	HA6 1PF	09:00 - 18:30	09:00 - 17:30	Closed
Boots	716 Field End Road, South Ruislip	HA4 0QP	09:00 - 19:00	09:00 - 17:00	Closed
Boots	169-171 Field End Road, Eastcote	HA5 1QR	09:00 - 18:00	09:00 - 18:00	Closed

Pharmacy Name	Address	Postcode	Monday - Friday	Saturday	Sunday
Uxbridge & West Drayton					
Adell Pharmacy	392 Long Lane, Hillingdon	UB10 9PG	09:00 - 19:00	09:00 - 17:00	Closed
Brunel Pharmacy	Kingston Lane, Uxbridge	UB8 3PH	09:00 - 17:30	Closed	Closed
Carewell Chemists	10 Mulberry Parade, West Drayton	UB7 9AE	09:00 - 18:00	09:00 - 13:00	Closed
Flora Fountain Ltd	283 High Street, Uxbridge	UB8 1LQ	09:00 - 17:30	09:00 - 16:00	Closed
H A McParland Ltd	118/120 Cowley Road, Uxbridge	UB8 2LX	08:45 - 18:00	09:00 - 17:30	Closed
Hillingdon Pharmacy	4 Sutton Court Road, Hillingdon	UB10 9HP	09:00 - 18:00	Closed	Closed
Anglebond Pharmacy	1 Swakeleys Road, Ickenham	UB10 8DF	09:00 - 18:30	09:00 - 14:00	Closed
Lawtons Pharmacy	8-9 Crescent Parade, Uxbridge Road Hillingdon	UB10 0LG	09:00 - 21:00	09:00 - 21:00	09:00 - 21:00
Mango Pharmacy	3 The Parade, High Street, Cowley	UB8 2EP	09:00 - 18:00	09:00 - 13:00	Closed
Oakleigh Pharmacy	Uxbridge Road, Hillingdon	UB10 0LU	09:00 - 18:00	09:00 - 13:00	Closed
Orchards Pharmacy	6 Laurel Lane, West Drayton	UB7 7TU	09:00 - 13:00 14:00 – 18:00	09:00 - 13:00	Closed
Phillips Pharmacy	84 High Street, Yiewsley	UB7 7DS	09:00 - 18:30	09:00 - 18:00	10:00 - 16:00
Puri Pharmacy	165 Ryefield Avenue, Hillingdon	UB10 9DA	M, Tu, Th, F 08:30 - 17:30 W 09:00 – 13:00	Closed	Closed

Pharmacy Name	Address	Postcode	Monday - Friday	Saturday	Sunday
Uxbridge & West Drayton					
Tesco Pharmacy	Yiewsley High Street, West Drayton	UB7 7GN	M 08: - 23:00 Tu, W, Th, F 07:00 - 23:00	07:00 - 22:00	11:00 - 17:00
Winchester Pharmacy	64 Swan Road, West Drayton	UB7 7JZ	M, Tu, Th, F 09:00 - 18:15 W 09:00 – 17:30	09:00 - 13:00	Closed
Winchester Pharmacy	79 Swakeleys Road, Ickenham	UB10 8DQ	09:00 - 18:00	09:00 - 17:00	Closed
Yiewsley Pharmacy	28 High Street, Yiewsley	UB7 7DP	Tu, W, Th, F 08:30 - 18:30 M 08:30 – 21:00	09:00 - 13:00	Closed
Boots	163 High Street, Uxbridge	UB8 1JZ	08:00 - 18:30	09:00 - 18:00	10:30 - 17:30
Boots	14/16 Station Road, West Drayton	UB7 7BY	M, Tu, Th, F 09:00 - 18:30 W 09:00 - 17:30	09:00 - 17:30	Closed
Boots	128 Intu Shopping Centre, Uxbridge	UB8 1GA	M, Tu, W, F 09:00 - 19:00 Th 09:00 - 20:00	09:00 - 19:00	11:00 - 17:00
Boots	380 Long Lane, Hillingdon	UB10 9PG	08:30 - 18:30	09:00 - 17:30	Closed

Pharmacy Name	Address	Postcode	Monday - Friday	Saturday	Sunday
Hayes & Harlington					
Daya Ltd	750 Uxbridge Road, Hayes	UB4 0RU	09:00 - 19:30	09:00 - 18:00	Closed
Grosvenor Pharmacy	788 Uxbridge Road, Hayes	UB4 0RS	09:30 - 19:00	09:30 - 18:00	Closed
H A McParland Ltd	522 Uxbridge Road, Hayes	UB4 0SA	M, Tu, Th, F 08:45 - 18:30 W 08:45 – 17:30	09:00 - 14:30	Closed
Hayes Town Pharmacy	11 Coldharbour Lane, Hayes	UB3 3EA	08:00 - 23:00	08:00 - 23:00	08:00 - 23:00
Joshi Pharmacy	315 Harlington Road, Hillingdon	UB8 3JD	09:00 - 19:00	09:00 - 13:00	Closed
Kasmani Pharmacy	6 Northfield Parade, Station Road, Hayes	UB3 4JA	09:00 - 19:00	09:00 - 13:00	Closed
Lansbury Pharmacy	102 Lansbury Drive, Hayes	UB4 8SE	09:00 - 19:00	09:00 - 18:00	Closed
Medics Pharmacy	11 Dawley Road, Harlington	UB3 1LS	09:00 - 18:30	09:00 - 13:00	Closed
Nuchem Pharmacy	24 Coldharbour Lane, Hayes	UB3 3EW	09:00 - 19:00	09:00 - 18:00	Closed
Pickups Chemist	20-21 Broadway Parade, Coldharbour Lane, Hayes	UB3 3HF	08:30 - 21:00	09:00 - 20:00	10:00 - 16:00
Lloyds Pharmacy in Sainsburys	Lombardy Retail Park, Coldharbour Road Hayes	UB3 3EX	08:00 - 22:00	08:00 - 22:00	11:00 - 17:00
Superdrug	2-8 Station Road, Hayes	UB3 4DA	09:00 - 18:00	09:00 - 17:30	Closed
Tesco Pharmacy	Glencoe Road,Hayes	UB4 9SQ	08:00 - 21:00	08:00 - 20:00	10:00 - 16:00

Pharmacy Name	Address	Postcode	Monday - Friday	Saturday	Sunday
Hayes & Harlington					
The Village Pharmacy	218 High Street, Harlington	UB3 5DS	09:00 - 18:30	09:00 - 14:00	Closed
Vantage Chemists	1 Park Parade, Barra Hall Circus, Hayes	UB3 2NU	M, Tu, Th, F 09:00 - 18:30 W 09:00 – 18:00	09:00 - 14:00	Closed
Vantage Pharmacy	252 Kingshill Avenue, Hayes	UB4 8BZ	09:00 – 18:00	09:00 - 14:00	Closed Except when on duty
Boots	1266 Uxbridge Road, Hayes	UB4 8JF	M, Tu, Th, F 09:00 - 18:00 W 09:00 - 17:30	09:00 - 17:30	Closed
Boots	236 Yeading Lane, Hayes	UB4 9AX	09:00 - 19:00	09:00 - 17:30	Closed
Boots	28-30 Station Road, Hayes	UB3 4DD	09:00 - 18:30	09:00 - 17:30	Closed
Boots	T5, Unit 3044 Departures Level (check in), Heathrow Airport	TW6 2RQ	05:30 - 21:30	05:30 - 21:30	05:30 - 21:30
Boots	T3 Landside Departures, Heathrow Airport	TW6 1QG	05:30 - 21:30	05:30 - 21:30	05:30 - 21:30

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Hillingdon Pharmaceutical Needs Assessment 2018

Appendix 5: Pharmacy Survey

March 2018

Pharmaceutical Needs Assessment 2018
Appendix 5: Survey

Pharmaceutical Needs Assessment, Pharmacy Survey 2018

*Required

Pharmacy Details

ODS Code (PPD Code)

Name of Contractor (ie name of individual, partnership or company owning the pharmacy business)

Trading Name

Address of pharmacy premises

Address 2

Town

Borough

Postcode

Pharmacy email address

Pharmacy telephone number

Pharmacy fax

Pharmacy website address

Please answer the following questions. *

	Yes	No
Can we store the above information and and use this to contact you?	○	○
Are you an appliance only contractor?	○	○
Are you a 100 hour contract pharmacy?	○	○
Is the pharmacy a distance selling pharmacy? (i.e. It cannot provide essential services to persons present at the pharmacy)	○	○
Does the pharmacy hold a Local Pharmaceutical Services (LPS) contract? (ie It is not the standard pharmaceutical service contract)	○	○
Is your pharmacy private? (ie no NHS contract)	○	○
Is the pharmacy entitled to Pharmacy Access Scheme Payments?	○	○

Is your pharmacy independent or part of a national group?

- ○ Independent
- ○ Group with 2-5 pharmacies
- ○ Group with 6-10 pharmacies
- ○ Group with more than 10 pharmacies

Opening Times and Accessibility

Please indicate the times your pharmacy is open.

Please complete opening and closing times followed by lunchtime hours in 24 hour format for each day i.e. 09:00 - 17:00 13:00 - 14:00

If you have days that you are closed please input CLOSED.

If your pharmacy does not close for lunch please input NO LUNCH.

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

With regard to the above opening times, what are your core contracted hours at the pharmacy?

Please complete opening and closing times followed by lunchtime hours in 24 hour format for each day i.e. 09:00 - 17:00 13:00 - 14:00

If you have days that you are closed please input CLOSED.

If your pharmacy does not close for lunch please input NO LUNCH.

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

Does your pharmacy provide printed information in the following formats?

- [ ] Easy Read
- [ ] Large prints
- [ ] Braille
- [ ] None of these

Consultation Areas and Premises

Please answer the following questions about your premises. *

	Yes	No	No, but planned within the next 12 months	Don't know
There are free car parking facilities available close to the premises during opening hours	○	○	○	○
Car parking facilities that require payment are available close to the premises during opening hours	○	○	○	○
Disabled car parking facilities are available close to the premises during opening hours	○	○	○	○
The consultation area /room is clearly signposted as a private consultation area within the pharmacy	○	○	○	○
Conversations in the consultation area/room cannot be overheard when talking at normal speaking volumes by other patients and staff	○	○	○	○
Seating is available for patients and staff within the consultation area/room	○	○	○	○
Hand washing facilities are available close to the consultation area/room	○	○	○	○
Patients have access to toilet facilities	○	○	○	○
There is a consultation area/room which complies with MUR/NMS requirements	○	○	○	○
The consultation area/room is accessible to wheelchair users with ramped access	○	○	○	○

The consultation area/room is accessible to wheelchair users with wide door				
The consultation area/room is accessible to wheelchair users with electric door				
We can undertake consultations in patients' homes (or other suitable sites)				
The access to the pharmacy premises complies with the Equalities Act				
There is access to an offsite consultation area/room				

Information Technology

Please answer the following questions on your Electronic Prescription Service.

	Yes	Intended within the next 12 months	No intention	Don't know
Is your system 'Release 2' enabled?				
Do you have access to an IT system within the consultation area/room?				

If you have said you have access to an IT system within a consultation area/room. Does this IT system have access to patient records?

- Yes
- Intending to within the next 12 months
- No and no intention to gain access
- Don't know

Please answer the following questions on the software/file formats on your pharmacy IT system. *

	Yes	No
Do you have access to a Microsoft Office package (eg Word/Excel)?		
Do you have access to NHS.net email?		
Is NHS mail being used?		
Is your NHS Summary of Care Records (SCR) enabled?		
Do you have an up to date NHS choice entry?		

Services

Does your pharmacy dispense the appliances below?

	Yes	Intending to begin within the next 12 months	No and not intending to
Stoma appliances	○	○	○
Incontinence appliances	○	○	○
Just dressings	○	○	○

If your pharmacy dispenses other appliances please provide information in the text box provided below.

Are the following ADVANCED services offered? *

	Yes	Intending to begin within the next 12 months	No and not intending to provide	Don't know
Medicines Use Review (MUR)	○	○	○	○
Appliances Use Review	○	○	○	○
Stoma Appliance Customisation	○	○	○	○
New Medicines Service (NMS)	○	○	○	○
NHS urgent medicine supply advanced service	○	○	○	○

Other than the dispensing services, does your pharmacy offer any of the following disease specific services? *

	Currently provide via NHS	Currently provide privately	Currently provide via Local Authority	Would be willing to provide if commissioned	Not willing or able to provide
Allergies	○	○	○	○	○
Alzheimer's/Dementia	○	○	○	○	○
Asthma	○	○	○	○	○
CHD	○	○	○	○	○
COPD	○	○	○	○	○
Depression	○	○	○	○	○
Diabetes Type I	○	○	○	○	○
Diabetes Type II	○	○	○	○	○
Epilepsy	○	○	○	○	○
Heart failure	○	○	○	○	○
Hypertension	○	○	○	○	○
Parkinson's Disease	○	○	○	○	○

If your pharmacy offers any other disease specific services please provide information in the text box provided below.

Services - Part 2

Are the following screening and monitoring services offered at your pharmacy? *

	Currently provide via NHS	Currently provide privately	Currently provide via Local Authority	Would be willing to provide if commissioned	Not willing or able to provide
Alcohol	○	○	○	○	○
Anticoagulant monitoring service	○	○	○	○	○
Asthma management	○	○	○	○	○
Chlamydia screening service	○	○	○	○	○
Cholesterol	○	○	○	○	○
Diabetes management	○	○	○	○	○
Gonorrhoea	○	○	○	○	○
H pylori	○	○	○	○	○
HbA1C	○	○	○	○	○
Hepatitis	○	○	○	○	○
Spot HIV testing	○	○	○	○	○

If your pharmacy offers any other screening and monitoring services please provide information in the text box provided below.

Are the following vaccinations services offered at your pharmacy? *

	Currently provide via NHS	Currently provide privately	Currently provide via Local Authority	Would be willing to provide if commissioned	Not willing or able to provide
Pneumococcal or pneumo jab (PCV)	○	○	○	○	○
Rotavirus vaccine	○	○	○	○	○
Meningitis C (Men C)	○	○	○	○	○
5-in-1 vaccine	○	○	○	○	○
Hib/Men C (booster)	○	○	○	○	○
MMR	○	○	○	○	○
Seasonal influenza vaccination	○	○	○	○	○
Intranasal flu vaccine for children	○	○	○	○	○
4-in-1 pre-school booster	○	○	○	○	○
HPV vaccine (girls only)	○	○	○	○	○
3-in-1 teenage booster	○	○	○	○	○
Chickenpox vaccination (varicella)	○	○	○	○	○
Shingles	○	○	○	○	○
BCG (tuberculosis) vaccination	○	○	○	○	○
Hepatitis A immunisation	○	○	○	○	○
Hepatitis B immunisation	○	○	○	○	○
Meningococcal meningitis	○	○	○	○	○
Rabies	○	○	○	○	○
Japanese encephalitis	○	○	○	○	○
Tick-borne encephalitis	○	○	○	○	○
Tuberculosis (TB)	○	○	○	○	○
Yellow fever	○	○	○	○	○
Diphtheria, polio and tetanus (combined booster)	○	○	○	○	○
Typhoid	○	○	○	○	○
Cholera	○	○	○	○	○
Whooping cough (Pertussis for children)	○	○	○	○	○
Whooping cough (Pertussis for pregnant women)	○	○	○	○	○
Immunisations and travel vaccines	○	○	○	○	○

If your pharmacy offers any other vaccination services please provide information in the text box provided below.

Services - Part 3

Are the following other services offered at your pharmacy? *

	Currently provide via NHS	Currently provide privately	Currently provide via Local Authority	Would be willing to provide if commissioned	Not willing or able to provide
Advice to Care Homes Service	○	○	○	○	○
Chlamydia treatment service	○	○	○	○	○
Emergency Hormonal Contraception service - 72 hours (Levonorgestrel)	○	○	○	○	○
Emergency Hormonal Contraception service - 120 hours (Ulipristal)	○	○	○	○	○
Gluten Free Food Supply Service i.e. not via FP10	○	○	○	○	○
Independent/Supplementary Prescribing Service	○	○	○	○	○
Language access service e.g. language line	○	○	○	○	○
Medication review service	○	○	○	○	○
Diet and nutrition advice	○	○	○	○	○
Diet and nutritional supplements	○	○	○	○	○
Monitored Dosage Service (MDS)/Medicine Reminder Services (MRS)	○	○	○	○	○
Minor Ailment Scheme	○	○	○	○	○
MUR plus service	○	○	○	○	○
Obesity management (adults)	○	○	○	○	○
Obesity management (children)	○	○	○	○	○
PGD: Erectile Dysfunction	○	○	○	○	○
PGD: Weight Loss	○	○	○	○	○
PGD: Quit Smoking	○	○	○	○	○
PGD: Hair Loss	○	○	○	○	○
PGD: Malaria	○	○	○	○	○
PGD: Emergency Hormonal Contraception	○	○	○	○	○
PGD: Oral Contraception	○	○	○	○	○
PGD: Chlamydia treatment	○	○	○	○	○
Adrenaline Injection	○	○	○	○	○
Phlebotomy Service	○	○	○	○	○
Prescriber support service to General Practice	○	○	○	○	○
Stop Smoking Service	○	○	○	○	○
Substance misuse service - supervised consumption	○	○	○	○	○
Needle and syringe exchange service	○	○	○	○	○
Sharps disposal service	○	○	○	○	○

NHS Health Checks (Vascular risk assessment) service					
In hours palliative care services					
Out of hours palliative care services					
Anti-viral Distribution service					
Collection of prescription from GP practices					
Home Delivery Service - delivery of dispensed medicines (Free)					
Home Delivery Service - delivery of dispensed medicines (Chargeable)					
Home Delivery Service - delivery of dispensed medicines (Selected areas)					

If there are any other services offered at your pharmacy please provide information in the text box below.

Does your pharmacy provide any of the following non-commissioned services? *

	Yes	No
Collection of prescriptions from GP surgeries		
Delivery of dispensed medicines - free of charge on request		
Delivery of dispensed medicines - free of charge to selected patient groups only		
Delivery of dispensed medicines - selected areas		
Delivery of dispensed medicines - chargeable		
Repeat prescription services		
The pharmacy has achieved Healthy Living Pharmacy (HLP) status?		
The pharmacy is working towards Healthy Living Pharmacy (HLP) status?		

Skills/Working Relationships

Please confirm the number of pharmacist hours a week within your pharmacy.

Do you have any pharmacists with a specialist interest (PHWSI)?

- Yes
- No
- Don't know

How many other support staff do you have in your pharmacy (in WTE)? Please include any dispensing staff and dispensing appliance contractors.

In addition to English, please list any languages spoken by members of staff at the pharmacy.

Do you have Health Champions working with your pharmacy?

- Yes
- No
- Don't know

If 'Yes', how many?

Do you have any Health Trainers working with your pharmacy?

- Yes
- No
- Don't know

Do you have any Dementia Friends working with your pharmacy?

- Yes
- No
- Don't know

What could be done or changed to improve pharmaceutical services for your local population?

What do you see as the major opportunities and challenges for pharmaceutical services locally in the next three years?

Do you have any other comments?

Please read the statements below and select the most appropriate response. *

	Yes, totally	Yes, partly	Not at all
The clinical skills in your pharmacy are well utilised	○	○	○
You have a good relationship with local General Practices	○	○	○
You have a good relationship with your local Clinical Commissioning Group (CCG)	○	○	○
You have a good relationship with your local authority (Public Health/Adult Services)	○	○	○
You have a good relationship with your NHS England local area team	○	○	○

Your Details

Your name

Your position

Contact telephone number

Your email address

How would you like to complete this survey in the future?

- Online
- Email
- Hard copy (paper version)

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES UPDATE SEPTEMBER 2017

Relevant Board Member(s)	Dr Ian Goodman Councillor Philip Corthorne
Organisation	Hillingdon CCG (HCCG) London Borough of Hillingdon (LBH)
Report author	Ian Kent, HCCG
Papers with report	Appendix 1 - CAMHS local transformation plan performance update. Appendix 2 - Thrive Model of Care

1. HEADLINE INFORMATION

Summary	This report provides the Board with next steps in accelerating the transformation of CAMHS in Hillingdon together with an update on delivery of Hillingdon's 2017/18 CAMHS Transformation plan.
Contribution to plans and strategies	Hillingdon's Health and Wellbeing Strategy Hillingdon's draft Sustainability and Transformation Plan Hillingdon CCG's Commissioning Intentions 2017/18 Hillingdon Joint Children and Young Persons Emotional Health & Wellbeing Transformation Plan
Financial Cost	The CCG has been provided with additional non recurrent resources totalling £128k to assist with improving waiting times, which has been spread evenly across 2016/17 and 2017/18. The proposal to move to a more seamless pathway through the system will require a review of how existing resources (funding and people) can be better utilised to focus on improving outcomes for children and young people.
Ward(s) affected	All

2. RECOMMENDATIONS

That the Health and Wellbeing Board:

a) **approves recommendations outlining a new approach to commissioning CAMHS services which are to be developed and are subject to approval by HCCG GB and LBH.**
b) **notes the current performance against CAMHS waiting times (Appendix 1).**

3. INFORMATION

This paper provides a progress update, further to the paper that went to the Health and Wellbeing Board on 27 June 2017. The Anna Freud National Centre for Children and Families (AFNCCF) held a seminar on 18 July with key stakeholders, including parents and young people to co-produce a set of recommendations for a comprehensive care pathway for children's mental health in Hillingdon.

HCCG received a report from AFNCCF at the end of August, one month later than expected. This in turn has delayed the formulation of a detailed implementation plan for the redesign of local CAMHS services. This report will outline the key findings from the AFNCCF report and propose recommendations for implementation.

Current CAMHS waiting times for specialist services can be reviewed under Appendix 1 of the report. Appendix 2 outlines the Thrive Model of Care showing the planned movement of services after local adoption of this methodology.

Comprehensive care pathway

AFNCCF key priority areas for developing a coherent care pathway for children's mental health:

1) **Thriving: Prevention and mental health promotion**:
   - Hillingdon Based Website: This is a priority for Hillingdon, especially from young people. This will contain up-to-date information on mental health promotional activities within Hillingdon; that included within it or signposted young people and their families to on-line support; and that had an interactive element (blogs, parent forums etc. – focused on promoting emotional well-being). It was felt this should build upon existing information tools in Hillingdon such as the Local Offer website hosted by the LBH.
   - Programme of Mental Health support in schools: Mental health promotional work should be further developed in conjunction with schools. A priority area should be developing and testing out a model of peer-to-peer support; with training and support for staff so that they could promote children's mental health.
   - Mental Health Needs Co-ordinators (MHeNCo): This presents a significant opportunity for Hillingdon, both in respect of promoting children and young people's mental health as well as acting as a key point of liaison and support for those children and young people requiring initial advice and additional support together with specialist support where needed from mental health practitioners.

2) **Advice and Support:**
   Single Point of Access - Hillingdon stakeholders supported the development of a Single Point of Access for Hillingdon. There was acknowledgement that CNWL is proposing to develop a Single Point of Access (SPA) to access CAMHS, and whilst this was viewed positively, there was agreement for the need for a Hillingdon specific service, focused on early intervention. It was agreed that such a service should:
   - Be centrally located – improving accessibility for children, young people and their families and facilitating parenting classes and other programmes offering initial advice and support directly to parents and young people;
   - Have access to a range of practitioners with core mental health expertise, so that advice and support could be offered to parents and young people alongside providing advice and support to staff in mainstream services (early years, schools, etc) to

enable them to better support children and young people experiencing difficulties – via the MHeNCo;

- It is acknowledged that whilst the majority of the 'early intervention work' offered by the SPA would be through advice and support to practitioners working within mainstream settings (early years practitioners, teachers, youth workers, etc), that they would also be able to offer some group work and training work (parent support/training, alongside group work with young people, etc).
- Further develop the ongoing work undertaken by LBH in providing information and signposting for those families of children with additional support needs, e.g., those young people diagnosed with Autism Spectrum Disorder (ASD).
- Be a core point of referral for CAMHS and other specialist services – but to continue to work with/support young people, families and relevant professionals whilst such referrals were being made.

3) **<u>Getting help in mainstream settings</u>**:

- Website/social media: The importance of building on existing sources of information and support currently being delivered via websites was highlighted by families – as was the importance of bringing this information together into a centrally held and regularly updated web-based and interactive resource – for parents and young people.
- MHeNCo – These are a key potential source of support and advice – for parents and young people in mainstream settings alongside providing key advice and support to other professionals working with them. This role should not be an additional role but a formalisation of an existing role within early year's settings/schools. The role should have status but does not have to be a senior management role. It is expected that the role will co-ordinate all emotional well-being/mental health support delivered in school; manage peer to peer support; deliver training for other staff members; act as a point of co-ordination of referrals and support from SPAs and other services; as well as provide liaison with and for parents.
- Effective training and on-going support for practitioners carrying out the MHeNCo and other mental health roles in mainstream settings is key to the successful delivery of the role. Such training could be delivered via train the trainer model - this training to include:
  1. All MHeNCo's to access train the trainer Mental Health First Aid training;
  2. All staff in schools (particularly MHeNCo's) to access 'Mind-Ed', E-learning package for teachers, so that there is a clear focus on school and class based interventions.
- School Heads support of a local Well-being strategy: This will be linked to the provision of support and training via the Single Point of Access and co-ordinated and delivered through the MHeNCo's. A focus is required on those pupils most at risk of exclusion as a result of social, emotional and mental health difficulties and/or ASD who also exhibited challenging behaviours. An increase in educational provision for this group of children/young people should also be considered, possibly via the development of a Virtual Free School Alternative provision.
- Integrated pathway for ASD/MH: The needs of children and young people with ASD/MH difficulties have been recognised by all partners as a pressing priority for Hillingdon. Future work will continue to develop:
  1. High quality and accessible advice and support for parents/carers – on strategies for parenting and support children with ASD/MH problems, advice on clubs/activities and support groups;

2. Effective early intervention for children and young people with ASD and their families, prior to any formal diagnosis – to be delivered in early years settings and schools; and
3. A clear 'pathway' for accessing assessment, help and support – delivered via the SPA which involves parents/carers accessing support prior to any diagnosis, during assessment and after any assessment has been carried out.

4) **Getting help in targeted and specialist settings**:
   - Young People's Health Passport: To ensure all of those working with the young person could be made aware easily of the difficulties that the young person was experiencing, their likely triggers and what support would be most helpful for them.
   - Co-location of mental health professionals working in mainstream settings in mental health: This is an identified priority area, with specialist input for young people being delivered within community based settings.

Actions required to deliver a comprehensive care pathway.

The identified action areas have been prioritised into the following key actions which will help to implement a model of care for CAMHS following key principles of the Thrive Model of Care. The recommendations, upon approval, will be included in the Hillingdon CCG commissioning intentions submission which are issued at the end of September 2017. This will include potential for market engagement to identify models of best practice. The financial implications of these recommendations are covered within the finance section of the report.

Development of a Hillingdon Single Point of Access (SPA):

There is a requirement for a Hillingdon SPA for CAMHS services. This will define the Hillingdon offer, formalising the location as well virtual aspects to the service. Specifically, this will involve defining the 'offer' – how much support beyond guidance, information and advice can be offered at stage one as well as clarifying and formalising access to services. If this direction of travel can be approved by the Health and Wellbeing Board, market engagement activities will need to be conducted to understand a model of best practice.

Programme of Support within Schools - Mental Health Coordinators (MHeNo)

Children, young people and their families believed schools should be supported in not only providing low level support but also equipping professionals with tools to best support children and young people in settings they are most comfortable in. This proposal suggests:

1. Agree a Provider to run training and MHeNCo programmes.
2. Agree with schools how the 'resource' of a MHeNCo will be funded and maintained across sectors.
3. Design and propose a well-being and behaviour strategy identifying schools with most need which will include an agreement (between Schools Heads) on managing behavioural issues consistently across the Borough.
4. Involve parents and carers in development of this programme.

Early Intervention and Peer Support - Clinical Peer Support Lead

Proposal for a full-time, dedicated, Clinical Peer Support Lead to provide expert guidance and advice to professionals within schools. There is an immediate need to provide effective early intervention and support in community settings such as schools to ensure needs do not escalate.

This will be a management level post providing assurance in the local community. The job description will be agreed between partners on approval and will focus on pupil need across the Borough. This role will be developed with schools leads.

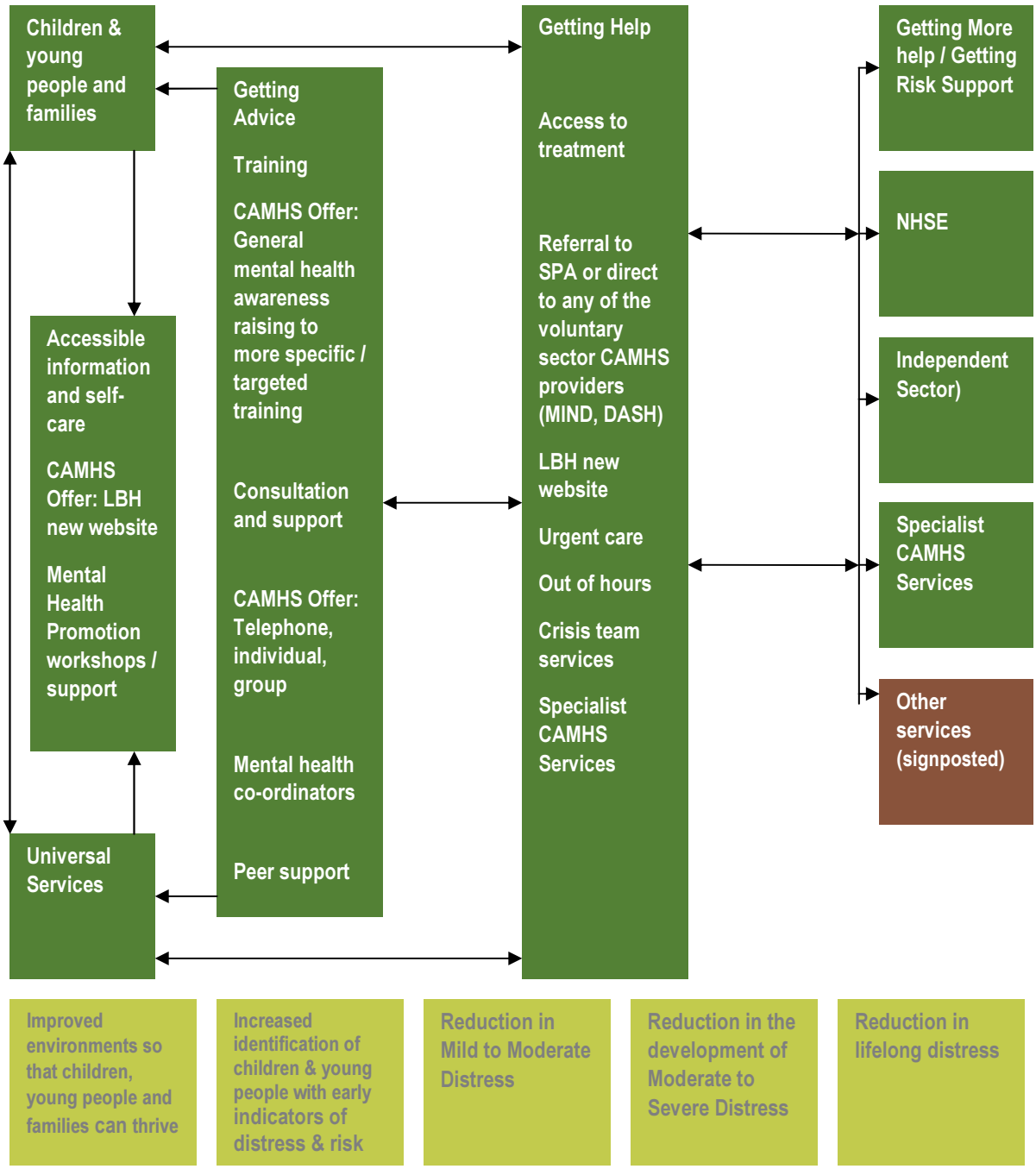
Hillingdon Specific Website

This will provide a fully comprehensive, easy to access information tool for young people and their families. LBH Social Care is currently moving from two providers for its online requirements to a single site that will include all Children, Family Information & Adult Services which will meet requirements for the Care Act 2014, Children & Families Act 2014 and SEND reforms. LBH has awarded a contract to PCG Technology Solutions (the provider), for a fully managed service with unlimited content and changes to the website during the year at no additional cost. It is proposed that this website outlines all dedicated CAMHS provision and services whilst operating in a manner which suits the needs of service users as identified though the recent co-production consultations. LBH colleagues are proposing to work with colleagues in Health as well as Children and Family representatives to ensure the new website content meets their requirements and also to work with the monitoring team thereafter to ensure it continues to meet their needs.

It is expected the new website will go-live from the end of September 2017, with CAMHS colleagues invited from mid-September onwards to trial the new site and scope requirements whilst also creating a project plan monitoring progress on amendments they suggest. Attributes of the new website:

1. Functionality includes - Information & Advice pages, Directory of Services, online booking, online assessment, Marketplace: including management of personal budgets and purchasing.
2. Site will be branded under 'Connect to Support Hillingdon', a site that is already being promoted and seen as the go-to site for information to meet care and support needs.
3. Infrastructure and resource is in place to manage the site from LBH, although representatives from health will be able to join and lead on developing/integrating relevant content.

Proposed New Care Pathway



The aim of the pathway is to ensure mental health services and support is accessible to all children, young people and their families within Hillingdon. It is proposed that the pathway will be made up of a range of providers from the voluntary and statutory sector. The pathway takes an asset based approach, ensuring accessible information and support is available at all levels, i.e., public health, early intervention, early identification, prevention and intervention.

It is a stepped model of care ensuring children and young people can access the pathway at any stage dependant on their mental health needs with the primary focus being that children, young people and their families are supported at the universal level within their communities.

4. FINANCIAL IMPLICATIONS

The performance data in Appendix 1 outlines the ongoing work HCCG and CNWL are undertaking in reducing the waiting time backlog, utilising the 2016/17 investment of £128k provided to the CCG, £64k of which has now been allocated to the 2017/18 financial year.

The financial implications for each of the recommendations outlined earlier in the report are:

Hillingdon Single Point of Access (SPA) for CAMHS.

Initially this will involve bringing together the CAMHS referral management system across Brent, Harrow and Hillingdon (BHH). The second stage will be aligning more effectively the Crisis service and Out of Hour's service following additional funding across North West London. Any further developments will require a clear value proposition and business case for investment.

Programme of Support within Schools - Mental Health Co-coordinators (MHeNo)

Training programmes for MHeNCo will cost approximately £1,000 per school. It is proposed this is tested as a pilot across five Primary and five Secondary schools across the Borough prior to full implementation across Primary and Secondary schools in Hillingdon.

HCCG have commissioned 5 x full day in-house training sessions from 'Young Minds' on children and young people's mental health for a maximum of 20 practitioners which could be utilised for this initial pilot exercise.

Discussions with schools will need to consider how the resource of a MHeNCo will be funded in each school.

Early Intervention and Peer Support - Clinical Peer Support Lead

This will be a full-time dedicated resource for professionals in Hillingdon Schools funded out of existing commissioning resources designed to provide effective early intervention and support ensuring in the community.

The post is expected to be fall within NHS Agenda for Change 2017/18 pay Band 8a - salary range £40,428 - £48,514 with additional subject to a minimum payment of £3,553 and a maximum payment of £4,528. On-costs for the post will be approximately 20%.

Maximum cost of this post is expected to be £63,650.

Hillingdon Specific Website:

There is not expected to be any additional cost resulting from modification of this newly commissioned LBH website to deliver the information requirements for CAMHS provision.

At this stage, it is not proposed to include the CAMHS budgets within the Better Care Fund (BCF) pooled budget. Whilst our ambition remains to move to joint-procurement of a model without tiers, the BCF continues to focus on the development and delivery of an improved model of care for older people.

Timeline for Change

A full implementation plan will be formulated in October 2017 following HWBB. Monthly monitoring of Programme via Hillingdon CAMHS Steering Group and Hillingdon Mental Health Transformation Board.

Activity	Date	Lead officer	Status / Comments
HWBB approve recommendations following Hillingdon Co-Production project.	September 2017		
Hillingdon Website Development PCG Technology Solutions working with LBH Lead Officer will develop a tailored, interactive website covering local CAMHS provision.	 September - October 2017	LBH 'Connect to Support' Lead - Sasha Jeffries.	 Representatives from Hillingdon's CAMHS Steering Group (including CNWL, HCCG, service users and Third Sector) will develop the new website with LBH lead officer.
School Engagement Programme: 'Young Minds' Practitioner training event for Schools. 5 all day events. Development of Mental Health Coordinator role in schools Development of Clinical Peer Support Lead role for Schools	 October/ November 2017 October 2017 - March 2018	Schools Lead tbc.	 HCCG commissioned 5x days of training will be used to provide a programme of training for school practitioners who could subsequently take up the role of School based Mental Health support Co-Coordinators. School Leads involved in the programme of consultation to date have requested a separate period of consultation to commence in September, specifically with schools to isolate their specific requirements for mental Health Support within schools.
Single Point of Access for CAMHS New integrated referral management system	 January 2018	 Jane Hainstock,	 . Further development may require a Business

introduced with additional staff taking up posts across North West London to allow full integration of Crisis Services' and Out of Hours service. Market Engagement exercise	 January 2018 - March 2018	Head of Mental Health, HCCG Pranay Chakravorti CAMHS Project Officer CCG/LBH	Case
Thrive Model of Care in Hillingdon	1st July 2018		New Model in place providing supportive, effective and early intervention services for children, young people and families.

5. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

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

Consultation Carried Out or Required

Hillingdon CCG commissioned the 'Anna Freud National Centre for Families' to facilitate a series of co-production workshops between May and July. This culminated on 18 July 2017 with a seminar with key stakeholders, including parents and young people to review the emerging set of recommendations for a comprehensive care pathway for children's mental health for Hillingdon.

Participants took part in group discussions, involving young people and parents, to review emerging themes, which were set out within the 5 core 'Thrive Headings'. They also reviewed:

- Whether there were core groups of children, young people or parents who had been omitted from the set of emerging recommendations and, if so, to set out who these were.
- Their priorities for improvement (within each of the Thrive headings).
- Suggestions for how these might be best taken forward within Hillingdon.

This follows consultation work The 'Future in Mind team' undertook across NW London, including Hillingdon, in 2015, prior to the submission of the CAMHS Local Transformation Plan. There has also been consultation with children and young people in Hillingdon at the Youth Council, forums and through schools. A children and young people's mental health event took place in July 2016 (Fundamentals Health Event) to allow children and young people to have their say on Hillingdon services.

In 2015, Healthwatch Hillingdon undertook consultation with children, young people and families which focussed upon self-harm and was instrumental in the development of the new self-harm service. Feedback from Hillingdon children and young people, to date, has also included a CAMHS Focus group.

Policy Overview Committee comments

The Children, Young People and Learning Policy Overview Committee at its meeting on 27 September 2017 to update on the work undertaken in relation to CAMHS since June 2017.

6. BACKGROUND PAPERS

None.

Appendix 1- LOCAL TRANSFORMATION PLAN: CURRENT PERFORMANCE AUGUST 2017

a) CAMHS

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

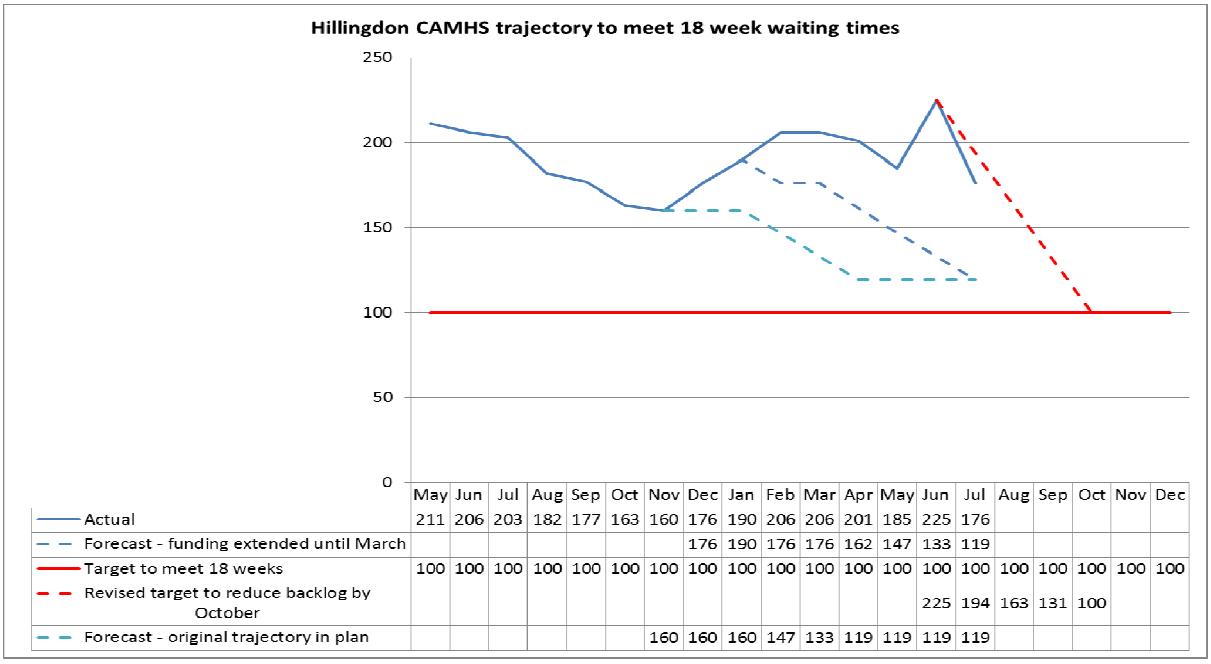
NHS England released funding nationally to all CCG's in 2016 to reduce waiting times for CAMHS services; this funding was not fully utilised in 2016/7 and is therefore being used in 2017/8 to further address the waiting time backlog. CNWL have submitted trajectories for reducing waiting lists with this funding and have received the following allocations. NHS England had provided HCCG with £64,000 in the first tranche of funding to be released and a further £64,000 is the second tranche as outlined below:

CCG	First tranche	Second tranche
Hillingdon	£64,000	£64,000

CNWL have recruited to agency staffing posts using core and the additional funding from NHS England. In addition four staff from the core team focused on additional cases during the week are offering Saturday appointments to families. Two additional agency staff is in place and the service is looking for additional agency staff whilst permanent recruit takes place. The assumptions in the graphs below assume no further growth in referrals above the 14% already seen. Again in terms of waiting time's funds and trajectory the service has seen more Children and Young People than planned.

In addition the expectation is that by the end of October the numbers on the waiting list will have reduced to 100 resulting in sufficient capacity within the team for 85% of referrals being seen within the 18 week target.

Number on CYP under 18 on waiting list	Latest position known as at 30/09/2017	Quarter 3 31/12/2006		Q quarter 4 31/03/2017		Quarter 1 30/06/2017	
		Planned Reduction	Actual Reduction	Planned Reduction	Actual Reduction	Planned Reduction	Actual Reduction
Total Number of CYP waiting for Assessment	125	100	127	75	142	75	149
Total Number of CYP waiting for Treatment	52	40	49	30	64	30	76
Average waiting time from referral to treatment (days)	76	76	120	76	112	76	99



	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Actual	211	206	203	182	177	163	160	176	190	206	206	201	185	225	176					
Forecast - funding extended until March								176	190	176	176	162	147	133	119					
Target to meet 18 weeks	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Revised target to reduce backlog by October														225	194	163	131	100		
Forecast - original trajectory in plan							160	160	160	147	133	119	119	119	119					

b) Paediatric Eating Disorders

Target Description	Target	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17
Waiting times - routine	30%	75	67	100	100	100	100	100	100	100	100	100	100	100
Waiting times - urgent	100%	100	67	100	100	100	100	100	100	100	100	100	100	100

c) Self-Harm

There are currently two patients in Tier 4 inpatient settings receiving treatment for self-harm. This represents a similar position to the number of patients identified in the last report. HCCG are working closely with NHS England to facilitate safe discharge of these patients when their conditions are stabilised.

Scoping work has also been conducted by NHSE ahead of the Local Transformation Plan refresh at a STP level. Tier 4 beds are to be reviewed at national level by NHSE in conjunction with Public Health. There are currently sufficient beds in the system but not located in the correct places with the profile of the beds not matching the needs of those requiring complex care. NHSE are currently aligning this work with local areas with further timelines to be released once this initial work is complete.

d) North West London Update

The Common priorities identified across North West London are as follows:

- Needs Assessments
- Supporting Co –Production
- Workforce Development and Training

- Specialist Community Eating Disorder Service
- Re-Designing Pathways- A Tier Free System
- Enhanced Support for Learning Disabilities
- Crisis and Urgent Care Pathways
- Embedding Future in Mind and the Five Year Forward View.

Appendix 2: Thrive Model

Thriving: prevention and health promotion – the child or young person has no mental health issues and their need is to be kept emotionally healthy through the application of active prevention and health promotion strategies

Advice and support – the CYP/Family have issues but all they need is some advice and support to manage it

Getting help – the CYP/Family has a clearly identified mental health issue that is likely to be helped by a goal focused intervention working with a professional (part of this intervention may also include advice and support, and management of risk, but this will be part of an ongoing intervention)

Getting more help – as above but the CYP needs higher level multi-agency intervention

Risk Support – this group of CYP present with high risk but for various reasons there is not a goal focused intervention that is thought likely to help – but the CYP needs to be kept safe.

Current Local Offer

Future Model - In Two Years

UPDATE: STRATEGIC ESTATE DEVELOPMENT

Relevant Board Member(s)	Dr Ian Goodman, Chair, Hillingdon CCG Councillor Phillip Corthorne
Organisation	Hillingdon Clinical Commissioning Group
Report author	Sue Hardy, Head of Strategic Estate Development, Hillingdon CCG Nicola Wyatt, S106 Monitoring & Implementation Officer, Residents Services Directorate, London Borough of Hillingdon
Papers with report	Section 106 Healthcare Facilities Contributions (June 2017)

1. HEADLINE INFORMATION

Summary	This paper updates the Board on the CCG strategic estate initiatives and the proposed spend of s106 health facilities contributions in the Borough.
Contribution to plans and strategies	Joint Health & Wellbeing Strategy, Out of Hospital Strategy, Strategic Service Delivery Plan
Financial Cost	To be identified as part of the business case for each individual project.
Relevant Policy Overview & Scrutiny Committee	N/A
Ward(s) affected	All

2. RECOMMENDATION

That the Health and Wellbeing Board notes the progress being made towards the delivery of the CCGs strategic estates plans.

3. HILLINGDON ESTATE STRATEGY - OVERVIEW

Below is an outline of the Hillingdon vision of how the key priorities outlined within the Five Year Forward view and the STP guidance will be addressed:

Health & Wellbeing

- Working collaboratively across health, social care and public health, we will improve outcomes and reduce inequalities for our population with a focus on those with both

traditional Long Term Conditions (including both physical and mental health LTCs) and emergent categories of LTCs such as pain, frailty and social isolation.
- Our coordinated programme of work will bring together our existing plans for the BCF and our Health & Wellbeing Strategy (HWBB) and engage our whole community to create a resilient population and assist people to remain independent with better quality of life for longer.

Care & Quality

- We will provide care that is safe, effective and delivered by experienced practitioners through collaborative working across health and social care services.
- We will be able to share information that improves the quality of health and social care services and that enables our population to make informed choices.
- We will deliver the best and highest quality care possible within the constraints of our local economy and the growth in demand that we are predicting.

Finance & Efficiency

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

Key Drivers and Challenges

- To meet an estimated increase in demand and complexity of care delivered in the community for out of hospital care across the area of 30%-35%.
- Enable a major shift in care from within a hospital setting to an out-of-hospital setting so more people are treated closer to their homes.
- A need to improve utilisation of the existing estate and effectively target strategic investment in new estate in locations appropriate for a Hub health care delivery model.

Forecast population and demographic growth in Hillingdon suggests an increasingly diverse population.

<u>Key points emerging from the strategic estates plan</u>

- The need to progress the aims of the Out of Hospital strategy. Focussing investment in locations which support implementation of the strategy at Uxbridge/West Drayton, North Hillingdon and Hayes & Harlington.
- The need to secure long term premises solution for the Shakespeare Medical Centre and Yeading Court Surgery.
- The need to address poor primary care infrastructure by making sure GP practices are in the right location and in fit for purpose accommodation.
- To build primary care estate capacity in Hayes Town to respond to the growth derived from the Housing Zone.
- To secure a replacement site for Yiewsley Health Centre and build additional capacity to respond to local residential development.
- The need to improve access to health care for people living in the Heathrow Villages.

- Consideration of any potential impact from the Southall Gas Works site development on Hillingdon practices.
- To develop a plan for the future of the Northwood and Pinner Community Hospital that respects the heritage of the site and realises the potential of its location.
- Consider any opportunity created by the future plans of Brunel University.
- Support The Hillingdon Hospital Trust with its master planning for both sites.

Current status of strategic estate priorities

The table below summarises the projects and the current status.

Project	Status
Create an Out of Hospital Hub in North Hillingdon	The CCG has completed a Project Initiation Document for the creation of a new Out of Hospital Hub for the North of the Borough preferably on the Mount Vernon Hospital site. Negotiations with The Hillingdon Hospital Trust continue to establish whether the Hub is delivered as part of the new Skin Clinic or an alternative location on the hospital site.
Create an Out of Hospital Hub in Uxbridge and West Drayton	The CCG has continued to work in partnership with Central and North West London NHS Foundation Trust (CNWL) to identify a potential location for the Hub. A feasibility study has been commissioned to establish the development potential of the existing Uxbridge Health Centre site to meet the Hub requirements.
Building capacity for Hayes and Harlington	The CCG, working in partnership with the Council, has been successful in securing circa 900m2 of accommodation for a new health facility as part of the Old Vinyl Factory development. Negotiations are now underway to establish commercial terms and the detailed design. Using Council housing projections the CCG has established a further requirement of circa 600 m2 of health care space in Hayes to accommodate the new population. Discussions are now taking place with the developer of the Nestle site to establish whether additional health accommodation can be provided on this site.
New premises for Shakespeare Medical Centre and Yeading Court Surgery	Negotiations between the practice, CCG and Council are progressing well for the proposed relocation of the practice to new premises on the former Woodside Day Centre site. The indicative design and final draft Heads of Terms have been signed by the practice. Cabinet approval will now be needed to progress the scheme.
Yiewsley Health Centre	The CCG has been successful in securing funding to refurbish some recently vacated space at the site into additional clinical accommodation. This will create additional capacity for primary care provision at the site. A long term solution for the site is still being explored with the support of CNWL and the Council planning team.
Future of Northwood and Pinner Community Hospital	The business case has been approved which enables NHS Property Services (NHS PS) to commit funds to working up

	a preferred option for Northwood and Pinner Community Hospital and Northwood Health Centre combined, including re-provision of the health centre. A design team and planning consultants have been appointed to work on the project and provide options for mixed-use redevelopment with a new health facility on the Pinner Road site and dealing with the site specific sensitivities. The requirements from the CCG are being used to develop options, with on-going engagement to refine the design and floor space requirements. NHS PS met with Hillingdon Council informally in July to discuss the principle of redevelopment and NHS PS is now working towards producing a preferred option in order to submit plans to the Council for more detailed pre-application discussions.
Improving Access to Primary Care	The CCG continues to review the quality and capacity of primary care premises across the Borough. A primary care strategy has been developed and is due to be approved by the Primary Care Board in September 2017. Thirteen GP practices have received NHS funding to invest in improving practice premises. The total amount of investment being made totals £2.7 million and will benefit more than 70,000 patients.

Financial considerations

The NWL Strategic Outline Case Part 1 (SoC1) for the first tranche of capital required to deliver the Shaping Healthier Future and Strategic Transformation Plan estates projects has been approved by NHS England. The SoC was a bid for £513m of capital funding to invest in buildings and facilities for GP practices and Hubs across NW London and acute hospitals in outer NWL.

In Hillingdon this includes:

- additional investment in a number of GP practice premises to improve access, clinical capacity and quality;
- the capital investment required to deliver the North Hillingdon and Uxbridge & West Drayton Hubs; and
- the expansion of A&E and the maternity unit at Hillingdon Hospital.

The SoC will also require the approval of NHS Improvement, the Department of Health and Treasury and a programme is in place for approvals to be progressed throughout the remainder of the year.

Hillingdon Council, on behalf in consultation with the NHS in Hillingdon, has been collecting s106 contributions for health from residential developers where the size and scale of the

housing scheme has been identified as having an impact on the delivery of local health services. Funding has been secured by the Council for investment in health premises and services in the Borough in order to help meet increased demand for health services as a result of new development. This additional non-recurrent funding has been used to build capacity within the primary care estate and subject to the Council's formal s106 allocation process, it is proposed that any further contributions received are used to the remainder will help to offset the cost of the Hubs.

The CCG will identify the financial implications of all estate investment as part of the business case development process for each project.

5. S106 HEALTH CONTRIBUTIONS HELD BY THE COUNCIL

1. Appendix 1 (attached to this report) details all of the s106 health facilities contributions held by the Council as at 30 June 2017. The Council has received two further contributions, since the last report to the Board in June. These have been added to Appendix 1 and are highlighted in bold. As at 30 June 2017, the Council holds a total of £1,261,845 towards the provision and improvement of health facilities in the Borough.

2. The CCG has "earmarked" the s106 health contributions currently held by the Council towards the provision of the health hubs as outlined in Appendix 1. To note, two contributions held at case references H/20/238F (£31.4K) and H/37/301E (£13K) have spend deadlines within the next 18 month period. These contributions are currently earmarked towards the provision of a new health hub in the North of the Borough. Given the short timescales for spending these contributions, HCCG are also considering other options to ensure that the funds can be utilised towards a valid scheme within the relevant timescales. A request to allocate individual contributions towards further schemes will be submitted as each scheme is brought forward.

HILLINGDON COUNCIL FINANCIAL IMPLICATIONS

As at 30 June 2017, there is £2,545,633 of Social Services, Housing, Health and Wellbeing s106 contributions available, of which £1,328,788 has been identified as contributions towards affordable housing. The remaining £1,216,845 is available to be utilised towards the provision of facilities for health and £564,596 of these contributions have no time limits attached to them.

The s106 contributions referenced H/20/238F and H/37/301E have a time limit to spend by February 2018 and July 2018 respectively, both of which have been earmarked to the North Hub Health Scheme. There is a risk that these contributions will be returned to the developer with accrued interest if not utilised by the spend deadline as stipulated by the conditions attached to them.

Officers in conjunction with the CCG and NHSP continue to work actively towards allocating all outstanding health contribution to eligible schemes. To date funds totalling £1,161,839 are provisionally earmarked towards proposed health hub schemes as detailed by below:

Proposed Health Hub Scheme	Amount
North Hub	184,884
Uxbridge / West Drayton Hub	520,593
New Yiewsley Health Centre	452,460

Pine Medical Centre	3,902
Total Earmarked	**1,161,839**

The remaining balance of £55,006 comprising two separate contributions is yet to be earmarked to any schemes although it is anticipated that they will be expedited by their respective deadlines. The contributions are £35,621 (ref H/30/276G) and £19,385 (ref H/69/404F) respectively.

HILLINGDON COUNCIL LEGAL IMPLICATIONS

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

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

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

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

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

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

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid August 2017)
			AS AT 30/06/17	AS AT 30/06/17			
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.
H/20/238F *72	West Ruislip	Former Mill Works, Bury Street, Ruislip. 6157/APP/2009/2069	31,441.99	31,441.99	2018 (Feb)	North Hub	Contribution received as the health facilities contribution towards providing health facilities in the Authority's Area. Funds to be spent towards (but not limited to); expansion of health premises to provide additional facilities and services to meet increased patient or user numbers or, new health premises or services at local level or, any new facility required to compensate for loss of health facility caused by the development. First instalment to be spent by February 2018. Second instalment to be spent by June 2018.
H/22/239E *74	Eastcote	Highgrove House, Eascote Road, Ruislip. 10622/APP/2006/2494 & 10622/APP/2009/2504	7,363.00	7,363.00	No time limits	North Hub	Funds received towards the cost of providing health faciities in the Authority's Area including (but not limited to); expansion of health premises to provide additional facilities and services to meet increased patient numbers or, any new facility required to compensate for the loss of a health facility caused by the development. No time limits.
H/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/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/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.

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid August 2017)
			AS AT 30/06/17	AS AT 30/06/17			
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/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/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	17,600.54	17,600.54	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/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/63/385D *129	Northwood Hills	Frank Welch Court, High Meadow Close, Pinner. 186/APP/2013/2958	10,195.29	10,195.29	No time limits	North Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. No time limits for spend.
H/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
Total "earmarked " towards North Hub			**184,884.41**	**184,884.41**			
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.

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid August 2017)
			AS AT 30/06/17	AS AT 30/06/17			
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/39/304C *97	Yeading	Fmr Tasman House, 111 Maple Road, Hayes 38097/APP/2012/3168	6,448.10	6,448.10	2020 (Aug)	Ux/WD Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development.
H/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/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/49/283B *108	Uxbridge North	Former RAF Uxbridge, Hillingdon Road, Uxbridge 585/APP/2009/2752	624,507.94	447,149.63	2024 (Aug)	Ux/WD Hub	Funds to be used towards the provison of healthcare facilities serving the development in line with the Council's S106 Planning Obligations SPD 2008. Funds to be spent within 10 years of receipt. £177,358 from this contribution is allocated towards capacity improvements at Uxbridge Health Centre (Cabinet Member Decision 12/06/2015). £177,358 transferred to HCCG July 2015.
H/58/348B	North Uxbridge	Lancaster & Hermitage centre, Lancaster Road, Uxbridge 68164/APP/2011/2711	7,587.72	7,587.72	No time limits	Ux/WD Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. No time limits
H/64/387E *136	Uxbridge North	Norwich Union House, 1-2 Bakers Road, Uxbridge. 8218/APP/2011/1853	15,518.40	15,518.40	2023 (Sept)	Ux/WD Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. Funds to be spent within 7 years of receipt.
Total "earmarked" towards Uxbridge/West Drayton Hub			**697,951.28**	**520,592.97**			

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid August 2017)
			AS AT 30/06/17	AS AT 30/06/17			
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/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/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/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).
H/61/382F *128	West Drayton	Kitchener House, Warwick Rd, West Drayton. 18218/APP/2013/2183	8,872.64	8,872.64	2026 (April)	New Yiewsley HC	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. Spend within 10 years of receipt (April 2026).

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid August 2017)
			AS AT 30/06/17	AS AT 30/06/17			
H/62/384F *128	Yiewsley	Caxton House, Trout Road, Yiewsley. 3678/APP/2013/3637	15,482.07	15,482.07	No time limits	New Yiewsley HC	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. No time limits for spend.
H/66/390D *137	West Drayton	Fmr Anglers Retreat, Cricketfield Road, West Drayton (11981/APP/2013/3307)	8,319.90	8,319.90	2021 (Sept)	New Yiewsley HC	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. Funds to be spent within 5 years of receipt.
H/67/402E	**Yiewsley**	**21 High Street, Yiewsley 26628/APP2014/675**	**18,799.72**	**18,799.72**	**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 limit for spend**
Total "earmarked" towards New Yiewsley Health Centre			**452,460.20**	**452,460.20**			
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/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. Remaining balance to be spent by February 2022.
H/69/404F	**Botwell**	**The Gatefold Building, land east of the former EMI site , Blyth Road, Hayes 51588/APP/2011/2253**	**19,384.77**	**19,384.77**	**2024 (Apr)**	**To be determined**	**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 services at the local level; any new facilities required to compensate for the loss of a health facility caused by the development. Funds to be spent within 7 years of receipt (April 2024).**
To be determined			**127,605.83**	**58,907.57**			
		TOTAL CONTRIBUTIONS TOWARDS HEALTH FACILITIES	**1,462,901.72**	**1,216,845.15**			

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THHFT DELAYED TRANSFER OF CARE (DTOC) INITIATIVES AND IMPROVEMENTS

Relevant Board Member(s)	Shane Degaris, Chief Executive Officer
Organisation	The Hillingdon Hospitals NHS Foundation Trust
Report author	Julie Wright, Director of Integrated Care
Papers with report	Appendix 1 – Red2Green Graphs Appendix 2 – Number of DTOC and medically optimised patients Appendix 3 -. Stranded Patients – Snap Shot Audit

HEADLINE INFORMATION

Summary	This paper provides an outline description and update to the Health and Wellbeing Board on key initiatives and improvements implemented within the Hillingdon Hospitals NHS Foundation Trust to reduce the number of patients experiencing delays in being discharged from an acute bed.
Contribution to plans and strategies	This paper support system wide transformation work described in a number of strategies across organisations.
Financial Cost	N/A
Ward(s) affected	All

RECOMMENDATION

That the Health and Wellbeing Board notes the content of the paper.

Information

This paper provides context behind several schemes and initiatives being set up to reduce delays in discharge for patients able to leave the hospital and provides an outline and progress update on the following schemes:

- Red to Green
- SAFER
- Discharge home to assess
- Stranded patients audit and actions
- Ending PJ paralysis
- Criteria led discharge
- HHCP integrated frailty pathway
- DTOC action plan
- Safer Efficient Hospital Internal Professional Standards

1. Context

During Winter 2016/17 demand for inpatient services exceeded the number of beds available within the hospital. Hillingdon's DTOC position has fluctuated over time and currently is within the nationally agreed target of 2.5%. However the number of medically optimised patients within the hospital remains a challenge and is currently at 9.4% (38 patients on average). The national target is 3%. This is driven by a high number of so-called stranded patients (defined nationally as patients with a length of stay above 7 days) which is currently at 53% of our bed base (215 patients). The national benchmark is 35% to 40% so the Hillingdon system in an outlier in this respect. The combined impact of this will cause additional bed pressures through the 2017/18 winter months if the trend continues resulting in patients in A&E waiting for a bed but unable to be moved out of the department.

A Hillingdon emergency care recovery board has been established which is chaired jointly by the CEO's of the Hospital Trust and the CCG and an extensive programme of system wide work agreed which is being monitored by system regulators. This consists of five main theme programmes – Demand management, A&E processes, Patient Flow and 'SAFER'. The final programme work stream is focussed on integrated discharge - the Executive sponsor is Tony Zaman Director of Adult Children and Young People's Services and the programme group is chaired by Maria O Brien, Board Director Community Services/Deputy COO for CNWL.

As part of a whole system integrated recovery programme there are several distinct schemes underway in the hospital aimed at reducing the length of stay (LOS) and freeing up bed capacity. Equally important is the national evidence highlighting the negative impact on patients who have prolonged length of stay in an acute hospital environment especially the frail and elderly.

This paper details the schemes most relevant to expedite discharge and reduce LOS.

2. Red to Green

Red2Green is a method of ensuring that the care which is planned to take place for a patient on any given day actually does take place. It links to SAFER (see section 3 below) in that the care required for the day is identified at the senior review, and then tracked to ensure it happens through Red2Green. The basic principle of Red2Green is that a day on which everything which should happen for a patient does happen is a Green day. If something should happen, but doesn't, it is a Red day. By focussing staff on moving patients from a Red day to a Green day, and by identifying those things which block any individual patient from having a Green day, the Hospital (and the wider health and social care system) are able to identify processes and systems which are not working, and which need to be improved. In turn, resources can be directed at resolving these blockages, which will mean more patients have Green days in the future. In this way, Red2Green will enable more patients to follow the SAFER patient flow bundle, and help to realise the benefits of a reduced length of stay in hospital.

See Appendix 1 - Red2Green graphs which show a reduction in the average length of stay; an increase in total number of discharges per week and reduction in discharges after 5pm with a gradual increase in discharges before mid-day and 3pm.

3. SAFER

SAFER is a patient flow bundle: This consists of five elements. **S** = All patients should have a review every day by a senior doctor. This review should determine what happens next for every patient, and identify the plan for the patient to get better and leave hospital. **A** = All patients should have a planned date of discharge, which everybody involved in their care can work towards; family, hospital staff, social services, community support teams etc. **F** = The movement (flow) of patients in the hospital should start as early as possible. First discharges from the acute wards should be by 10am. **E** = Early discharge - at least a third of patients should go home by midday. **R** = Review of patients who have been in hospital for more than 7 days. Any patient who has been in hospital for more than a week should have an individual plan of what is required to get them home.

Implementation of the SAFER patient flow bundle should significantly speed up patient movement through the hospital, and decrease pressure on the emergency department (ED) and the assessment units. This will provide a better patient experience and reduce the risk of patient harm through deconditioning. It is well known that keeping patients in hospital for longer than necessary can lead to other problems.

All patients will have estimated dates of discharge (EDD) established and reviewed as part of SAFER flow bundle. As an example, ordering of tablets to take out (TTO) 24 hours in advance is also to be embedded as part of SAFER flow bundle. SAFER will be rolled out across the Trust by the end of September.

4. Hillingdon Health Care Partners (HHCP)

The Accountable Care partnership – HHCP - has several clinician led work streams; the 2 examples provided specifically impact positively on improving discharge:

- Frailty Pathway - The frailty pathway is designed to deliver care across the whole system, at the hospital Geriatricians are present in the ED, also offering telephone advice line for health and social care providers inside and out of the hospital. The frailty unit opened in March 2017, and is also having a positive impact on length of stay. The unit is a 10 bedded inpatient unit open 24/7 with a targeted maximum Length of Stay (LOS) of 72hrs. The frailty unit now offers a co-located ambulatory and assessment service which commenced the first week in September.

- Discharge home to assess - Whilst this model is still evolving, the principle of discharge home to assess is to ensure that once a patient deemed medically optimised then all efforts should be made that day or the next to discharge. The standard definition of a medically optimised patient is when the treatment in acute care is completed and the patient is now fit for discharge from a medical perspective. All relevant investigations have been completed and none further are anticipated. The patient may, however, require further therapy or social or nursing care input. This should be provided in an alternative setting.

Since starting this new model, 123 patients have benefitted from being discharged on the day or the day after being classed at medically optimised. More work is required to increase the out of hospital team capacity in order to meet the emerging demand of patients eligible for this service.

5. Review of 'Stranded patients' (patients with a length of stay above 7 days)

Appendix 2 details the number of DTOC and medically optimised patients over time and Appendix 3 details findings from the most recent stranded patients review, which was a snapshot audit on several of the hospital wards on a particular day. This audit details the reasons for patient delays that are deemed medically optimised and waiting on hospital processes and also patients delayed waiting for processes external to the hospital.

The following process is in place to identify and manage the stranded patients who may also be medically optimised:

- The discharge co-ordinators will have a freshly generated list every day for their wards with stranded patients including those medically optimised. The discharge co-ordinators will discuss progress and plans with the ward multi-disciplinary team (MDT) ensuring progress which will be used to update the wards, the Red2Green patient champion, the Head of Site and the Director of Operations. Patients suitable for Discharge Home to Assess will be identified on a daily basis.
- The daily Red2Green meetings will take place with the partner agencies at 10:00 to go through all the red and stranded patients presented by the ward leads ensuring support to unblock delays in the patient journey inside and outside the hospital.
- The red and stranded patient task list will be distributed to all the internal and external support teams with feedback on progress by 15:00.
- The discharge team will provide a 7 day service including daily tracking of progress and discharges.
- The Director of Operations will hold a DTOC and medically optimised (MO) conference call every Wednesday at 09:30 with senior system leaders providing escalation of any delays in the hospital to partner agencies.

In addition to other schemes, the expected outcome of the process described above will be to achieve the NHS target for 92% bed occupancy, 162 to 182 stranded patients by November 17 (40 to 45% of bed base), medically optimised patients below 3% and DTOC consistently less than 2.5%.

Themes from the stranded patient reviews and Red2Green will continue to inform system wide plans for improving timely discharges from the hospital going forward.

6. Ending 'PJ' paralysis

Pyjama of 'PJ' Paralysis is a recognised phenomenon and highlights the detrimental effect on patients of remaining in pyjamas or nightwear and in bed for extended periods while in hospital.

Ten days of bed rest for someone over 65 years old can lead to 10% loss of aerobic capacity and 14% loss of muscle strength. Research shows that patients who stay in nightwear and in bed lose muscle condition, mobility and may be more vulnerable to infection.

Getting dressed is something we do every day, but for hospital patients it can mean the difference between going home to live independently or needing support. Getting patients moving if they are able is proven to reduce hospital stay, aid recovery and accelerate the return home to independent living.

‘End PJ paralysis’ is a national campaign and has now been launched across all medical and Care of the Elderly wards, with Trust staff encouraging patients to get out of bed and to get dressed during the day.

7. Criteria led discharge

Through the implementation of criteria led discharge (CLD) nurses and therapists have been supported to safely discharge patients rather than waiting for medical staff to attend the ward and agree the patient can be discharged. This can help reduce or potentially eliminate acute care delays in the discharge of patients.

On Beaconsfield East the multidisciplinary team (occupational therapists, physiotherapist, nurses, speech and language team and medical staff) agree the criteria that the patient needs to achieve in order to be discharged from acute care. Once the patient has met these criteria the nurse or therapist can discharge the patient without a follow up review from the medical team. This model has received very positive evaluation and roll out to other wards within the Trust is being worked through with ward teams.

8. Whole system DTOC action plan (BCF)

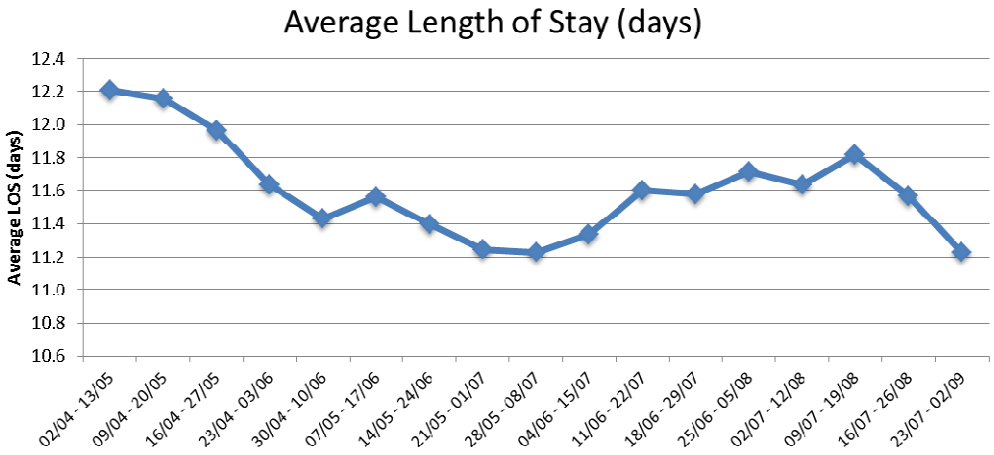
The Trust is working with whole systems health and social care partners to achieve the requirements of the agreed action plan. The actions are tabled under 8 high impact change domains and detailed in the Better Care Fund. Whilst many of the actions are progressing, some of the requirements to make a difference to the delayed transfers of care for both health and social care remain a concern to the Trust, namely care home placement capacity for both patients with and without challenging behaviour and the availability of packages of care in patients homes.

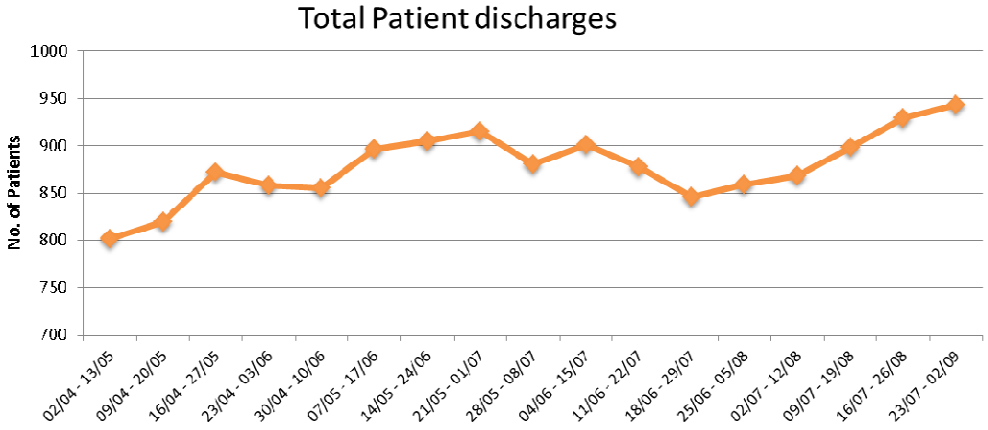
9. Safer efficient hospital Internal professional standards for wards

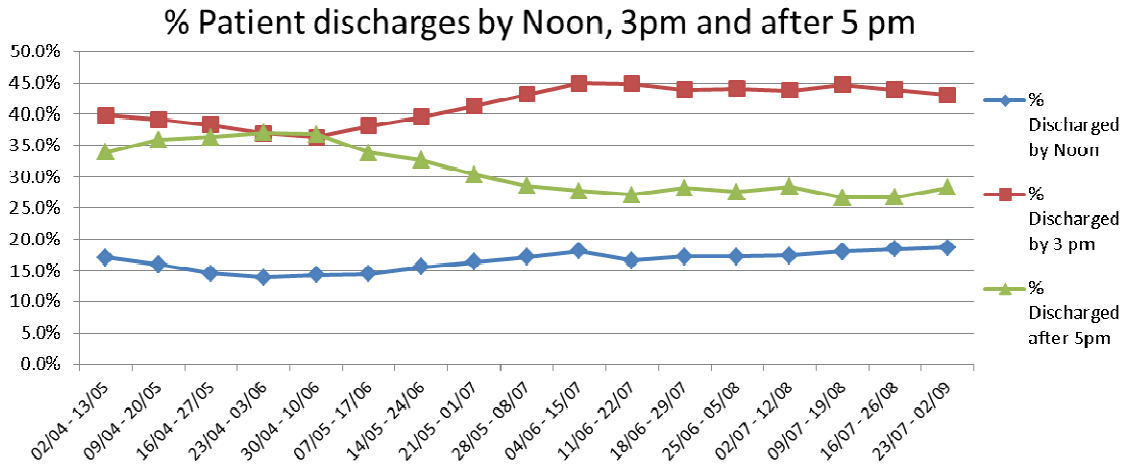
These standards are based on those already successfully used and working at other hospitals and have been developed and agreed by all the Trusts’ senior clinical leads including the medical director at THHFT. The standards represent the Trusts key values and expectations of each other to ensure safe patient care and effective patient flow. Clinical teams adhering to the standards results in teams working better together in ‘high pace areas’ like the Emergency Department and on all the trusts wards.

All Ages

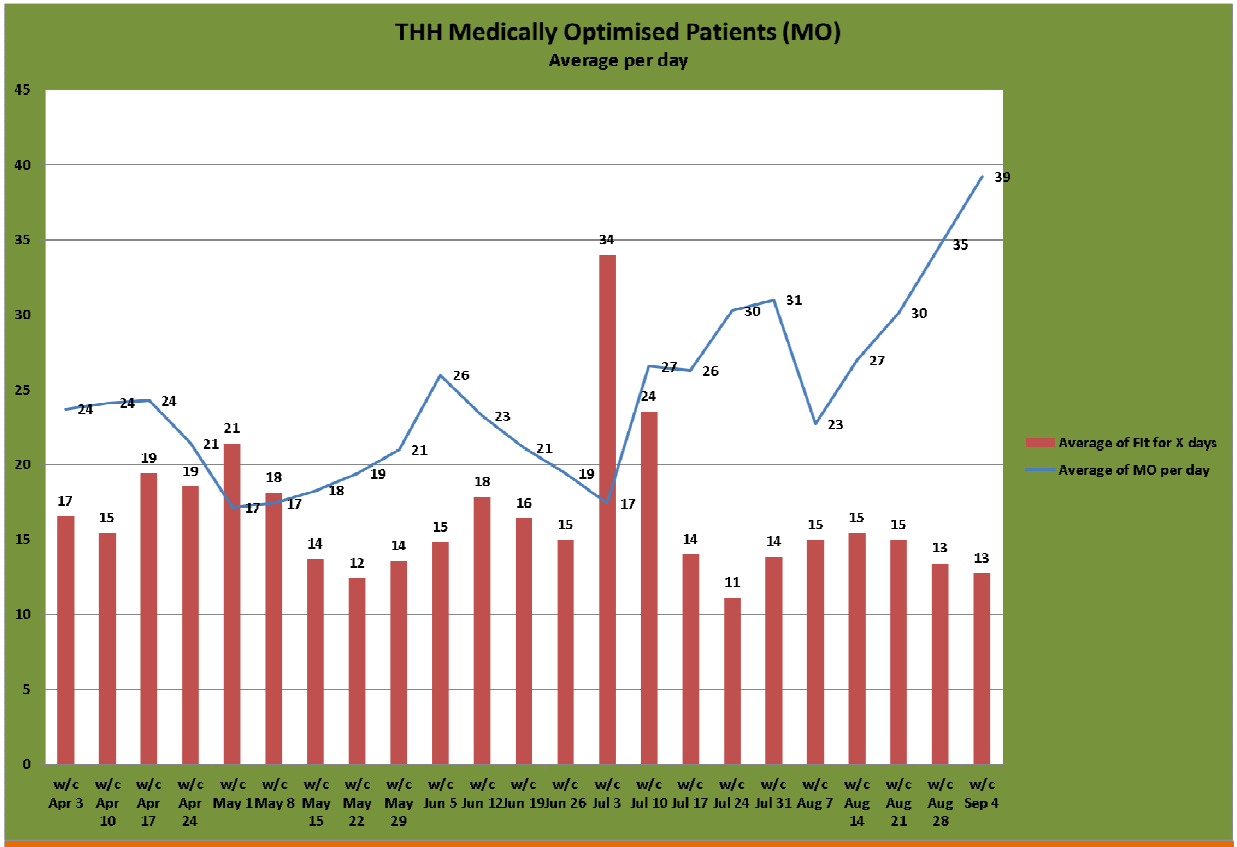
Red2Green Graphs

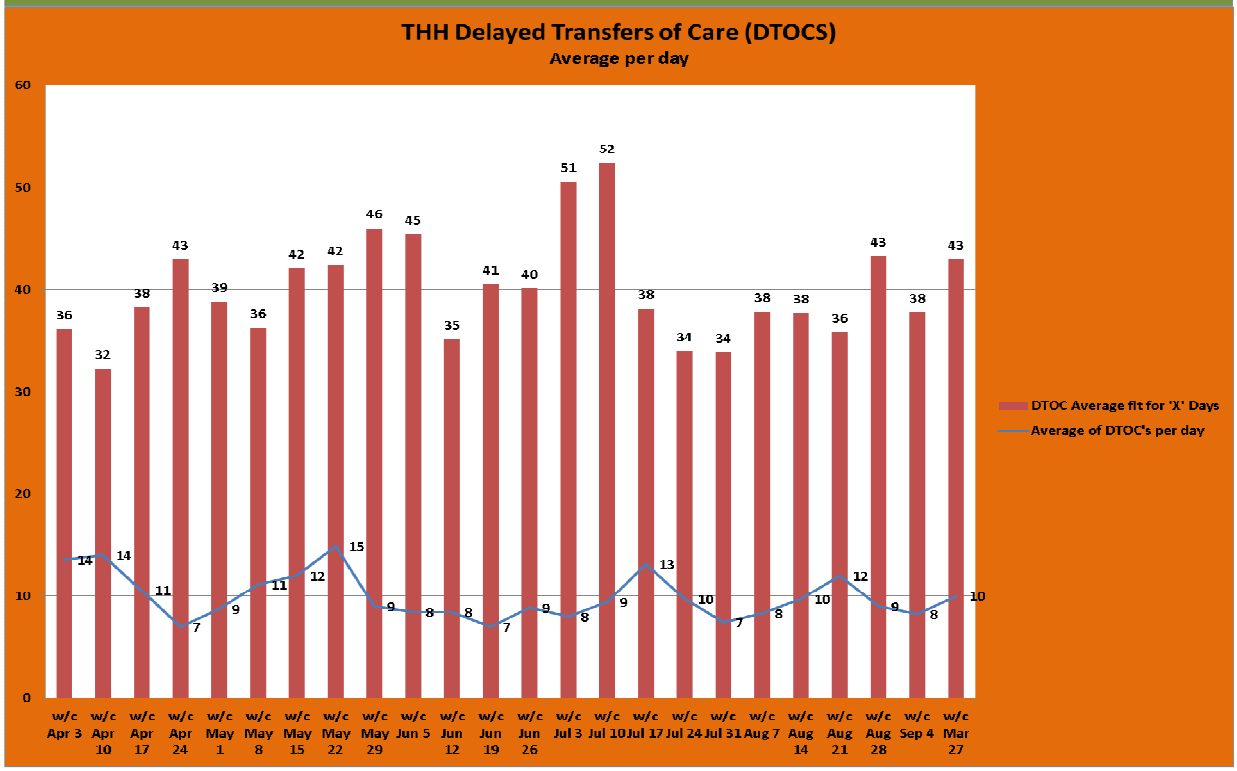






DTOC, MO Patients

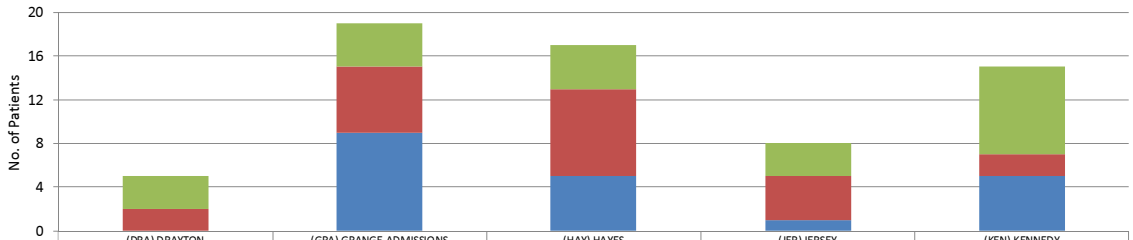




Review of Patients with Length of Stay over 7 Days

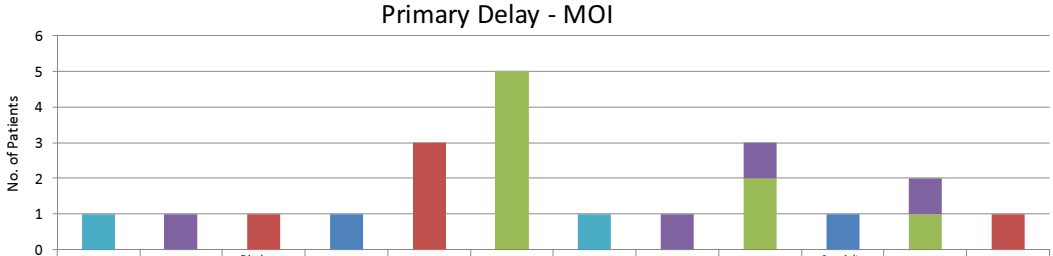
The Hillingdon Hospitals NHS
NHS Foundation Trust

Classifications by Ward



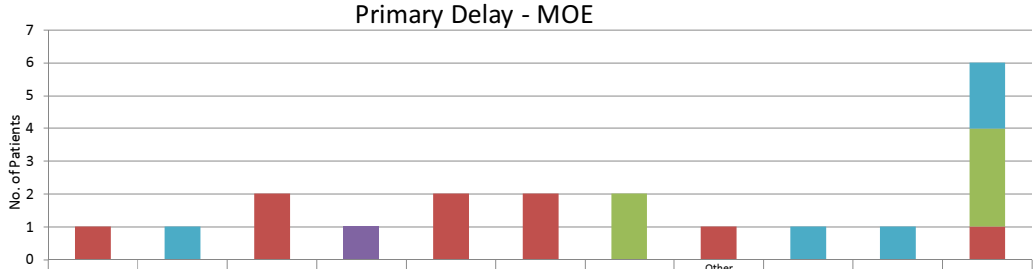
	(DRA) DRAYTON	(GRA) GRANGE-ADMISSIONS	(HAY) HAYES	(JER) JERSEY	(KEN) KENNEDY
MU	3	4	4	3	8
MOI	2	6	8	4	2
MOE		9	5	1	5

Primary Delay - MOI



	Assessment notification	Care Conference	Discharge requirement not identified	Equipment	LHNA	Occupational Therapy	Patient/family choice	Physiotherapy	Rehab ward transfer	Specialty (secondary) review	Specialty nurse review	X-Ray
(KEN) KENNEDY	1						1					
(JER) JERSEY		1						1	1		1	
(HAY) HAYES						5			2		1	
(GRA) GRANGE-ADMISSIONS			1		3							1
(DRA) DRAYTON				1						1		

Primary Delay - MOE



	Discharge requirement not identified	District Nurse	Equipment	External palliative bed transfer	Housing	LHNA	Nursing home assessment	Other investigation required - please comment	Package of care delay	Patient/family choice	Residential/Nursing home placement
(KEN) KENNEDY		1							1	1	2
(JER) JERSEY				1							
(HAY) HAYES							2				3
(GRA) GRANGE-ADMISSIONS	1		2		2	2		1			1
(DRA) DRAYTON											

HILLINGDON CLINICAL COMMISSIONING GROUP'S COMMISSIONING INTENTIONS 2018-2019

Relevant Board Member(s)	Dr Ian Goodman
Organisation	Hillingdon CCG
Report author	Sarah Walker, Assoc Dir QIPP Transformation & Planning
Papers with report	Appendix 1: DRAFT 2018/19 Commissioning Intentions

1. HEADLINE INFORMATION

Summary	This report sets out an overview of the HCCG's plans to commission high quality health care to improve the health outcomes for Hillingdon patients in 2017/18 and to set the scene for transforming these services over future years. The Commissioning Intentions (CIs) have been shared early with partners and matched against the priorities in Hillingdon's Sustainability and Transformation Plan, as well as the Joint Health and Wellbeing Strategy 2018-2021 (currently in draft). The final iteration of commissioning intentions will be signed off at the Governing Body meeting on 13 October 2017.
Contribution to plans and strategies	The CIs will be an important part of delivering against the Hillingdon STP which is integral to the North West London STP and based on the NHS five year forward view. The CIs are developed based on the Borough's Joint Strategic Needs Assessment (JSNA) and consistent with the Joint Health and Wellbeing Strategy (JHWS).
Financial Cost	There are no costs arising directly from this report.
Ward(s) affected	All

2. RECOMMENDATION

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

3. INFORMATION

Background Information

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

The identification and prioritisation of the CIs are based on:

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

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

This year's intentions carry forward the good work done in 2017/18 and to reflect the special circumstances of the two-year multi-year contracts required by regulators last year covering 2017/18 and 2018/19 financial years. The priorities therefore remain built around the agreed 10 priorities of Hillingdon's Sustainability and Transformation Plan together with the 6 enabling theme together with indicative expenditure against each theme.

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

Financial Implications

The financial implications of the CIs are in calculation at the time of this report due for end-September estimates, and a verbal update will be provided at the Board meeting.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

The CIs will be developed into contracting plans and form the foundation of STP delivery in 2017/18.

Consultation Carried Out or Required

The consultation undertaken to develop the CIs is set out in section 4.

Policy Overview Committee Comments

None at this stage.

5. BACKGROUND PAPERS

NIL.

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NHS
Hillingdon
Clinical Commissioning Group

Commissioning Intentions 2018/19

DRAFT September 2017

Content

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

Section 1a: About Hillingdon CCG

Hillingdon Clinical Commissioning Group (CCG) is the public agency responsible for purchasing most of the health services for the people of Hillingdon. We operate within a financial budget and aim to ensure that we use the money given to us to purchase health services that are appropriate, effective and safe and that offer value for money. Hillingdon CCG's role is to ensure that the health services in Hillingdon are designed in a manner that meets the highest possible standards of quality as well as the needs and reasonable expectations of our population now and prepares the way for changing health needs over the coming years. We are required to meet statutory financial obligations to remain in balance and maintain a 1% surplus. This document aims to set out how we will achieve these requirements in 2017-18.

**The population of Hillingdon includes all patients registered with a Hillingdon based GP and unregistered people resident in Hillingdon. Some elements of health care are commissioned by the London Borough of Hillingdon (LBH) and, particularly for Primary Care, other bodies such as NHS England (NHSE). In 2015/16 the CCG entered into an agreement around Co-Commissioning for Primary Care with NHS England (where the parties share responsibility for commissioning GP Based Services in Hillingdon) and this relationship continues to evolve.*

Section 1b: Aim of the Commissioning Intentions

The aim of these Commissioning Intentions is to provide an overview of Hillingdon CCG's plans to purchase (commission) high quality health care to improve the health outcomes for Hillingdon patients for the Financial Year 2017-18 (FY18/19) and to set the scene for how we envisage services transforming over future years. To develop these Commissioning Intentions we have talked to a wide range of local people including patients, carers and the wider public along with our providers of healthcare services and our members in General Practice. We have also drawn on a wide range of sources of information and feedback. In Hillingdon we are continuing to work towards establishing a model of 'accountable care' where we commission providers of services to work together to look after the needs of a whole population, rather than commissioning distinct services that can sometimes be fragmented and duplicative. 2017-18 will provide us with an opportunity to test the effectiveness of this approach with our local providers.

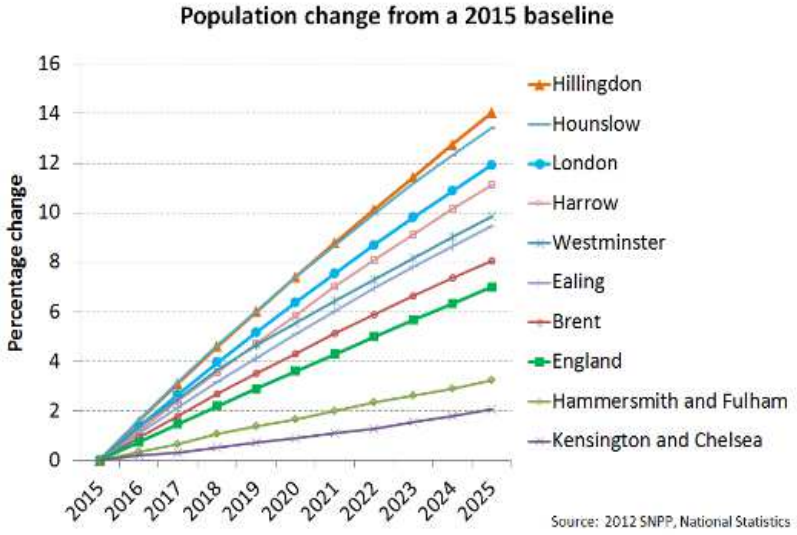
The Commissioning Intentions for 2017-18 is a living document that will evolve over time based on further engagement activities with the public, partners and providers. This document should also be read in conjunction with the Commissioning Intentions stated for NHS England (NHSE) and for the North West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

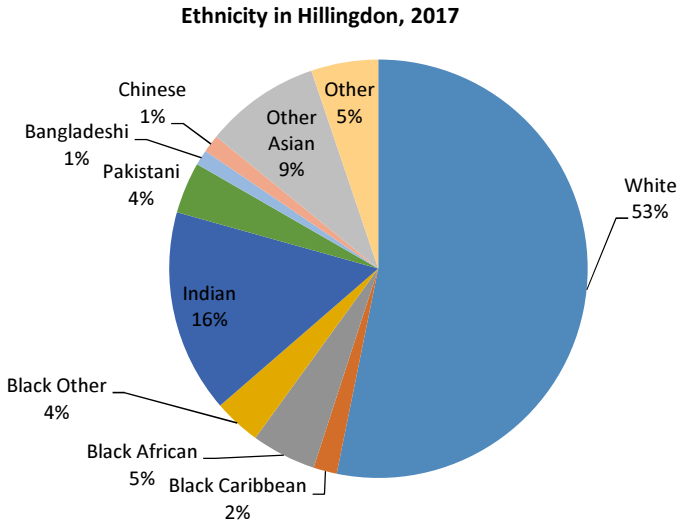
Section 2: The Health Landscape in Hillingdon

Section 2a: Demographics

Hillingdon is the second largest London borough by area, located 14 miles from central London with the 12th largest population. Projections from the Office for National Statistics (ONS) indicate the Hillingdon population in 2018 will be 314,300 with 23,200 (7.4%) aged 0-4 years, 41,500 (13.2%) aged 5-14 years, 208,400 (66.3%) aged 15-64 years, 21,700 (6.9%) aged 65-74, 13,100 (4.3%) aged 75-84, and 5,800 (1.8%) aged over 85. The age structure of the population in Hillingdon is intermediate between London and England, with a distribution that is slightly older than London as a whole but younger than England. Among children and young adults however, there is a larger proportion resident in Hillingdon than for both London and England. Growth of just over 13,300 residents is projected between 2018 and 2021, with the largest growth being those aged 15-64 (9,300 [4.5%]) and 5-14 (3,700 [8.8%]). However by proportion older people aged 75-84 (11.3% [1,500]) and aged 85 and over (15.6% [900]) will grow faster than other age groups. Comparatively, the population growth in Hillingdon is projected to be higher than any other North West London CCG and will be above both the average for London and England. Hillingdon is also an ethnically diverse borough with 46.9% of residents in 2017 from Black and Minority Ethnic (BAME) groups. Population projections for Hillingdon suggest that BAME groups are increasing as a proportion of the population, with 50.4% of residents from BAME groups by 2021.

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





Section 2b: Health profile

Overall, our health outcomes in Hillingdon are varied when compared to the average for England. Hillingdon compares well against the England average in many areas, with some positive indicators being:

- People living in Hillingdon live longer and healthier lives compared to the average for England.
- Adults in contact with secondary mental health services live in stable and adequate accommodation.
- Good levels of breastfeeding, which provides the best start in life for babies and leads to a healthier life, are higher in Hillingdon than the national average.
- A lower proportion of pregnant women in Hillingdon smoke, compared to the rest of England.
- Rates of teenage pregnancy in Hillingdon are similar to England average.
- Fewer people are admitted to hospitals in Hillingdon with an alcohol-related condition than the England average.
- Early death rates (under age 75) from respiratory diseases are lower than the England average.

However, this is just one part of the picture as some of our health outcomes are also significantly worse than the national averages.

- Rates of social isolation among social care users and their carers are still too high.
- Accommodation and employment needs of adults with learning disabilities are not being adequately met.
- A higher proportion of children aged 10-11 are overweight / obese as compared to the national average.
- Proportion of 5 year old children free from dental decay are significantly worse than the national average.
- Rates of childhood vaccination are lower than the national average.
- Proportion of adults who are physically active is lower than the national average.
- Deaths rates for men aged 75 or under from cardiovascular diseases is significantly higher than the England average.
- Cancer screening rates are low and the percentage of population being offered an NHS health check is low.

Furthermore, health status is not the same in all parts of Hillingdon, There are health inequalities, i.e. differences in life expectancy depending on where people are living in the borough. As a result that there is a difference of around 8 years in the life expectancy of people living in Botwell ward compared to people living in Eastcote and East Ruislip ward. Socio-economic circumstances have a complex relationship with unhealthy lifestyle choices which increase the risk of ill-health, including smoking, poor diet, lack of physical activity, higher levels of alcohol consumption and/or binge drinking. Our increasing frailty as we age also affects health and wellbeing. Over half of people aged 65 and over are diagnosed with multiple long term conditions, such as dementia,

which increases dependency on care and support. Some of us are born with conditions which might require long term care and management, including physical and/or learning disability, and child and adult mental illness.

Hillingdon's Joint Strategic Needs Assessment (JSNA) identifies key health and wellbeing needs of people in Hillingdon toward informing strategic prioritisation of health and care transformation programs. It is regularly updated with the latest available information to ensure our programs and priorities are able to respond to the changing needs of our population. Our JSNA is available to read online at http://www.hillingdon.gov.uk/jsna. The JSNA is a key document informing the priorities and outcomes in this strategy. The JSNA underpins Hillingdon's Joint Health and Wellbeing Strategy (JHWBS), which is the overarching local strategy roadmap to addressing health and wellbeing needs and outcomes in Hillingdon.

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

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

Section 3a: The National Strategic Context

In 2015, the NHS Five Year Forward View articulated a major shift in policy towards place based systems of care through Sustainability and Transformation Partnerships. The approach envisions health and care organisations taking joint responsibility for the health of an entire population, within a particular geographic area. The shift in policy follows a period during which time public providers of care services operated with a greater degree of autonomy and competition. The new policy context requires organisations to recognise their strategic role as central hubs in place based systems of care.

The Five Year Forward View further sets the Triple Aims of improving people's health and well-being, improving the quality of care that people receive and addressing the financial gap between the cost of expected services and planned budgets. This new approach across health and social care works to ensure that services are planned with a focus on the needs of people living in the area. As part of this new approach, the NHS recently organised itself into 44 Sustainability and Transformation Partnerships (STP) across England. Hillingdon is a member of the North West London STP (NWL STP). Through joined up STP working, the NHS will address population health and wellbeing needs through new ways of delivering care; better public health and prevention of ill health; joining up services across health and social care; empowering patients and communities; strengthening primary care; and achieving needed efficiencies in health and care services.

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

NHS organisations and local authorities of NWL STP have developed Sustainability and Transformation Plans, taking as its starting point the ambitions and knowledge in the national NHS Five Year Forward View strategy and applying them to the needs of the NWL STP. The NWL STP plan is characterised by broad and overarching themes common to each of the local areas to align local and regional goals. It aims to bring together local organisations to answer the challenge of delivering better health and care services according to the Triple Aims of the Five Year Forward View through nine priorities and five Delivery Areas. The NWL STP priorities and Delivery Areas are set out below.

North West London Priorities and Delivery Areas

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

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

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

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

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

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

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

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

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

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

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

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

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

The overarching outcomes of the TCP are to:

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

This is with view to:

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

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

Section 3e: The Local Financial Challenge

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

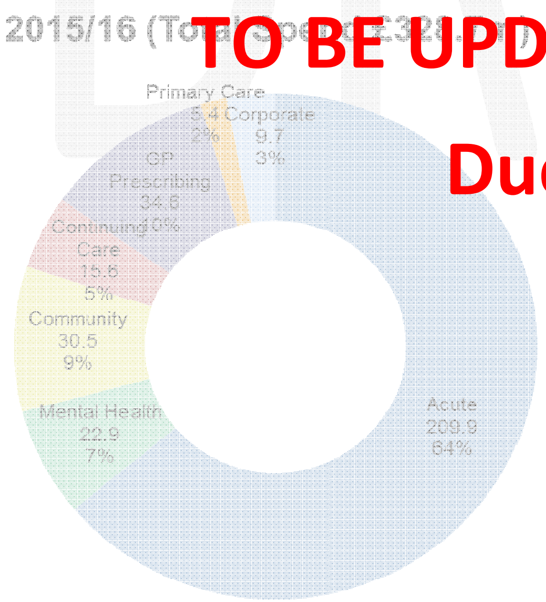
If we compare the expected growth in demand with the financial allocations we expect from NHS England over the next five years (this being the amount of money available to Hillingdon CCG to spend on healthcare services) we predict that Hillingdon CCG will develop a gap of ~£40m between now and 2020/21.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

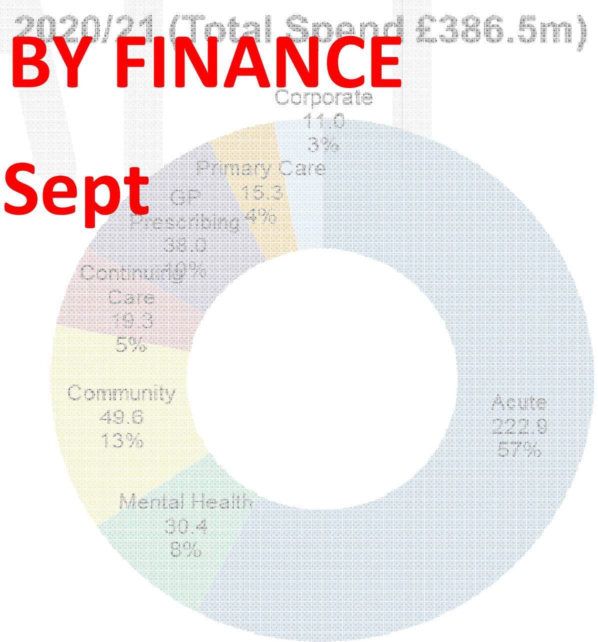
The following diagrams show how expenditure is likely to change based on projected allocations to the CCG over the period to 2020/21:

LOCAL FINANCIAL CHALLENGE

TO BE UPDATED BY FINANCE

Due end Sept





As mentioned, the growth in allocated funding for the CCG is expected to be less than the costs associated with the growth in demand. The savings (QIPP efficiencies) that are therefore required to ensure the CCG is sustainable are aligned to 10 Transformation Themes described in Section 7. Indicative efficiencies are stated for each year from 2016/17 to 2020/21. The reason for these figures being indicative is that it is difficult to fully disaggregate the expenditure for (say) Urgent & Emergency Care from the expenditure on Children & Young People as there is a significant overlap between the two. Both the QIPP targets stated in Section 7 and the estimated expenditure against each Theme stated below are therefore meant as an estimate and are both subject to change.

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

LOCAL FINANCIAL CHALLENGE

TO BE UPDATED BY FINANCE

Due end Sept

NET QIPP SAVINGS	16/17	17/18	18/19	19/20	20/21	Total
	£'000	£'000	£'000	£'000	£'000	£'000
QIPP						
Acute	(8,977)	(9,118)	(8,602)	(8,520)	(8,765)	(43,982)
MH	(483)	(500)	(507)	(583)	(596)	(2,528)
Community	(1,354)	(714)	(293)	(618)	(574)	(3,552)
CHC		(305)	(174)	(304)	(182)	(1,459)
Primary Care	(1,500)	(1,650)	(1,574)	(1,512)	(1,444)	(7,680)
Reprovision Costs	4,163	2,950	3,700	3,100	2,750	16,663
Total	(8,646)	(9,137)	(7,509)	(8,436)	(8,811)	(42,539)

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

	16/17 £'000	17/18 £'000	18/19 £'000	19/20 £'000	20/21 £'000	Total £'000	Total Activity
Acute QIPP PODs							
A&E	(173)	(544)	(454)	(453)	(453)	(2,076)	(18,135)
Non-Elective Spells	(4,329)	(4,647)	(5,083)	(4,503)	(5,056)	(23,617)	(11,787)
Elective Spells	(75)	(1,001)	(1,001)	(1,001)	(1,001)	(4,079)	(3,299)
1st Outpatient attendances	(787)	(581)	(533)	(432)	(605)	(2,938)	(17,995)
All Subsequent Outpatient attendances	(1,298)	(1,276)	(1,203)	(1,102)	(1,124)	(6,004)	(58,586)
Other	(2,315)	(1,966)	(525)	(1,029)	(526)	(5,267)	(8,995)
Total	(8,977)	(10,014)	(8,802)	(8,520)	(8,765)	(43,982)	

LOCAL FINANCIAL CHALLENGE

TO BE UPDATED BY FINANCE

Due end Sept

Section 3f: Responding to Local Challenges

The previous section outlined the financial challenge faced by the CCG in the forthcoming years. To enable the CCG and our partners to continue to be able to deliver high quality, accessible services then we will need to change the way that patients are identified, supported, informed and involved including through the ways described below:

1. Proactively identifying people at risk of developing disease and ill-health and supporting them to avoid developing Long Term Conditions.
2. Managing people with Long Term Conditions to keep them stable and healthy for longer and therefore reducing the need for hospital based services.
3. Ensuring that people with an urgent or unplanned need are treated in the most appropriate setting which may not be at hospital.
4. Working across health and social care boundaries to provide truly integrated services for children, people with a mental health need and older people.
5. Moving services out of hospital into lower cost settings where appropriate.

To support the changes in our services outlined above we intend to test a new way of commissioning our providers that enables staff from different services and organisations to work together, delivering care that is centred on the patient without different funding streams, organisational targets and incentives getting in the way. **[UPDATE ON ACP TBC AFTER SEPTEMBER WORKSHOP]**

Transformation Plan (STP) and what we wish to do locally Hillingdon CCG has built the 18/19 Commissioning Intentions around 10 Transformation Themes and 6 Enabling Themes. The full list of the Transformation and Enabling Themes are detailed below and are expanded upon in Section 7:

Transformation Themes	
T1. Transforming Care for Older People	**T6. Supporting People with Serious Mental Illness and those with Learning Disabilities**
T2. New Primary Care Model of Care	**T7. Integrated Care for Children & Young People**
T3. Integrating Services for People at the End of their Life	**T8. Integration across the Urgent & Emergency Care System**
T4. Integrated Support for People with Long Term Condition (LTCs)	**T9. Public Health and Prevention of Disease & Ill-Health**
T5. Transforming Care for People with Cancer	**T10. Transformation in Local Services**
Enabling Themes	
E1. Developing the Digital Environment	**E4. Delivering Our Statutory Targets Reliably**
E2. Creating the Workforce for the Future	**E5. Medicines Management**
E3. Delivering Our Strategic Estates Priorities	**E6. Redefining the Provider Market**

These Themes (Transformation & Enabling) are aligned to the 22 Improvement Areas stated within the NWL STP as shown in the table below:

NWL STP Improvement Area	Main Alignment To The Hillingdon CCG Transformation & Enabling Themes
1. Enabling & Supporting Healthier Living	All 10 Transformation Themes
2. Wider Determinants of Health Interventions	(T4) (T9)
3. Helping Children To Get The Best Start In Life	(T7)
4. Address Social Isolation	(T1) (T4) (T5) (T9)
5. Improve Cancer Screening To Increase Early Diagnosis & Faster Treatment	(T5)
6. Better Outcomes & Support For People With Common Mental Health Needs, With A Focus On People With Long Term Physical Health Conditions	(T4)
7. Reducing Variation By Focusing On RightCare Priority Areas	(T2)(T4)(T5)(T9)(T10)
8. Improve Self-Management & "Patient Activation"	(T4)
9. Improve Market Management & Take A Whole Systems Approach To Commissioning	(T10)(E6)
10. Implement Accountable Care Partnerships	(E6)
11. Implement New Models of Local Services Integrated Care To Achieve Consistent Outcomes & Standards	(T1)(T2)(T3)(T8)(E4)(E5)
12. Upgrade Rapid Response & Intermediate Care Services	(T1)(T8)
13. Create A Single Discharge Approach & Process Across North West London	(T1)(T8)(T10)
14. Improve Care In The Last Phase Of Life	(T3)
15. Implement The New Model Of Care For People With Serious & Long Term Mental Health Needs To Improve Physical & Mental Health & Increase Life Expectancy	(T6)(E5)
16. Address The Wider Determinants Of Health	(T1)(T4)(T9)
17. Deliver Crisis Support Services Including Delivering The 'Crisis Care Concordat'	(T6)(T8)
18. Implementing "Future In Mind" To Improve Children's Mental Health & Wellbeing	(T4)(T7)
19. Specialised Commissioning To Improve Pathways From Primary Care & Support Consolidation Of Specialised Services	(T2)(T10)(E5)
20. Deliver The 7 Day Services Standards	(T10)(E4)
21. Reconfigure Acute Services	(T8)(T10)(E4)
22. Deliver The North West London Productivity Programme	All Transformation & Enabling Themes

Section 4: Listening to the Voice of Local People

Engagement has been a journey for Hillingdon. It started in 2012 with the formation of CCGs. The focus on membership engagement was necessary to first agree the principles that would be set out in the CCGs constitution. The process taken to agree the constitution paved the way and the CCGs approach to public engagement and involvement. Now in its fifth year of operation the CCGs approach to engagement has matured enabling the organisation to offer a tailored approach to the gathering and feeding back of patient, public and member intelligence.

For example patients, members of the public and CCG members told us:

- They needed a more in-depth Hillingdon-specific data set to understand the needs of the different communities across Hillingdon
- The CCG needs to engage with voluntary sector organisations who also manage patients and policies across Hillingdon
- The CCG needs to inform every one of the changes to their GP services and get their views on what is needed
- You wanted to further engage with residents of both Heathrow Villages and the traveller populations so that service specification recommendations could be reflective of this disempowered cohort

So we:

- Designed and delivered a successful targeted engagement strategy to specifically involve and include the diverse population across the borough
- Identified and nurtured relationships with key stakeholders from local and national patient facing organisations, engaging via various platforms including face to face and digitally, to both learn from their experiences with Hillingdon residents and engage outwards with our parallel patient engagement opportunities.
- Designed and implemented a communication and engagement strategy to inform and empower patients of both relevant practices, to invite and listen to their views, and to feedback regularly on the various stages of the consultation and decision making process.
- Reached out to these communities and had conversations with key stakeholders from the community action groups and public representation organisations, as well as the council and desk based research into current provision and demographics. We collated this information and data into a key recommendation which has been adopted in the final service specifications.

In summary NHS Hillingdon CCG want every resident and member to have a voice, to know, by evidence of the CCGs actions and not just from writing on a PowerPoint presentation that their involvement is respected and that their views can and will support the transformation and longevity of local health services. To do this the CCG have been and will continue to work in a way that will meet and exceed the outcomes of this vision. We will be flexible with our approach by tailoring its methods and reviewing its equality and diversity approach regularly to constantly align with changing plans and demographics of Hillingdon.

Section 5: Our Local Quality Priorities

Section 5a: Our Vision for Quality: 'Improving quality creating consistency'

We believe that the people of Hillingdon are entitled to a high quality and safe experience in any of the healthcare services commissioned by Hillingdon CCG. We will continue to listen to our patients and carers and work with all our service providers to achieve continuous improvement and reduce variation in the quality of their services.

Our quality duty is a statutory obligation and we consider we are well placed to assure people about the quality of the health services they commission. This is because we:

- Are a clinically led commissioning organisation
- Have in-depth knowledge about local health services and communities
- Involve local people in the design of healthcare services and receive and analyse their feedback
- Are dedicated to placing quality at the heart of commissioning activities
- Work in close partnership with other commissioners

We will ensure learning from our quality and safety assurance processes is triangulated from a variety of sources to inform what high quality, safe and effective care looks like across the Borough of Hillingdon.

From our engagement sessions we have learnt that the following are key priorities for our patients and carers:

Key priority for our patients and carers	What We Will Do
Provide Seamless Services Across Providers	We will continue to foster partnership working across organisations both through our on-going Clinical Quality Review Group structure and through the development of our Accountable Care Partnership. The development of the Sustainability & Transformation Plan for North West London has also given us the opportunity to work with partners to understand how we can improve services. Lastly, we will continue to progress the existing integrated care services we have already introduced and those we are planning including for people at End of Life and those for people with various Long Term Conditions.
Improve partnership working across health and social care services	We will continue to share ideas and discuss opportunities with our social care partners and have various forums for this to occur within. We are exploring additional opportunities for joint working and joint commissioning with a focus on Children and Young People as well as services provided for older people.
Rapidly reduce the variation in care received across and within providers	This is a major reason for the work we have done to date to integrate services for people with Long Term Conditions (which include Diabetes, Respiratory Diseases and Cardiology). We will extend this work and will also be working with Primary Care Colleagues to develop a new Model of Care for Primary Care and a joint Prevention Strategy that will focus on both primary prevention (preventing disease and ill-health) and improving outcomes for people with Long Term Conditions once diagnosed.
Be open and transparent and be honest when things do not go as planned	We continue to undertake audits and to manage complaints we receive robustly. We monitor provider quality through our Clinical Quality Groups and constantly review whether we are seeking sufficient and appropriate assurance of the quality they are receiving, something we obtain through direct and indirect patient feedback as well as a range of quality indicators.
Ensure care is delivered with compassion and that it is personalised to the needs of each person	We will monitor and review the trends and themes from our provider patient experience teams which includes; complaints, friends and family test results and patient surveys. Any concerns in relation to these will be explored via the Clinical Quality Review Group.
Ensure providers continue to have a safe and skilled workforce that feel valued in their work	We will continue to monitor the providers' safer staffing reports and their staff surveys via the Clinical Quality Review Groups and seek assurances and actions when there are concerns raised in relation to the workforce.

Section 5b: Our Quality Principles

The CCG Quality and Safety team apply the following principles to all of the work done within the CCG:

- Apply systematic approaches to monitoring and improving quality with the patient at the centre and with them in the line of sight.
- Proactively address any organisational barriers which hinder quality of care.
- Foster an open and transparent culture across the local health system.
- Maintain a systematic approach to proactive and early identification of service quality failures.
- Ensure there are robust links between commissioning priorities, the strategy and transformation plans and quality.
- Prioritise our quality assurance and improvement efforts developing an integrated approach with social care to reflect the Better Care Fund changes.
- Drive effective engagement with key stakeholders across BHH to achieve the delivery of robust measurable outcomes that reflect *"what matters most to patients".*
- Build work streams to define robust integrated quality & safety indicators that will deliver agreed Place Based outcomes.
- Ensure evidence based guidance & learning from assurance processes across Health and Social Care underpin & inform the design of outcomes to support place based care.
- Ensure "I statements" from patients, families and carers engagement events are reflected in indicators and outcomes when redesigning services and measures.
- Ensure that governance and assurance mechanisms are appropriate to support "Place based" commissioning between the local authority and the CCG including: integrated pathways, integrated contractual monitoring (CQRG), integrated assurance visits, shared quality improvement plans.
- Embed the application of Quality Impact Assessment methodologies across Local Authority and CCG **QIPP (Quality, Innovation, Productivity and Prevention**) & financial plans including commissioned providers.

As an integral part of the commissioning process we will monitor the impact of our intentions and the quality improvements to services on a regular basis. We will do this via a series of quality and health impact and outcome assessments including carers impact assessments.

Everything we do is focused on delivering high quality care for the population we serve and these Commissioning Intentions have been written to align with our vision, priorities and principles.

Section 5c: Safeguarding

Hillingdon CCG has the required professionals, roles, systems and processes in place to protect and safeguard vulnerable children and adults. There are safeguarding strategy and policies available on the CCG website for further information. The CCG's quality governance roles and committees oversee reporting and monitoring of compliance with safeguarding requirements.

We will:

- Continue to be active members of Hillingdon Safeguarding Adults Boards and Safeguarding Children's Boards and ensuing task and finish groups.
- Continue to work together with Quality and Safety colleagues to ensure valuable learning and triangulation of data is effectively utilised alongside Safeguarding alerts and concerns.
- Work in close affiliation to the Continuing Healthcare team who manage and support some of the most vulnerable people in the community.
- Have joint meetings, alignment of complaints, serious incident and Never Event data, and feedback from quality assurance processes such as Clinical Quality Assurance Visits, CQG meetings etc. This will involve the coproduction of systems and processes to enable the timely sharing of such information.
- Participate in any Reviews relating to Adults or Children e.g. Domestic Homicide Reviews, Serious Adult Reviews or Serious Case Reviews and ensure that the CCG and Provider organisations complete all actions.

Our Safeguarding Priorities	What We Will Do
Listening to children & young people and adults at risk	• Work with children's services to review the needs of all Hillingdon's children and young people especially those with additional needs; children looked after and those involved with the youth offending services. • Make Safeguarding Personal (MSP) by involving adults at risk in safeguarding decision making • Ensure compliance with The Mental Capacity Act 2005; The Deprivation of Liberty Safeguards (DOLS, 2009/2014), and The Care Act 2014 • Ensure that this vulnerable group is consulted when new or changes in existing services are being considered/planned.
Safeguarding Education and Training (Adults & Children)	• Continue to monitor and challenge Providers of contracted services to comply with safeguarding responsibilities and achieve expected targets e.g. Training. • Safeguarding Children and Adults training should also include Child Sexual Exploitation (CSE), Female Genital Mutilation (FGM), Domestic Violence and Abuse, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS • CCG staff will also be compliant with the required safeguarding training • Gain assurance that lessons learnt from DHRs, SARs, SCRs, Incidents and complaints are disseminated throughout organisations. • Support the Safeguarding Adult Board in the provision of a multi-agency training programme
Safeguarding Medicals	• Continue to work with the commissioner and providers (community and acute) to ensure that robust arrangements are in place.

PREVENT	• Ensure training is delivered to staff that is commensurable to their level of responsibility as per the NHS England competency Framework. • Ensure that both Commissioner and Provider organisations are compliant with the Counter Terrorism and Security Act (2015) and the related Prevent Duty Guidance. • Ensure compliance with DHR actions and NICE Guidance for anti social personality disorder prevention and management
Domestic Violence and abuse	• Monitor compliance with Nice Guidance (2014/ph50; 2017) to ensure that staff are trained and that victims and families at risk are identified, assessed and referred for appropriate care. • Monitor number of victims identified by all providers, ensure that a system is in place to flag high risk victims and that their Policy reflects locally agreed pathways e.g. IRIS and IDVA service in a Health setting
Work with the sector to provide an evidence and needs base for CSE	• Working across North West London to develop a comprehensive and easily accessible service provision for children at risk of, or suffering as a result of, Child Sexual Exploitation (CSE), Child Sexual Abuse (CSA) or Female Genital Mutilation (FGM).
Information Sharing	• Continue to highlight responsibilities and importance of information sharing and support the CCG and providers to share information appropriately. Adhere to the Multi agency Safeguarding information sharing guidance and the relevant GMC Guidance.
Young Offenders, Looked After Children and Children with Disabilities and Additional Needs	• Work with children's services to ensure their health needs are identified and met. • Work with the providers to ensure they understand their roles and responsibilities.
Reduce the incidence of Pressure Ulcers	• Monitor compliance of Nice Guidance (2014) to ensure that staff are taking preventable measures to reduce pressure ulcer risks and are considering a safeguarding referral on review
Ensure adults at risk are protected from avoidable harm.	• Monitor providers adherence to the Care Act 2014 in relation to prevention of harm, promoting an outcomes approach to safeguarding and compliance with NHS England Safeguarding Vulnerable People in the NHS Accountability & Assurance Framework 2015
Medication	• Monitoring providers through Quality Review meetings in relation to adult safeguarding concerns being considered for medication incidents.
Learning Disability Mortality Reviews	• Ensure providers have the correct processes in place to be compliant in carrying out a Learning Disability Mortality Review • Monitor providers regarding NHS England Learning Disability Mortality Review Programme and embedding any lessons learnt.

Section 6: The Provider Market in Hillingdon

Hillingdon CCG is responsible for the commissioning of the majority of healthcare related services in Hillingdon. These services are delivered by a variety of different organisations (providers) in different settings (such as hospitals, community clinics and GP practices) but also includes services delivered by Carers, Voluntary and Third Sector partners in a variety of domestic and other settings and collectively these organisations and partners along with services commissioned by NHS England and our Local Authority (The London Borough of Hillingdon) form 'The Provider Market'. This section provides an overview of the Provider Market in Hillingdon as it stands today and gives a look forward as to our intentions for 2018/19.

Section 6a: The Current Provider Market

This section provides an overview of the current situation of the main aspects of the provider market in Hillingdon.

Primary Care

Primary Care services are predominantly those delivered by GPs in practices and until recently were mostly commissioned by NHS England. This approach is changing with *delegated commissioning* where the responsibilities for commissioning, monitoring and assuring primary care services will be shared between CCGs and NHS England. Hillingdon CCG having taken on delegated commissioning of primary care in 2018/19. There are currently 46 GP Practices within Hillingdon and these (with the exception of two practices) are organised into four GP Networks which provide opportunities for shared learning, capacity building on a scale greater than an individual practice and also for developing and delivering new services. The vast majority of GP Practices provide their own Out of Hours support to patients with only a minority 'opted out' which places the responsibility for provision with the CCG. More recently Hillingdon GPs have inaugurated a GP Confederation to represent their interests in the borough and through which Hillingdon CCG can engage with regarding at-scale primary care transformation and delivering the priorities of the GP Forward View. Primary care services also include our recently opened Hubs, pharmacy, dental, and optical, among other services.

Community Services

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

Mental Health Services

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

Hospital Based Acute Care

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

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

In addition to being the leads on the contracts for THH and RBH, Hillingdon CCG is also an associate commissioner on the contracts for other acute trusts where our residents receive care. We work closely with the lead commissioners of those trusts to ensure that the commissioning intentions laid out here are applied across all providers from which our residents access care.

Voluntary & Third Sector

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

Local Authority Commissioned Services

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

Carers

We must not forget the valuable contribution made by carers of all types who support individuals of all ages and greatly add to their quality of life and the outcomes they experience.

Section 6b: Our Intentions for 2018-19

This section provides a high level overview of our Commissioning Intentions for 2018-19 in respect to the Provider Market. This lists on the left what we intend to do and on the right the expected benefits to the population we serve.

General Intentions (Applicable to all Providers)	
• We expect all providers to make full use of eReferrals and aim to eliminate any referrals issued via other means. No referrals should be made by fax. • We expect all NHS providers to utilise EMIS compatible systems to access, update and use a full Shared Care Record that is integrated across Health and Social Care to improve patient care. This goes beyond the limited expectations set out for the Summary Care Record (SCR). • We will implement a schedule of clinical and quality audits guided by anomalous activity, CQC reports, patient feedback or other sources. • We will explore opportunities across NWL with partner commissioners to undertake joined up procurement of services that may benefit from at-scale provision • We will seek to procure pathways of care to focus operational resource, accountability, and strategic development of services through service consolidation	**What does this mean for the population we serve?** • Referrals sent immediately and with less chance of being 'lost' • Improved data sharing between clinicians enabling care to be better coordinated. • Improve quality of care provided from different healthcare organisations and more assurance that the CCG is commissioning high quality services.
Integration	
• The CCG is committed to the concept of an Accountable Care Partnership (ACP) or similar structure as outlined in the NHS Five Year Forward View. We tested the clinical model of care in 2017-18 in anticipatory care and escalated care for the older population aged 65 years and over. We also commenced design work further development of care models including the discharge to assess and frailty pathways. We have agreed a baseline for services in scope and intend to move to a capitated payment model based on the outcomes of the assurance process for 2017-18 progress. Through this process we will expect providers involved in the ACP to contribute to the delivery of the three main NHS challenges (Health & Wellbeing, Care & Quality & Finance & Efficiency) and also address how membership of the ACP can flex and change if needed over time. **UPDATE DUE AFTER SEPT W/SHOP**	**What does this mean for the population we serve?** • A joined up, integrated and coordinated health care system across all health care providers in Hillingdon including voluntary and third sector providers. • Improved coordination of services across health and social care.

• In line with the Commissioning Standards for Urgent & Emergency Care (UEC) we will be seeking to design and commission Integrated Urgent Care services to improve the coordination of care between the various elements including the NHS 111, Urgent Treatment Centre, GP Out of Hours and A&E based services.	• A coordinated and capable urgent care system that will improve access to information to enable clinicians to make timely and appropriate decisions.
• Greater integration across care settings will need to be supported by the evolution of shared care records (including the NWL Diagnostic Cloud) across health and social care and work on this will continue into 18/19 and on-going delivery of our Better Care Fund (BCF) plan.	
• The CCG is also committed to seeking additional opportunities to jointly commission services with our local authority and to the delivery of the joint objectives outlined in our Better Care Fund programme.	
Primary Care	
• We will continue to support the development of our GP networks and GP Confederation and will work with them to design, shape and deliver a new Model of Care for Primary Care that sees them playing an essential role in supporting our Out of Hospital Strategy and an increasingly important role in supporting patients with Long Term Conditions to self-manage elements of their care.	**What does this mean for the population we serve?** • Improved access to Primary Care particularly for those with complex needs and a reduction in the variation of care received by people with Long Term Conditions. • Better coordination between Social, Primary, Community and Secondary (hospital) care and improved sharing of appropriate information to enable clinicians to make appropriate and timely decisions.
• The new Model of Care will include current commissioned services including the Integrated Care Programme (ICP) and a new approach to the Primary Care Contracts (PCCs) and various other contracts we hold with practices as well as new services focused on supporting Older People and those with Long Term Conditions.	
• We will continue with our local delivery plan for the strategic commissioning framework for primary care (as set out by NHS England) that focusses on accessible, proactive and coordinated care	
• We remain committed to supporting Primary Care in areas such as access, premises and workforce development to enable practices to support the CCG's Out of Hospital and QIPP Agendas.	
• We will work with acute and urgent care services to support the delivery of local services strategy actions and outcomes, as well as the integrated urgent care agenda.	

Community Care	
• We recognise that service specifications that were written in the past may not now reflect the way forward and as such need to be revised in line with the direction of travel for the CCG.	**What does this mean for the population we serve?** • Services redesigned to meet the future needs of our population and which are integrated fully with other provider organisations. • More services delivered closer to home.
• We will work with our main Community Provider (CNWL) on how they can support our need to move more activity out of hospital and to align Community Services to the emerging Primary Care Model of Care and Older People Model of Care and to embed and expand the existing work around supporting people with Long Term Conditions.	
• We will continue to work closely with CNWL on the delivery of the efficiencies within the contract and also additional, opportunistic, efficiencies.	
Mental Health	
• We will continue to work collaboratively with the main provider of Mental Health Services CNWL to develop cost effective high quality services in the borough, evaluating the impact on the whole Mental Health system of the Business Cases approved in 2015/16.	**What does this mean for the population we serve?** • Improved access to Mental Health Services for people of all ages whether they have a need that is unplanned or planned. • Improved outcomes for the investment we make in Mental Health services.
• We expect to see a positive impact of additional investment in perinatal services in line with the 5 year Implementation Plan.	
• We expect Talking Therapy Services to achieve the Access and Recovery Targets within existing resources, Early Intervention in Psychosis Services to meet national targets and agreed outcome measures and the full implementation of the Hillingdon Dementia Action Plan.	
• We will continue to roll out the 5 year CAMHS Transformation Programme and will expect to see a reduction in local waiting times and the number of admissions to Out Of Area (OOA) Tier 4 services.	
• We will work in partnership with key stakeholders to develop a fully integrated Children and Young Peoples Mental health Service from wellbeing and prevention to specialist interventions	
• We will expect to see evidence of a reduction in psychiatric admissions via A&E and to see a positive impact of additional investment in Learning Disability Services.	
• We anticipate the local development of Employment support services embedded in both Talking Therapies and Primary Care plus Services in line with the Trailblazer Employment initiative.	
• In conjunction with the Local Authority we expect to see the development of a comprehensive Rehabilitation Pathway.	

• We will work in partnership to expand the Primary Care Plus service to full coverage across the Borough.	
• We will expect to see a positive impact on reducing Bed numbers following investment in the Urgent Care Business Case.	
• We will work in partnership to develop a Personality Disorder Pathway.	
• We will work in partnership to implement the Like Minded 5 Year Vision for services for people with Serious and Long Term Mental Health problems, Common Mental Health problems, Primary Care, Wellbeing and Health Promotion.	
• We will work in partnership to lay the foundations to ensure we are best placed to achieve the vision for the delivery of services over the coming years to 2020/21 as set out in the Five Year Forward View for Mental Health.	
Hospital Based Acute Care	
• We will work with our main acute provider (THH) to consistently achieve our Operating Plan priorities around A&E Performance, Referral to Treatment (RTT) Targets and those associated with Cancer and Diagnostics.	**What does this mean for the population we serve?** • Continued delivery of our access and quality targets. • Improved access to services delivered both 7 days per week and, where appropriate, "Out of Hospital" and nearer to patients' homes. • Improved access to clinical information across organisations to improve clinical decision making and ultimately improve outcomes for patients.
• We will seek to move more activity out of hospital where possible and to transform our local pathways so that patients who do not need to be treated in hospital are treated in a more appropriate setting in line with the NWL Local Services Strategy.	
• We will work to embed our existing Integrated Services for people with Long Term Conditions and seek new opportunities to improve outcomes for people living with LTCs, for example extending access to Talking Therapy IAPT services for people with LTCs such as Diabetes, COPD and Cancer as set out in the Hillingdon CCG Cancer Improvement Plan.	
• We will focus attention on the Community Assessment & Treatment Services (CATS) delivered by THH to ensure they continue to deliver our Out of Hospital aspirations and will focus on developing new CATS for Gastroenterology and Neurology Services.	
• We will work to achieve relevant 7 Day Standards in partnership with THH.	

• We will use and build upon the RightCare analysis undertaken to commission care that brings the quality, effectiveness and efficiency of our services in line with best practice in our peer group. In the first instance this involves a focus on MSK, Diabetes, Cardiology, Circulatory, Respiratory Disease, Cancer, and Neurology pathways.	
• We will be seeking to improve the coding of appropriate co-morbidities with THH so as to improve the ability of the CCG to plan services and access data, particularly in relation to Long Term Conditions such as Diabetes, Cardiology and Respiratory.	
Carers, Voluntary & Third Sector	
• We will seek to strengthen the voluntary and third sector involvement in delivery of services and to integrate where them into the ACO where appropriate.	**What does this mean for the population we serve?** • Improved support to carers. • Improved coordination of support across health care and the third sector which will lead to improvements in wellbeing as well as health.
• We will assess the impact of the Health & Wellbeing Service delivered by Hillingdon for All (H4All) and determine whether this will continue to be funded.	
• We will seek to achieve all of our obligations to carers as defined in the Care Act 2014 and to support young carers (those under 18) in collaboration with our Local Authority colleagues.	
Service for Children and Young People:	
• We will continue to work with the Local Authority to deliver our obligations as defined in the Children & Family Act 2014 integrating services and co-producing redesign with children young people their families and carers as part of our five year plan. This will involve proactively working with children and young people and ensuring that their voice is clearly heard in the design of services to support them.	**What does this mean for the population we serve?** • Improved integration in the support of Children and Young People across health providers and across health and social care which will ultimately lead to improved outcomes.

Section 7: 2018-19 Commissioning Intentions

As stated in Section 3 our Commissioning Intentions for 2017-18 are focused on the delivery of 10 Transformation Themes supported by 6 Enabling Themes and this section provides a breakdown of our intentions for each of these and how they will contribute to our priorities and objectives including an **indicative** QIPP efficiency (saving) associated with each Transformation Theme and one of the Enabling Themes.

<table>
<tr><th colspan="3">1. New Model of Care for Older People</th></tr>
<tr><th>2020/21 Outcomes</th><th>Commissioning Intentions 18/19</th><th>Indicative Commissioning Intentions Beyond 18/19</th></tr>
<tr>
<td>By 2020/21 we will be delivering the following outcomes:
Coordinated Care for Older Peoples' Planned & Unplanned Care Needs across Care Settings
Improved Health Outcomes and reducing Unplanned Care needs through focusing on LTCs and age related complicating factors such as frailty
Integrated Health & Social Care support for those patients who need it
Empowering people to plan for their own care
A diverse market of quality care providers maximising choice for local people who have complex needs covering both older people and other vulnerable groups</td>
<td>We will:
Enhance and embed the capacity and capability of the Care Connection Teams in Hillingdon
Develop new 'Core Offer' for Care Homes and extra care sheltered housing, including support for the EMI and people with SMI and Dementia with Challenging Behaviours as part of BCF
Improve coordination between health and social care around support from Continuing Health Care (CHC)
Continue to develop and embed the integrated model of care for older people including self-care (PAM)
Implement an integrated, shared care record across health and social care
Develop and implement frailty pathway aligning with new discharge pathways including Home2Assess as well as support for carers
Undertake integrated commissioning and brokerage with partners, including joint specifications
Integrating End of Life projects with Older Peoples agenda</td>
<td>We will:
Progress the next phase of an integrated system for older people including transition to capitated payment and outcome based commissioning.
Commission a single integrated system of care via a full capitated budget.</td>
</tr>
<tr><th>Measuring Success</th><th>Supporting the Integration Agenda</th><th>Supporting Strategies & Assurance</th></tr>
<tr>
<td>Delivery of this Transformation Theme will realise:
Reduction in Non-Elective Admissions for people aged >65 years old
Reduction in Zero-Length of Stay Admissions for people aged >65 years old
Reduction in overall costs associated with supporting Older People</td>
<td>The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:
Joint projects with regard to Care Homes, extra care Sheltered Housing and Home Care between LBH and HCCG
Specifying and commissioning of a framework of services for older people as part of the development of the ACO</td>
<td>The work for this Transformation Theme is underpinned by the following strategies:
Whole System Integrated Care Strategy
Better Care Fund
Local Digital Roadmap
The delivery of this Transformation Theme will be managed and monitored via the Older People's Delivery Group which in turn reports to the Transformation Group.</td>
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2. New Primary Care Model of Care

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19

By 2020/21 we will be delivering the following outcomes:
 	
• Strengthened primary care provider landscape able to deliver new primary care models of care primary care services at scale
• Increasing number of people cared for and supported outside of the hospital setting with integration across Primary, Community & Secondary Care Services and Social Care
• Improved access to routine and unplanned services in primary care during the week, evenings and weekends
• Reduced variation in service and patient outcomes in primary care via outcomes based commissioning
• Sustainable primary care workforce and access
	We will:
	
	• Commission the first phase of the Primary Care Model of Care focused around Enhanced Access in core and extended hours, Unplanned Care, Care Homes, LTCs and enhanced access
	• Exploit existing investment in EMIS Web Clinical Services and ability of practices to access each other patient records and share data across Hillingdon, to support new services and delivery models within Networks & Hubs
	• GP Practices will pro-actively review their referral data at practice and sub-group (locality) level. They will develop sub-group based plans to reduce avoidable referrals in identified areas of concern. As part of their plans sub-groups will provide peer support to top referring practices in their areas and help improve decision support for all practices
	• Work with top referring practices to address variation and improve decision support
	• Roll out NWL Referral Criteria to top 20 priority specialities
		We will:
		
		• Continue to develop primary care providers via the integrated outcome based primary contracts with an emphasis in addressing variation
		• Link the Primary Care Models of Care to the CCG Hub Strategy
		• Deliver Phase 2 of the Primary Care Model of Care including:
		  ○ Embedding Mental Health Support in Primary Care and parity of esteem (with a special focus on physical health)
		  ○ Improving Acute Flows (and reducing demand for acute services)
		  ○ Further develop multimorbidity strategy (see LTCs section)

Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Increase in activity managed outside of a hospital setting. • Reduction in hospital referrals and outpatient follow up appointments • Reduction in A&E/UCC activity • Co-ordinated care for people with long-term conditions including primary prevention for sections of the population developing risk profiles; and secondary prevention for people with multi-morbidities to reduce hospital admissions • Reduction in variation of outcomes across general practice for key clinical indicators	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • The Primary Care Model of Care is a key element in the delivery of integrated services across Community and Acute Services and is key to the delivery of Out of Hospital Targets.	**The work for this Transformation Theme is underpinned by the following strategies:** • Five Year GP Forward View • NWL Local services delivery plan • Local Digital Roadmap • Hillingdon primary care strategy The delivery of this Transformation Theme will be managed and monitored via the **Primary Care Transformation Group** which in turn reports to the **Primary Care Transformation Board and Primary Care** Commissioning Board

3. Integrating Services for People at the End of their Life

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Increasing number of people able to die in their preferred place • Reducing number of admissions for people in the last 30 days of their life • Improve information access for clinicians and professionals supporting people at End of Life to anticipatory care plans • Coordination of support to people at End of Life and their families/carers on a 24/7 basis and across all care settings	We will: • Rollout the End of Life Strategy and manage via the Older Peoples Strategy Group • Implement an integrated service model including 24/7 SPA and Palliative Overnight Nursing Service (PONS) in collaboration with Social Finance • Consolidate End of Life services commissioning to enable an integrated and consistent service delivery • Increase usage of Coordinate My Care (CMC) and use of the Shared Care Record • Improve support from the CHC Fast Track programme for eligible patients • Seek to integrate health care and social care services for people at the end of their lives to improve the quality of care received and the support to families and carers • Enhance the bereavement support to carers and family • Implement the ReSPECT DNAR form	We will: • Embed the Single Point of Access (SPA) and Palliative Overnight Nursing Service (PONS) and continue to increase the number of people who die in their preferred place of death • Increase the percentage of people in the last phase of life with an Anticipatory Care Plan to greater than 60% of those in their last 12 months of life (measured via CMC usage)
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Increase in people dying in their preferred place • Increase in people with anticipatory care plans • Reduction in the costs associated with managing people at End of Life	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • This supports the integration agenda through the integrated service model and commissioning of services that will add a 24/7 SPA and PONS to the existing support spanning primary, community and secondary care plus consolidation of the services commissioned by the CCG from the third and voluntary sector • In addition, increasing access to Coordinate My Care (CMC) and the use of the Shared Care Record will support a more coordinated and integrated approach to supporting people at the end of their life	**The work for this Transformation Theme is underpinned by the following strategies:** • Hillingdon Joint End of Life Strategy • Better Care Fund • Local Digital Roadmap The delivery of this Transformation Theme will be managed and monitored via the **Older Peoples Strategy Group** which in turn reports to the **Transformation Group**.

4. Integrated Support for people with Long Term Conditions

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Improved outcomes and support for people with multiple LTCs and complex needs • Reducing unplanned care needs arising associated with LTCs • Reduced variation in care received by people with LTCs with a particular focus on variation in Primary Care • Increasing focus on improved outcomes through preventative measures (primary, secondary and tertiary prevention) • Pro-active and co-ordinated care for people with Multi-morbidities	We will: • Refresh the Long Term Conditions Strategy • Rollout Integrated Services for Respiratory and Diabetes • Ensure medication for AF and HF patients is optimised to prevent MI and stroke, improve patient outcomes and reduce admissions to hospital. • Develop a community based anticoagulation service which may involve decommissioning hospital provided anticoagulation to re-procure an integrated model. • Rollout an expanded Empowered Patient Programme (EPP) and increase usage of Patient Activation (PAM) • Improve support for GPs managing people with multiple co-morbidities through the introduction of virtual clinics with consultant and community MDT members. • Seek to reduce the number of Outpatient Follow Ups and Procedures associated with key LTCs • Develop plans around management of MH related LTCs • Pursue the opportunities identified in the RightCare methodology focusing on supporting people with Diabetes, Cancer, Cardiovascular and Respiratory diseases • Improve advice and support to carers of people with an LTC • Review rehabilitation services to develop a local pricing structure for hospital based cardiac rehabilitation or a combined cardiac/ pulmonary rehabilitation pathway. Rationalise hospital based Health Psychology at THH • Introduce an integrated, shared care record across health and social care and explore the use of apps and technology	We will: • Progress the next phase of the Integrated Services for Respiratory, Cardiology and Diabetes • Rollout the Complex Patient Programme to a wider cohort of people • Focus on improving the support to those who currently need to call 111 or 999 on a regular basis • Embed the concept of Mental Health Support for people with Physical LTCs to ensure their MH needs are met on a consistent and on-going basis • Ensure that Care Planning and PAM become the norm for people with LTCs • Further develop the multi-morbidities strategy
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Reduction in unplanned events for people with LTCs • Reduction in the costs associated with supporting people with LTCs • Increase in people with an LTC who self-manage elements of their care • Increase in people with an LTC who have an anticipatory care plan • Improved Quality of Life measures e.g. PAM • Improved support for Carers • Reduction in number of home visits, general practice appointments • Medicines Optimisation	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • The Integrated Services for Diabetes, Respiratory & Cardiology already combine the expertise of Acute/Secondary Care and Community Services and will be expanded to have much better integration with Primary Care.	**The work for this Transformation Theme is underpinned by the following strategies:** • Long Term Conditions Strategy • Hillingdon primary care strategy • Dementia Action Plan • Better Care Fund • Local Digital Roadmap The delivery of this Transformation Theme will be managed and monitored via the **Long Term Conditions Transformation Group** which in turn reports to the **Transformation Group**.

5. Transforming Care for People with Cancer

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Increasing rates of cancer prevented and increasing survival rates • Reduction in the rates of reoccurrence • Reduction in variation rates in the quality of care • Patients and their families better informed, empowered and involved in decisions around their care • Improved health, wellbeing and quality of life for patients after treatment and at the end of life • Increase in early diagnosis of cancer evidenced by reducing number of patients identified as having Cancer following a non-elective presentation	We will: • Develop access to psychological support for people with Cancer • Develop a digital care support menu jointly with our partners at the London Borough of Hillingdon • Fully implement stratified care pathways for priority cancers • Embed localised programmes for delivery of lung and prostate screening • Work with partners to improve access to and support to our BAME community suffering with Cancer • Achieve the 28 day standard for cancer diagnosis in three site-specific areas: Breast, Urology and Lung • Promote awareness of the Cancer Decision Support Tools within EMIS • Review Dexa scan pathway and outcomes • Explore potential for colorectal direct access pathway • Enhance early diagnosis in primary care with training and out of hospital testing, aligning with best practice and proof of concepts to enhance cancer outcomes • Promote and embed NHSE HLP common standards for digital transfer protocols and message formates.	We will: • Finalise rollout of Cancer Stratified Pathways across all Cancers • Embed Cancer Support (including proactive case finding and screening) into the Primary Care Model of Care • Implement a clear policy on DNA follow ups • Significantly improve the coding of Cancer within Primary Care • Continue the rolling education programme in partnership with Cancer Research UK • Enhance diagnostic capacity to meet expected prevalence growth rates • Develop enhanced support to people living with Cancer • Explore the use of a Shared Care Record across the London Cancer Network
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Reduction in the prevalence gap around Patients identified with Cancer in Primary Care • Increase in early diagnosis of cancer evidenced by a reduction in the number of patients identified with Cancer following a non-elective presentation • Increase in life expectancy at 5 years following successful treatment of patients	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • Cancer by its very nature is a cross-cutting issue affecting all aspects of health care provision including Mental Health, Hospital Based Care and Primary Care. The Cancer Improvement Plan being developed by the CCG will ensure that support is coordinated across the entire Cancer pathway from screening/prevention through to survivability and end of life. This will ensure that support from third sector and voluntary organisations as well as the support from social care are fully integrated with services provided via NHS providers.	**The work for this Transformation Theme is underpinned by the following strategies:** • National Cancer Strategy • London Cancer Strategy • NWL Sustainability and Tr Plan • NWL TCTS Transformation Plan • Hillingdon Cancer Improvement Plan The delivery of this Transformation Theme will be managed and monitored via the **Cancer Clinical Working Group** which in turn reports to the **Transformation Group**. Elements of delivery will be managed by the **Cancer Board** which is led by clinicians at THH.

6. Transforming Support for people with Serious Mental Health Needs and those with Learning Disabilities

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Reduction in inequalities associated with the care of people with one or more LD • Reduction in risk of harm to vulnerable people • Improved support for people with an urgent mental health need • Significant progress in closing the mortality gap between people with an LD and the wider population • Full Implementation of Five Year Forward plan for Mental Health	We will: • Support people in crisis by fully embedding Urgent Care, OOH, SPA and rapid response functions • Develop all age early intervention service and packages of care for first episode psychosis • Expand ICP to include people with dementia and MH Conditions • Develop new models of care for people with severe mental illness and learning disabilities in the community • Implement NWL Like-Minded Strategies covering severe mental illness, common mental health, primary care and wellbeing and promotion to ensure sustainability • Further develop an integrated 5 year plan for CAMHS including Tier 4, moving towards THRIVE Model • Improve support to carers where needed and appropriate • Signal intention to market test and potentially procure LD Services • Signal intention to market test and potentially procure CAMHs Services. • Development of a Personality Disorder Pathway • Ensure the local Dementia Plan is fully implemented including EOL care and Challenging behaviour services • Assess a Business Case to continue the provision of Mental Health awareness training • Jointly assess the level of unmet need for longer term Counselling • Develop a coherent local pathway for people with ASD and ADHD	We will: • Implement Like-Minded Business Cases • Implement the recommendations from CAMHS OOH, Urgent Care and Like-Minded evaluations • Review 16/17 CAMHS investment and business cases • Consider the rolling out the collaborative care and care planning process for adult mental health with LTC • Comprehensive plans in place to meet the expectations set out in the Five Year Forward plan for Mental Health • Progress delivery of Transforming carte for people with LD • Progress delivery of 5 year CAMHS transformation plan • Progress delivery of Like Minded plans Specifically: • Implement Like-Minded Business Cases • Implement the recommendations from Adult and CAMHS OOH, Urgent Care and Like-Minded evaluations • Progress to an integrated CAMHS model • Consider the rolling out the collaborative care and care planning process for adult mental health with LTC • Comprehensive plans in place to meet the expectations set out in the Five Year Forward plan for Mental Health
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • People with SMI (Severe Mental Illness) to receive complete list of physical health check to achieve reduction in the mortality gap • Access to community mental health services and IAPT from BME groups, crude rates per 100,000 population • Unplanned readmissions of mental health patient within 30days of inpatient admission. • Percentage of service users in adult mental health services in employment. • Reduction in Psychiatric admissions via A+E	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • Expanding the Integrated Care Programme to include people with Mental Health Conditions will bring better coordination between physical and mental health services • Like Minded strategy to develop enhanced primary care mental service, services for severe and common mental health problems and wellbeing and prevention	**The work for this Transformation Theme is underpinned by the following strategies:** • Learning Disability Transforming Care Programme • Dementia Action Plan • Mental Health Transformation Plan • CAMHS Transformation Plan The delivery of this Transformation Theme will be managed and monitored via the **Mental Health Transformation Group** which in turn reports to the **Transformation Group**.

7. Integrated Care for Children & Young People (CYP)

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Coordination of support for children and young people across all health and social care services • Improved outcomes for children and young people with one or more LTCs • Reduction in the risk of harm to children and young people	We will: • Integrated Community Clinics: To embed and continue to develop a network of Community Clinics. Integrating relevant services as indicated by need; such as paediatric phlebotomy, aligning with the asthma allergy clinics. Improving admission avoidance, reducing people's reliance on unplanned care systems patient and professional confidence. • Work with partners to identify and target programmes of care to reduce: o A&E attendances in <4 year olds o Improved dental care and childhood immunisations • Continue to test Community Integrated Clinics for General Paediatrics and the viability of extending the model to complex care. • Continue to develop a Liaison & Diversion model building on the rapid health review of need, carried out in 2017. • Review the health needs of children & young people with an additional health need, working with partners to prioritise areas of high need. Including the potential to market test and procurement services such as child Development Services, Looked After and services for young people in the criminal justice system. Linking to the CAMHS work. • Maternity; continue to prioritise with partners ways to improve services, improving efficiencies where possible. • Technology: working with partners identify key areas to improve shared care records, and evidence based treatments on line. • Transition: to work with partners to develop systems for transition for Children & Young People aged 18-25 who remain in education and have a Health, Education and Care Plan	We will: • Implement integrated community models of care across the borough, based on population need and evidence of clinical service use. • Vulnerable children and young people: as a co-produced programme implement a revised and improved provision • Working with partners continue to: provide education programmes for professionals, families and children and young people, to self-manage their care: preventing hospital use • Using local and national data and working with partners, such as the local authority; target high areas of need; o Immunisation take improvement , including vulnerable children o Weight management 10-11 year olds o Hospital admission for Dental Caries
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Reduction in the need for secondary care activity associated with CYP: • Reduction in GP referrals to secondary care • Reduction in unplanned care needs for CYP • Reduction in the costs associated in managing CYP per capita	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • Support to CYP is jointly commissioned across Health & Social Care and we will work increasingly closely with our Social Care and Local Authority colleagues to develop joint plans. • Integrate Community Clinics; moving skills and expertise into community • We will continue to work closely with NHS England around support to CAMHS patients with CAMHS commissioners.	**The work for this Transformation Theme is underpinned by the following strategies:** • CAMHS Action Plan • Children's Transformation Plan • The children's JSNA May 2016 • The Children & Family Act 2014 • Local Digital Roadmap The delivery of this Transformation Theme will be managed and monitored via the **Children's Strategic Transformation Group** which in turn reports to the **Transformation Group**.

8. Integration Across the Urgent & Emergency Care System

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Coordinated support across all Urgent & Emergency Care services • Increased number of patients who have their unplanned care needs met outside of a hospital setting • Increased awareness in the community about how to access appropriate services • Increased number of people supported to avoid an admission and those supported home with a reduced Length of Stay	We will: • Develop our integrated urgent care approach to align urgent care services across social, primary, community and acute settings • Rollout new 111 Service and Primary Care Triage Model aligned to national guidelines • Develop and enhance ambulatory care pathway services in out of hospital settings and continue to increase the effectiveness of our UCC based Health Connectors to support patients along appropriate pathways • Expand Intermediate Care Services and integrate with Homesafe • Commission a new Directory of Service (DoS) • Change the focus of DTOCs to also include those who are Medically Fit For Discharge (MFFD) and rollout a joint approach to reducing LoS with the Local Authority and CHC • Reduce the number of alcohol related presentations a THH • Improve the support to those with alcohol addiction that has caused a long term medical condition • Introduce 'follow up' nurse support to reduce readmission rates following a non-elective presentation at THH • Deliver the Ambulance Handover Time targets consistently	We will: • Commission a fully Integrated Urgent and Emergency Care system • Improve the effectiveness of our NHS 111 Service • Improve integration of acute unplanned care services with GP-led urgent care • Reduce demand at the door of A&E and the UCC through improved access in Primary Care, Community, Education and through our support to people with LTCs • Integrate IT system across the UEC system to ensure professionals have access to essential medical records for people • Expand and update the DoS in line with national standards • Link the Urgent Care System with the Primary Care Model of Care and the CCG Hub Strategy
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Reduction in rate of growth for unplanned attendances at hospital • Increase in people accessing non-hospital based support for their unplanned care needs • Reduction in the costs per capita managing unplanned care needs • Reduction in Zero-Length of Stay and Unplanned Admissions and a Reduction in Length of Stay following an unplanned admission	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • The Multidisciplinary Integrated Discharge Team and A&E Delivery Board are examples of Integration across health and social care associated with Unplanned Care • The development of the Older Peoples' Model of Care and the Primary Care Model of Care will both enhance integration further across the UEC System as will the development of a truly Integrated Urgent Care (IUC) System	**The work for this Transformation Theme is underpinned by the following strategies:** • Unplanned Care Strategy • Commissioning Standards for Integrated Urgent Care • Local Digital Roadmap The delivery of this Transformation Theme will be managed and monitored via the **A&E Delivery Group** which in turn reports to the **Hillingdon CCG Governing Body**

9. Prevention of Disease & Ill-Health

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Hillingdon wide self-management / education programme for all patients regardless of their length of diagnosis for a number of conditions • Reduced prevalence gap for key conditions meaning that more people are identified as having conditions such as Diabetes and Hypertension (adults and children • Fully informed, engaged and activated patients taking control of the process of care for their own conditions • Reduced rate of growth in prevalence to improve long term outcomes and slow the growth in demand for health related services • Reduced variation in management of conditions to reduce the number of exacerbations that occur for people and ultimately improve their long term outcome	We will: • Develop and rollout a Prevention Strategy as well as a Suicide Prevention Strategy • Develop targeted screening programmes for AF, Hypertension and Diabetes to diagnose patients earlier and prevent adverse events. identify further prevalence gaps to address in later years • Rollout an Air Quality Review with Public Health to understand why Hillingdon is an outlier for Respiratory related activity • Rollout of Proactive Case Finding in Primary Care as part of the Primary Care Model of Care • Expand access to and use of online advice and contribute to raising the awareness of the public around prevention of long term conditions • Utilise data from the JSNA, NHS RightCare and other external parties to support the development of the Prevention Strategy • Explore the use of apps and technology to help people stay well and prevent exacerbations	We will: • Close the prevalence gaps for Hypertension and Diabetes by more than 30% • Expand the range of conditions for which proactive case finding can be utilised to identify those at risk of developing disease and ill-health • Expand the range of conditions where the NHS can use prevention techniques to reduce complications and co-morbidities for those people who already have a long-term condition **Note:** much of the longer term impact of this Transformation Theme will be delivered via (T4) and (T5) with respect to Secondary and Tertiary Prevention.
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Reduction in the prevalence gap for key conditions including Hypertension, Cholesterol, and Diabetes • Reduction in the rate of growth of prevalence • Reduction in the costs of managing people with LTCs	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • Prevention is a shared issue between the NHS and the Local Authority. Although the development and rollout of the Prevention Strategy for the CCG will be very much focused on the NHS elements of prevention we will be working closely with our Local Authority colleagues (particularly public health and the health and wellbeing teams) to develop this strategy and roll it out.	**The work for this Transformation Theme is underpinned by the following strategies:** The delivery of this Transformation Theme will be managed and monitored via the **Long Term Conditions Transformation Group** which in turn reports to the **Transformation Group**.

10. Transformation in Local Services

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Reduced rate of growth in hospital attendances and admissions for people with planned care needs • Increasing scope and amount of activity delivered Out of Hospital and closer to home for patients • Reduction in Length of Stay following a planned admission • Increased use of alternative services to deliver planned care support	We will: • Deliver the 4 Priority Acute Standards for 7 Day Services • Reduce activity to NWL averages within the THH and RBH contracts for key specialties focusing on OPD and OPPROC • Consolidate clinical efforts through Planned Care Clinical Transformation Group • Identify opportunities for rehabilitation in the community • Enhance early diagnosis and intervention in Gastro to prevent unnecessary invasive procedures, as well as support patients to manage long term conditions such as IBS with community based diet advice and counselling support • Develop Neuro community support service to address and prevent emergency epilepsy admissions, help manage Parkinson's, and embed community neuro rehab outreach service, as well as explore phased piloting/implementation of additional neuro-related community services • Review and rationalise bariatric and sleep apnoea pathways • Explore opportunities to assess and treat minor conditions and minor surgeries in the community • Procure a community MSK service, including a Single Point of Access for all MSK conditions. Potential sub-delivery of the procuring community MSK service, including development of care plans to manage issues and pain due to flare-ups or ongoing pain • Develop and implement Virtual Fracture Clinic (VFC) with NWL collaborative team, and enhance the Fracture Liaison Service (FLS) with NWL collaborative team • Implement shared care guidelines for the management of stable Disease-Modifying Anti-Rheumatic Drugs (DMARDs) • Procure a community Dermatology service, and explore opportunity for teledermatology • Implement post discharge follow up calls to reduce readmissions • Ongoing embedding of integrated, shared care record across health and social care • Adoption and integration of NHS RightCare programme recommendations for key specialties (MSK, Diabetes, Respiratory, Cancer, Neurology) • Proactively engage in the negotiations for the contracts where HCCG are significant associates to obtain improved efficiency • Implement a Placement Efficiency Programme for patients with a physical need • Review elective pathways	We will: • Restructure and improve the effectiveness of Clinical Working Groups (CWGs) to empower them to take more control of clinical decision making across providers • Focus on additional 7 Day Standards in line with NWL and HCCG priorities • Reduce Length of Stay to the NWL Average wherever this exceeds the average by more than 10% • Increase the scope of services delivered Out of Hospital and closer to patients' homes as well as the amount of activity delivered Out of Hospital • Rollout NWL Referral Criteria to the next 20 specialities whilst continuing to monitor impact on the Top 40 specialties and the rate of growth • Reduce Internally Generated Demand to NWL average rates where applicable whilst ensuring the policy is applied where clinically appropriate to reduce delay and burden on primary care • Improve patient access to community MSK services by introducing self-referral to community MSK service
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Reduction in costs and growth rate for planned attendances and admissions • Increase in planned care provided in non-hospital based settings	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • The move to drive more activity out of hospital will contribute to the integration across secondary, community and primary care services and this will be combined with an increasing focus on self-care and patient activation	**The work for this Transformation Theme is underpinned by the following strategies:** • NWL Local Services Strategy The delivery of this Transformation Theme will be managed and monitored via the **Planned Care Transformation Group** which in turn reports to the **Transformation Group**.

Enabling Themes

The following pages provide the detail of each of the Enabling Themes.

1. Developing The Digital Environment		
2020/21 Outcomes	**Commissioning Intentions 18/19**	**Indicative Commissioning Intentions Beyond 18/19**
By 2020/21 we will be delivering the following outcomes: • Effective and efficient integrated care services enabled by shared health and care records • Relevant information, safely and appropriately available when needed to coordinate care for people • Clear analytical information available to aid planning of services	We will: • Improve access to and use of Shared Care Records to support integrated care, including the NW London Care Information Exchange • Improve use of digital analytics, where possible, to move towards population-level health management, using local and NHS NWL tools • Develop plans for digitally enabled self-care and the use of real time data in decision making for both clinicians and patients • Complete the implementation of electronic clinical correspondence (including e-Referrals and e-Discharges) and eradicate use of fax in care services	We will: • Encourage secondary care to move towards paperless operation at the point of care • Complete development of a shared care record across all care settings including social care, facilitating integrated out of hospital care, including the NWL and pan-London Care Information Exchanges • Extend patient records (from all settings) to patients and carers, and provide them with digital self-care and management tools such as apps, to help them become more involved in understanding and managing their own care; to include implementation of common digital identity and consent management functions across NWL and where possible, pan-London • Use dynamic analytics to inform care decisions and support integrated health and social care across the system through whole system intelligence
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • High utilisation of Shared Care Record across settings by appropriate health and care professionals • Services planned using accurate and timely data • Improved outcomes for patients through effective use of shared records and therefore better informed health and care decisions	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • The Shared Care Record will facilitate integrated working across settings and across providers.	**The work for this Enabling Theme is underpinned by the following strategies:** • Local Digital Roadmap • Hillingdon IT Strategy The delivery of this Enabling Theme will be managed and monitored via the **IT Transformation Group** and **Pan Hillingdon IT Group** which in turn report to the **Hillingdon CCG Transformation Group**. Providers are expected to participate in the **Pan Hillingdon IT Group**.

2. Creating the Primary Care Workforce for the Future

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • A primary care workforce that is sufficient to sustain general practice. • A workforce that grows new roles and skills to support patient care • New systems and processes to release clinical time • An expanded primary care workforce that is competent and confident to work in new models of care delivery and new provider structures. • A supported workforce environment that promotes Hillingdon as an attractive place to work. •	We will: • Increase the mentorship and student placement capacity in general practice for both clinical and non-clinical staff • Ensure supported, and sometimes targeted, recruitment of new staff into general practice including through apprenticeship programmes • Establish GP chambers • Continue to provide staff forums, training and education opportunities • Develop cross-organisational working within the GP Confederation and the ACP • Develop new workforce functions with a focus on sign-posting (care navigators) and medical correspondence Resource change management programme to embed new roles and processes in general practice • Resource local practice managers groups for peer support in IT, HR and general business sustainability	We will: • Establish multi-disciplinary, multi-organisational and multi-HEI packages of properly tariffed student placements • Create targeted, multi-organisational pipeline of new staff recruitment • Develop a CEPN (Community Education Provider Network) function sitting with the ACO provider for multi-disciplinary forums, training and education • Develop more generically skilled, multi-professional workforce managing patients across multi-morbidity packages of care • Continue to properly evaluate and develop new workforce functions and competency frameworks with HENWL and HEIs
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • The workforce required to sustain general practice and help deliver any new models of care or provider structures. • The skills and consistency required to care manage multi-morbidity and increasingly complex patients. • A supported environment in which staff want to stay and work. • Longer clinical appointments in primary care for patients with LTCs due to released clinical time	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • The practice of multi-organisational student placements, staff recruitment including apprenticeships, staff training and working patterns contribute to significant integration across health care settings, • The development of a more generically skilled, multi-professional workforce managing patients across multi-morbidity packages of care will further integrate how care is provided for people.	**The work for this Enabling Theme is underpinned by the following strategies:** NW London Workforce transformation Strategy -2016-2021 Hillingdon Primayr Care Strategy The delivery of this Enabling Theme will be managed and monitored via the **Primary Care Transformation Group** which in turn reports to the **Transformation Group**.

3. Delivering Our Strategic Estates Priorities		
2020/21 Outcomes	**Commissioning Intentions 18/19**	**Indicative Commissioning Intentions Beyond 18/19**
By 2020/21 we will be delivering the following outcomes: • An estate portfolio that meets the needs of our Transformation Themes.	We will: • Deliver Local Estate Strategy for Hillingdon to support the delivery of the Five Year Forward View and 'One Public Estate' vision • Deliver local services hub business cases for the North and Centre of the Borough • Maximise utilisation of existing estate and reduce void costs • Deliver a temporary solution for Yiewsley Health Centre whilst continuing to find a long term solution for the site • Identify a permanent premises solution for Shakespeare Medical Centre and Yeading Court Surgery • Build primary care estate capacity in Hayes Town to respond to the growth derived from the Housing Zone • To develop a plan for the future of the Northwood and Pinner Community Hospital that respects the heritage of the site and realises the potential of its location	We will: • Deliver a local service Hub in North of Hillingdon by 2020/21 • Deliver a local service Hub in the Uxbridge and West Drayton area by 2020/21 • Deliver a solution for Yiewsley Health Centre by 2019/20
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • A service with the capacity and capability to meet the needs of our population	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • Local services hubs provide physical locations to support patients with a variety of needs through the provision of varying services across primary, community and secondary care with the opportunity to integrate certain elements of services delivered by the Local Authority. • The provision of high quality premises and estate will both contribute to the improvement in the quality of care as well as improved financial performance allowing more funds to be released to support further integrated working elsewhere.	**The work for this Enabling Theme is underpinned by the following strategies:** • Strategic Estates Plan • Strategic Outline Case Part 1 (SoC 1) • Primary Care Strategy The delivery of this Enabling Theme will be managed and monitored via the Strategic Estates Group and **Governing Body Board**.

4. Delivering Our Statutory Targets Reliably		
2020/21 Outcomes	**Commissioning Intentions 18/19**	**Indicative Commissioning Intentions Beyond 18/19**
By 2020/21 we will be delivering the following outcomes: • Achievement of NHS Targets for Referral to Treatment (RTT), A&E and Cancer Waits and Diagnostics as well as our other statutory targets associated with Mental Health	We will: • Continue to achieve the 92% RTT target for Incomplete Pathways for Hillingdon CCG Registered population • Return performance of THH to the expected standard of 95% for 4 hr waits in A&E • Explore in detail the impact of Cancer Breach Sharing Standards and continue to achieve Cancer Wait Targets whilst undertaking an end to end review to ensure continued resilience based on projected prevalence growth in Cancer. • Continue to achieve the statutory targets for mental health	The plans beyond 18/19 will be dependent upon national statutory targets and any changes that are made centrally.
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • Achievement of our Statutory Targets	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • As delivery of our statutory targets normally requires integrated working across multiple providers such as Cancer which will involve Primary Care and a mix of secondary care providers.	**The work for this Enabling Theme is underpinned by the following strategies:** • Hillingdon CCG Operating Plan The delivery of this Enabling Theme will be managed and monitored via the **Planned Care Transformation Group, A&E Delivery Board, Cancer Clinical Working Group, and Mental Health Transformation Group** which in turn report to the **Transformation Group** and **Transformation Board**.

5. Medicines Management

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Reduction in overall medicines expenditure per capita including reduced wastage taking into account growth in costs • Improved outcomes for people utilising medicines and a reduction in avoidable harm • Supporting in reducing unplanned admissions related to medicines • Increased use of skilled workforce e.g. specialised clinical pharmacists in GP practice setting	We will: • Increase support to Care Homes to work towards reducing unplanned admissions in relation to medicines • Focus on medicines optimisation and rollout of practice level specialised pharmaceutical support for medicines reviews • Increase support for virtual clinics for CVD ,Respiratory and Diabetes • Undertake domiciliary medication reviews by specialist pharmacists for the frail and elderly • Undertake domiciliary medication review of newly discharged patients by specialised pharmacists • Review and streamline repeat prescription processes in practices to further support NWL initiatives • Focus on reducing wastage and reducing inappropriate usage of antibiotics • Focus on patient education related to medicines for LTCs via various portals e.g. Health videos • Increase joint working with health professionals across the interfaces and with NWL and London-wide Pharmacy Networks • Increase use of EPS2 and also implement EPS Release 4 and ePrescribing in THH	We will: • Carry on monitoring and supporting practices in ensuring high quality, cost effective prescribing is being carried out without compromising patient care • Support in improving quality and safety of medicines use • Support in the reduction of Medicines waste • Support in Improving patient experience • Increase joint working with health professionals across the interfaces and with NWL and London-wide Pharmacy Networks • Link medicines management within the primary care models of care • Support as an enabler in the transformation themes where appropriate. • Carry on integrated working across the CCG to support the wider strategic agenda
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • Reducing spend per capita on medication • Quality and safety of medicines use is improved • Reducing incidents of harm • Improving outcome for people arising from the effective use of medication • Patient experience is improved with their medicines • Medication waste is reduced • National and local guidance is implemented • Reduction in polypharmacy /Medicines Optimised • Partnership working with relevant stakeholder to improve patient care	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • Medication is an issue that spans the entire healthcare sector and also links into areas such as Care Homes, Social Care and the support provided by Carers. As such, medication and medicines management is by its very nature an issue of integration.	**The work for this Enabling Theme is underpinned by the following strategies:** • Medicines Management Plan The delivery of this Enabling Theme will be managed and monitored via the **Hillingdon Medicines Management Committee** which in turn reports to the **Hillingdon CCG Governing Body**.

AWAITING OUTCOME OF Sept JOINT SYSTEM PLANNING MEETING (JV)

6. Redefining the Provider Market		
2020/21 Outcomes	**Commissioning Intentions 18/19**	**Indicative Commissioning Intentions Beyond 18/19**
By 2020/21 we will be delivering the following outcomes: • Improved capability across the system in meeting the health needs of the local population within the financial constraints • Payment and risk share arrangements that incentivises innovation, quality and sustainability, based on delivery of defined patient-centred outcomes in order to improve quality and demonstrate system transformation • Improvements in clinical quality, integrated care systems and financial sustainability • System incentivised to work together to enable the needs of the whole person to be met	We will: • Develop a shadow outcome based commissioning model for older people via an ACO (locally referred to as an Accountable Care Partnership or ACP) and seek to identify further cohorts to work with, including recent developments in End of Life, stroke ESD, mental health and MSK, among transformation themes and projects intended for implementation in this year and future years • Create a GP Network Development Strategy	We will: • Enhance and drive forward the 3 year BCF plan with LBH to deliver longer term alignment and integration across Health and social care • Deliver a transformation in Primary Care support through our Primary Care Model of Care • Commission outcomes based services for further population groups including CHC (care homes and home care), other EOL, LTCs, integrated prescribing and children's services • Work with LBH to shape the market and re commission services currently delivered in institutional or Tier 4 care settings for people with complex needs. • Further develop the concept, scope and impact of our ACP • Further develop the scope of our capitated payment model and impact of ACP providers.
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • Significant proportion of care delivered through integrated delivery vehicles • A high functioning, cost effective Accountable Care Partnership • Established GP networks and federation capable of delivering services in out of hospital settings • Performance improvement against a set of 29 quality outcome measures of the ACP, linked to improved patient experience, patient and carer quality of life and independence, achievement of care planning goals and support to keep people at home if their needs escalate	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • The reshaping of our Provider Market and our work on our Better Care Fund (BCF) Programme is already driving improvements in integrated care across health and social care and will continue to do so. In particular the ACP brings together all health partners and third sector organisations and naturally therefore delivers on our integration agenda for health.	**The work for this Enabling Theme is underpinned by the following strategies:** • Hillingdon BCF • New Care Models for Primary Care & Older People • Local Service Plan • Hillingdon Strategic Estates Plan • NWL Digital Roadmap The delivery of this Enabling Theme will be managed and monitored via the **BCF Officers' Group**, the **ACP Commissioning Group** and **GP Co-Commissioning Board**. These groups are overseen by the **CCG's Governing Body, Transformation Board** and the **Health & Wellbeing Board** collectively.

Section 8: List of Abbreviations Used

Term	Meaning	Term	Meaning	Term	Meaning
A&E	Accident & Emergency	AEC	Ambulatory Emergency Care	ACP	Accountable Care Partnership or Alternative Care Pathway
ACO	Accountable Care Organisation	AF	Atrial Fibrillation	AIDS	Acquired Immune Deficiency Syndrome
BCF	Better Care Fund	BHH	Brent, Harrow, Hillingdon CCGs		
COTE	Care of the Elderly	CCG	Clinical Commissioning Group	CSE	Child Sexual Exploitation
CQC	Care Quality Commission	CQG	Clinical Quality Group	CYP	Children & Young People
COPD	Chronic Obstructive Pulmonary Disorder	CAMHS	Children & Adolescent Mental Health Services	CWHHE	Chelsea & Westminster, West London, Hounslow, Hammersmith & Fulham and Ealing CCGs
CHD	Chronic Heart Disease	CHF	Chronic Heart Failure	CNWL	Central & North West London NHS Foundation Trust
CKD	Chronic Kidney Disease	CMC	Coordinate My Care	CHC	Continuing Health Care
CIE	Care Information Exchange	CIP	Cost Improvement Programme	CVD	Cardio-Vascular Disease
CATS	Community Assessment & Treatment Service	CAATS	Clinical Advice & Triage Service	CQRG	Care Quality Reference Group
DES	Directed Enhanced Service	DTOC	Delayed Transfer of Care	DH/DoH	Department of Health
DNA/s	Did Not Attend/s				
ENT	Ear, Nose & Throat	EoL	End of Life	EGAU	Emergency Gynae Assessment Unit
ED	Emergency Department				
FGM	Female Genital Mutiliation	FY	Financial Year	FUP	Follow Up (Appointment)
FT	Foundation Trust				
GP	General Practitioner	GPwSI	GP with a Special Interest	GB	Governing Body
HCCG	Hillingdon CCG	HAI	Healthcare Acquired Infection	HF	Heart Failure
HRG	Healthcare Resource Group	HENWL	Higher Education North West London	HWB/HWBB	Health & Wellbeing Board
HIV	Human Immunodeficiency Virus	HICU	Hawthorne Intermediate Care Unit		
IT	Information Technology	IV	Intravenous	IPP	Independent Pharmacist Prescriber
ICP	Integrated Care Programme	IAPT	Improving Access to Psychological Therapies	IM&T	Information Management & Technology
ICO	Integrated Care Organisation	IUC	Integrated Urgent Care		
JSNA	Joint Strategic Needs Assessment				
LA	Local Authority	LIS/LES	Local Incentive Scheme Locally Enhanced Service	LoS	Length of Stay

LAS	London Ambulance Service	LAC	Looked After Children	LTC	Long Term Condition
LD	Learning Disability	LBH	London Borough of Hillingdon	LNWH	London North West Hospitals NHS Foundation Trust
MH	Mental Health	MMT	Medicines Management Team	MSK	Musculo-Skeletal
MIU	Minor Injuries Unit	MDT	Multi-Disciplinary Team	MFFD	Medically Fit For Discharge
NWL	North West London	NEL	Non-Elective	NES	Nationally Enhanced Service
NHSE	NHS England	NEPTS	Non-Emergency Patient Transport Service		
OBC	Outline Business Case	OOA	Out of Area	OOH	Out of Hours or Out of Hospital
PKB	Patient Knows Best	PH	Public Health	PCI	Practice Commissioning Initiative
PHB	Personal Health Budgets	PPC	Primary Procedure Code	PYLL	Potential Years Life Lost
PHE	Public Health England	Pt/Pts	Patient/s	PTS	Patient Transport Service
PPE	Public & Patient Engagement	PCC	Primary Care Contract		
QIPP	Quality, Innovation, Productivity & Prevention				
RTT	Referral To Treatment	RA	Rheumatoid Arthritis	RBH	Royal Brompton & Harefield Hospitals NHS Foundation Trust
SRG	System Resilience Group	STI	Sexually Transmitted Infection	SaHF	Shaping a Healthier Future
SSoC	Shifting Settings of Care	SCR	Shared Care Record or Summary Care Record	STARRS	Short-Term Assessment, Rehabilitation & Reablement Service
STP	Sustainability & Transformation Plan				
TB	Tuberculosis	TFC	Treatment Function Code	THH	The Hillingdon Hospital NHS Foundation Trust
UCC	Urgent Treatment Centre	UEC	Urgent & Emergency Care		
VTE	Venus Thromboembolism				
WSIC	Whole System Integrated Care	WTE	Whole Time Equivalent		
ZLOS	Zero Length of Stay				

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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; Sarah Walker
Papers with report	None

1. HEADLINE INFORMATION

Summary	This paper provides an update to the Health and Wellbeing Board on key areas of CCG work. The paper encompasses: • NHSE rating 2016/17 • Urgent Treatment Centre procurement • Accountable Care update • Finance update • QIPP delivery • NWL CCGs collaborative working • Changes to Governing Body
Contribution to plans and strategies	The items above relate to the HCCGs: • 5 year strategic plan • Out of hospital (local services) strategy • Financial strategy • Shaping a Healthier Future
Financial Cost	Not applicable to this paper
Relevant Policy Overview & Scrutiny Committee	External Services Scrutiny Committee
Ward(s) affected	All

2. RECOMMENDATION

That the Health and Wellbeing Board notes the 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 NHSE Assurance Ratings 2016/17

Hillingdon CCG has received official confirmation of its assurance rating for 2016-17. The CCG has been rated as 'Good' from the four potential ratings of 'Inadequate', 'Requires improvement', 'Good', and 'Outstanding'.

The improvement and assessment framework (IAF) rates CCGs against a range of indicators under four domains of 'Better Health', 'Better Care', 'Leadership' and 'Sustainability'. These include 6 clinical priority areas of mental health, learning disabilities, cancer, maternity and diabetes.

Key areas of achievement were noted as leadership, quality, performance (including delivery against targets for dementia diagnosis, cancer waits and access to IAPT services) and sustainability. Areas identified for improvement included delivery against the 4 hour A&E standard, use of personal health budgets and ongoing post-diagnosis dementia support, all of which are areas of focus in 2017/18 plans.

Assurance for 2017/18 will follow a similar methodology with workshops being held by NHSE during September to explain any changes in the approach.

3.2 Urgent Treatment Centre Procurement

The CCG is currently working to redesign Urgent and Emergency Care services into an integrated system. Within Hillingdon and NW London, the vision is to create an urgent and emergency care system that is capable of delivering equitable access to the right care first time for the majority of patients through a networked model with services provided along robust pathways 24/7. This will allow people requiring urgent care to be seen or redirected to the most appropriate service more often closer to home, improving satisfaction and reducing confusion, while reducing pressure on our accident and emergency departments. For those with more serious needs we must ensure access to high quality care in appropriate facilities with the right expertise.

The current Urgent Care Centre contract ends on 31st March 2018 which provides an opportunity for the CCG to commission a service that ensures we meet the new NHSE 'Urgent Treatment Centre' specification.

NHSE have produced a set of principles and standards to address the current variation in urgent care provision and provide a more consistent service offering to patients attempting to access urgent care. Our current service meets the majority of the requirements however key changes will include:

- Ability to pre book "urgent" appointments into the UTC via NHS 111, LAS and General Practice where clinically appropriate
- Booking direct appointments from the UTC into general practice where appropriate
- Ability to access and use the "Directory of Services" (DoS) to support effective onward signposting to alternative services
- Providing a 'patient education' function for long term behavioural change – i.e. provide adequate information on appropriate local services.
- IT interoperability with wider integrated urgent care services

We have incorporated feedback from our engagement process into the specification for the service which will be issued in September with the successful bidder notified at the start of December following the procurement process.

3.3 Accountable Care Partnership – progress and next steps

Hillingdon's Accountable Care Partnership has now moved to the testing stage following an assurance process which was approved by HCCG GB in May 2017. Hillingdon Health and Care Partners (HHCP, our Hillingdon ACP) have signed an alliance agreement which was approved by each constituent ACP member board in May 2017. This enables HHCP to formalise a joint commitment to test out new, collaborative working arrangements which deliver agreed outcomes for the care of people aged 65 and over, and to deliver the requirements of the ACP testing phase. We are now in the process of determining whether the model of care and system enablers deliver expected improvements in outcomes of care, patient experience and system sustainability. Implementation of the care model for older people is making good progress on the ground. Of the 15 HHCP care connection teams due to be rolled out, 13 teams are operational and 14 teams are fully recruited. All teams will be up and running during September 2017 as planned. Once the teams are at full capacity they are expected to carry a caseload of approximately 750 at any one time.

The H4All Wellbeing Service, which works as a key part of the HHCP model of care continues to demonstrate benefits, and the scope has been extended as a pilot to include people with diabetes who are below the age of 65 and their carers, trialling the carer's activation measure assessment. New pathways where health and care needs have escalated are being embedded including the frailty pathway.

The system wide Hillingdon outcomes framework has been developed which measures the impact of the service model against a number of domains, and this is currently being tested where data is available. HCCG and HHCP have also confirmed baselines for the capitated budget value for 2017/18, and are working jointly to establish the capitated payment model, associated payment mechanisms and risk share arrangements which will be implemented from 18/19. An approach to establishing new funding flows across the health care system has now been tested with HHCP resulting in continuation of the Early Supported Discharge Service for Stroke following a successful service pilot. HCCG and HHCP will be reviewing whether the ACP is on track to meet agreed 2017/18 development objectives, and this mid-year review will be completed in October 2017.

3.4 Financial Position 2017/18

Overall at Month 04, the CCG is reporting it is on target against its YTD in-year surplus of £0.2m and forecasting achievement of its £0.5m planned in-year surplus by year end. However the CCG financial position continues to be extremely tight at M04, with significant YTD and FOT adverse variances in Continuing Care and acute activity.

The acute position at M04 is a YTD overspend of £0.7m and a FOT overspend of £0.8m. The deterioration in the FOT position is largely due to Out of Sector providers in particular LAS.

Over performance in the contract with THH is mainly related to increases in planned care and non-elective activity and cost.

The Continuing Care position is currently a YTD overspend of £1m and a FOT overspend of £2m. This represents a significant increase in the run rate due to a number of high cost placements and 121 packages in Childrens' and Elderly Care.

To achieve its FOT plan, the CCG has now factored in a number of NR benefits into the position as well as deploying all its available reserves and is also reliant on the QIPP outside agreed SLAs being delivered in full (£3.9m).

Overall Position- Executive Summary Month 4 YTD and FOT

Table 1

EXECUTIVE SUMMARY		Year to Date Month 4			Forecast Outturn Position		
	Final Budgets (£000)	YTD Budget (£000)	YTD Actual (£000)	Variance Sur/(deficit) (£000)	FOT Actual (£000)	FOT Variance Sur/(deficit) (£000)	FOT QIPP Variance (£000)
Commissioning of Healthcare							
Acute Contracts	217,263	72,303	72,987	(684)	218,088	(825)	(439)
Acute/QIPP Risk Reserve	(3,865)	0	0	0	(3,865)	0	399
Other Acute Commissioning	11,751	3,976	4,147	(171)	11,920	(170)	(62)
Mental Health Commissioning	25,291	8,331	8,519	(187)	25,605	(314)	0
Continuing Care	19,837	6,612	7,645	(1,032)	21,833	(1,995)	(4)
Community	35,657	11,662	11,665	(3)	35,624	32	0
Prescribing	35,800	11,923	11,380	543	34,715	1,085	0
Primary Care	41,442	13,041	13,020	21	41,179	263	0
Sub-total	**383,175**	**127,850**	**129,364**	**(1,514)**	**385,100**	**(1,925)**	**(106)**
Corporate & Estates	4,408	1,476	1,569	(93)	4,710	(302)	0
TOTAL	**387,583**	**129,326**	**130,932**	**(1,607)**	**389,810**	**(2,227)**	**(106)**
Reserves & Contingency							
Contingency	2,060	1,523	0	1,523	0	2,060	0
Uncommitted Reserves	1,764	0	0	0	1,764	0	0
RESERVES Total:	**3,824**	**1,523**	**0**	**1,523**	**1,764**	**2,060**	**0**
Total 2017/18 Programme Budgets	**391,407**	**130,848**	**130,932**	**(84)**	**391,574**	**(167)**	**(106)**
Total Programme	**391,407**	**130,848**	**130,932**	**(84)**	**391,574**	**(167)**	**(106)**
RUNNING COSTS							
Running Costs	**5,784**	**1,912**	**1,828**	**84**	**5,617**	**167**	**106**
CCG Total Expenditure	**397,191**	**132,760**	**132,760**	**0**	**397,191**	**0**	**(0)**
In-Year Surplus/(Deficit)	**488**	**163**	**0**	**163**	**0**	**488**	**0**
NOTE							
Historic Surplus/(Deficit)	**7,764**	**2,588**	**0**	**2,588**	**0**	**7,764**	**0**
TOTAL	**405,443**	**135,511**	**132,760**	**2,751**	**397,191**	**8,252**	**(0)**

Year To Date Position- Acute Contracts and Continuing Care

Table 2

Acute Contracts

		Year to Date Month 04		
	Final Budgets (£000)	YTD Budget (£000)	YTD Actual (£000)	Variance Sur/(deficit) (£000)
In Sector SLAs				
Chelsea And Westminster Hospital NHS Foundation Trust	2,595	861	749	112
Imperial College Healthcare NHS Trust	12,505	4,144	4,200	(56)
London North West Hospitals NHS Trust	18,048	5,972	5,654	318
Royal Brompton And Harefield NHS Foundation Trust	7,901	2,635	2,397	239
The Hillingdon Hospitals NHS Foundation Trust	140,767	46,969	48,421	(1,453)
Sub-total - In Sector SLAs	**181,815**	**60,581**	**61,420**	**(840)**
Sub-total - Out of Sector SLAs	**33,678**	**11,144**	**10,989**	**155**
Sub-total - Non NHS SLAs	**1,769**	**578**	**578**	**1**
Total - Acute SLAs	**217,263**	**72,303**	**72,987**	**(684)**

Continuing Care

		Year to Date Month 04		
	Final Budgets (£000)	YTD Budget (£000)	YTD Actual (£000)	Variance Sur/(deficit) (£000)
Mental Health EMI (Over 65) - Residential	2,913	971	926	45
Mental Health EMI (Over 65) - Domiciliary	199	66	90	(24)
Physical Disabilities (Under 65) - Residential	1,895	632	891	(260)
Physical Disabilities (Under 65) - Domiciliary	2,370	790	701	89
Elderly Frail (Over 65) - Residential	1,968	656	926	(270)
Elderly Frail (Over 65) - Domiciliary	251	84	75	9
Palliative Care - Residential	509	170	194	(24)
Palliative Care - Domiciliary	596	199	261	(63)
Sub-total - CHC Adult Fully Funded	**10,701**	**3,567**	**4,065**	**(498)**
Sub-total - Funded Nursing Care	**3,025**	**1,008**	**1,075**	**(67)**
Sub-total - CHC Children	**1,445**	**482**	**817**	**(335)**
Sub-total - CHC Other	**1,325**	**442**	**484**	**(43)**
Sub-total - CHC Learning Disabilities	**3,341**	**1,114**	**1,204**	**(90)**
Total - Continuing Care	**19,837**	**6,612**	**7,645**	**(1,032)**

FOT Position- Acute Contracts and Continuing Care

Table 3

Acute Contracts

	Year to Date Month 04		Forecast Outturn Position		
	YTD Actual (£000)	Variance Sur/(deficit) (£000)	FOT Actual (£000)	FOT Variance Sur/(deficit) (£000)	FOT QIPP Variance (£000)
In Sector SLAs					
Chelsea And Westminster Hospital NHS Foundation Trust	749	112	2,260	335	
Imperial College Healthcare NHS Trust	4,200	(56)	12,950	(445)	(8)
London North West Hospitals NHS Trust	5,654	318	17,303	745	6
Royal Brompton And Harefield NHS Foundation Trust	2,397	239	7,544	357	(28)
The Hillingdon Hospitals NHS Foundation Trust	48,421	(1,453)	142,814	(2,048)	(408)
Sub-total - In Sector SLAs	**61,420**	**(840)**	**182,871**	**(1,056)**	**(438)**
Sub-total - Out of Sector SLAs	**10,989**	**155**	**33,450**	**229**	**(0)**
Sub-total - Non NHS SLAs	**578**	**1**	**1,767**	**2**	**0**
Total - Acute SLAs	**72,987**	**(684)**	**218,088**	**(825)**	**(439)**

Continuing Care

	Year to Date Month 04		Forecast Outturn Position		
	YTD Actual (£000)	Variance Sur/(deficit) (£000)	FOT Actual (£000)	FOT Variance Sur/(deficit) (£000)	FOT QIPP Variance (£000)
Mental Health EMI (Over 65) - Residential	926	45	2,668	245	
Mental Health EMI (Over 65) - Domiciliary	90	(24)	270	(71)	
Physical Disabilities (Under 65) - Residential	891	(260)	2,485	(590)	
Physical Disabilities (Under 65) - Domiciliary	701	89	1,992	378	
Elderly Frail (Over 65) - Residential	926	(270)	2,863	(895)	
Elderly Frail (Over 65) - Domiciliary	75	9	225	26	
Palliative Care - Residential	194	(24)	588	(79)	
Palliative Care - Domiciliary	261	(63)	853	(258)	
Sub-total - CHC Adult Fully Funded	**4,065**	**(498)**	**11,945**	**(1,244)**	**0**
Sub-total - Funded Nursing Care	**1,075**	**(67)**	**3,213**	**(188)**	**0**
Sub-total - CHC Children	**817**	**(335)**	**1,766**	**(321)**	**0**
Sub-total - CHC Other	**484**	**(43)**	**1,380**	**(55)**	**(4)**
Sub-total - CHC Learning Disabilities	**1,204**	**(90)**	**3,529**	**(188)**	**0**
Total - Continuing Care	**7,645**	**(1,032)**	**21,833**	**(1,995)**	**(4)**

3.5 QIPP update

2017/18 QIPP M4 YTD Performance

Since the last HWB, the 2017/18 QIPP target has increased from £12.6m to £14.4m, or 4% of the CCG allocation. The CCG is £332k behind target for M4, achieving £2,482k of £2,813k YTD plan.

Workstream	2017/18 Net Target Savings £'000	M4 Actual £'000	M4 Plan £'000	Difference £'000
Unplanned Care	(1,978)	(368)	(254)	114
Planned Care	(1,684)	(209)	(430)	(221)
Long Term Conditions	(2,160)	(351)	(438)	(87)
Older Peoples	(1,723)	(314)	(441)	(127)
Mental Health	(1,186)	(404)	(404)	0
Prescribing	(2,042)	(414)	(414)	0
Community & Primary Care	(1,403)	(186)	(186)	0
End of Life	(412)	(104)	(128)	0
Complex patients	(100)	(6)	(6)	0
Children & Young People	(354)	(126)	(113)	13
S&T	(1,331)	0	0	0
Total	**(14,373)**	**(2,482)**	**(2,813)**	**(332)**

Key risks for achieving 2017/18 QIPP:

- The CCG has historically delivered c£8m QIPP. £14.4m represents an additional 80% ask on historic delivery.
- No longer any 'easy' QIPP schemes and a lack of 'new' schemes to address productivity without an associated risk to quality of delivery/access.
- Provider capacity issues, notwithstanding efforts to improve process efficiencies and patient flows between organisations.
- Delayed implementation of QIPP programmes resulting in reduced in-year savings.
- Time to implement and embed transformation.

In mitigating these risks, the CCG has a robust QIPP plan that has been recognised by NHS England as having identified all the potential opportunities in the system, matching those outlined by RightCare and CEP. We nevertheless continue to look for additional opportunities to mitigate risk of non-delivery.

The focus of 2017/18 QIPP programme is largely transformational. These are not easy, nor 'new' schemes, but will result in care closer to home and in the community, avoiding expensive acute episodes. Furthermore, there is a greater focus on prevention, with investments in long term conditions and primary care capacity with primary care delegation. We have several demand management schemes aimed to help direct patients to the right care and prevent an acute attendance. Other opportunities are occurring in regards to assuring referral pathways and associated community/social care service support, as well as integrated care in relation to the ACP and other joined-up working. Continued attention and support to provider efficiency and best practice will also be important to a sustainable health system in Hillingdon.

2017/18 Workstream performance– exception reporting

Planned Care
Planned Care QIPP programmes have experienced delays to implementation of procurements due to the need for deep dives in several contracts that have come due for expiration, some of which have also underperformed in delivery.

Long Term Conditions
Underperformance in LTCs is due to roll out of programmes.

Older People's
Current underperformance in Older People's programmes are driven by the phasing in the return on investment in the Care Connection Teams, which have recently been fully recruited to (2014/15 teams) and have begun reporting from M4. Delivery should balance toward target over the 2017/18 FY.

3.6 NWL CCGs collaborative working

NWL CCGs are currently reviewing collaborative working arrangements to ensure we maximise our ability to take a strategic and transformational approach to commissioning. Current areas of focus are the future role of the Accountable Officer and the contracting function. Corporate functions such as finance, quality and performance will also form part of the review.

3.7 Changes to CCG Governing Body

We are pleased to welcome Sarah Crowther to the Governing Body as our new lay member for public and patient involvement and engagement. Sarah brings extensive knowledge, skills and experience of working in the third sector in Hillingdon and we very much look forward to working with her.

4. 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

HEALTHWATCH HILLINGDON UPDATE

Relevant Board Member(s)	Stephen Otter, Healthwatch Hillingdon Chair
Organisation	Healthwatch Hillingdon
Report author	Graham Hawkes, Chief Executive Officer, Healthwatch Hillingdon
Papers with report	Appendix A - Healthwatch Hillingdon Reports Update Appendix B - Healthwatch Hillingdon Annual Report 2016-17

HEADLINE INFORMATION

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

RECOMMENDATION

That the Health and Wellbeing Board note the report received.

1. INFORMATION

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

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

2. SUMMARY

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

Hillingdon Board Meetings and is available to view on our website: (http://healthwatchhillingdon.org.uk/index.php/publications)

Healthwatch Hillingdon Annual Report 2016-17

Healthwatch Hillingdon published our Annual Report 2016-17 on 30 June 2017 and formally submit it for consideration to the Health and Well Board as Appendix B.

The report is publicly available on our website and has also been submitted to Healthwatch England, the Care Quality Commission, NHS England, Hillingdon Clinical Commissioning Group, London Borough of Hillingdon, and the Hillingdon External Services Scrutiny Committee.

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 first quarter of 2017-18.

3.1. Changes to GP Prescribing

During this quarter we have been extensively engaged by the NWL CCG Collaborative on their proposed changes to GP prescribing. Through our seats on the NHS Hillingdon CCG and the NHS NWL Patient Participation Group we have been able to challenge the legality of the process, shape the proposals, and the development of the engagement materials, to ensure they were fair and not confusing for the public.

On 12 June 2017, following the general election purdah, the NHS North West London CCG Collaborative entered into a brief engagement exercise with the public on its proposed changes.

Healthwatch Hillingdon is very disappointed that a decision is being taken by Hillingdon CCG to change the way in which it is asking GP's to prescribe after a brief 3-week engagement exercise. Especially as NHS England is carrying out similar prescribing changes and are consulting nationally for 12 weeks and that during engagement people asked for more time to be given to understand the implications of the proposals.

We are however pleased that Hillingdon CCG have agreed that robust communication plans will be put into place prior to implementation and further work will be carried out to support GP practices and patients with behaviour change.

This is clearly needed, as following the initial proposals being shared with GPs Healthwatch Hillingdon saw a sharp rise in the number of calls from concerned residents who had been told by their GP that the over the counter medication they are normally prescribed is no longer available on the NHS.

Further information, including the letter we sent to NHS Hillingdon CCG and their response, can be found on our website. http://bit.ly/2s8HquS

3.2. Patient Information Booklet

As a direct result of our hospital discharge project we have worked with Health and Social Care Partners to redesign the 'Working together' booklet at Hillingdon Hospital which provides patients with important information about their inpatient stay, their discharge and ongoing care if required. The new booklet, which now also incorporates a section which will aid communication

for the patient and their families, was rolled out across the Trust in June 2017 and will be given to every patient. Further information on this and other recent recommendations are detailed in section 5 of this report.

3.3. **Information, Advice and Support**

During this quarter we recorded a total of 96 enquiries from residents into our signposting service.

74% of residents accessed our service through the shop, which remains the main point of contact. Nearly 85% of people contacted us for the first time and 40% of people were either signposted to the voluntary sector, or given information about their services. The following tables give a full breakdown of the activity.

How did we assist?	Qty	%
Signpost to health or care service	28	29%
Signpost to voluntary sector svs	17	18%
Requesting information / advice	35	36%
Requesting help / assistance	3	3%
General Enquiry	13	14%
Total	**96**	

How did we receive enquiry?	Qty	%
shop	71	74%
phone	20	21%
email	0	0%
website	0	0%
event	1	1%
Unknown	4	4%
Total	**96**	

How person heard about us?	Qty	%
shopper	54	56%
known	16	17%
referral	6	6%
advert	1	1%
Other	10	10%
Unknown	9	9%
Total	**96**	

Signposted to?	Qty	%
Age UK Hill	4	5%
Hill Carers	3	4%
DASH	6	8%
Hillingdon MIND	3	4%
H4All	0	0%
Citizens Advice	7	9%
Other -Voluntary	9	12%
HCCG	1	1%
NHSE	1	1%
GP	10	13%
THH	0	0%
CNWL-MH	5	6%
CNWL-CH	2	3%
Other -CH	5	6%
Optician	0	0%
Dentist	7	9%
Pharmacy	2	3%
LBH - SS	2	3%
LBH – PH	0	0%
LBH - Other	4	5%
CQC	0	0%
POhWER	1	1%
Other Local HW	2	3%
Other	3	4%
Total	**77**	

3.4. **Concerns and complaints**

Healthwatch Hillingdon recorded 112 experiences, concerns and complaints in this quarter. The areas by organisational function are broken down in the following tables.

Primary Care / Other Services	Qty	**%**
Community MHT	4	8%
Community Nursing	1	2%
Continuing Care	1	2%
GP Services	30	57%
Other	6	11%
Pharmacy	3	6%
Rehabilitation Services	1	2%
NHS 111	2	4%
Equipment Services	5	9%
TOTAL	**53**	

Social Services	Qty	**%**
Nursing Care Home	1	4%
Assessment	1	4%
Aftercare	1	4%
Residential Care Home	1	4%
Assisted Living	1	4%
Children Services	1	4%
Care at Home	9	35%
Care Assessments	2	8%
Drug & Alcohol Services	3	12%
SS - adult physical disability	1	4%
Other	5	19%
TOTAL	**26**	

Hospital service	Qty	**%**
A&E	3	9%
Acute Care	1	3%
Cancer Services	3	9%
Care of the Elderly	3	9%
CAMHS - NHS	3	9%
Ear, Nose & Throat	1	3%
Gastroenterology	3	9%
Haematology	2	6%
MH - Ward based	2	6%
Minor Injuries Unit	1	3%
Neurology	1	3%
Occu Therapy	1	3%
Orthopaedics	3	9%
Outpatients	1	3%
Renal Medicine	1	3%
Urology	1	3%
Other	3	9%
TOTAL	**33**	

3.5. **Referring to Advocacy**

Advocacy Referrals	Qty
SEAP (Bucks NHS Complaints Advocacy)	1
AvMA (Action against Medical Accidents)	1
LBH Safeguarding	1
NHS Safeguarding	0
H4All Wellbeing Service	7
PoHwer (LBH NHS Complaints Advocacy)	14
TOTAL	**24**

3.6. **Overview from data**

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

Staff Attitude

The attitude of staff remains one of the highest reasons for complaint reported to us by the public. This account is on the extreme but similar are recorded where patients feel they are spoken at and their views ignored.

“I was very disappointed with my appointment at the surgery with Dr. S on xxth April 2017. It was our first meeting! I had been worried about a pain in my right side abdomen, and possible ovarian cancer risk. I was given an examination and then the doctor proceeded to bombard me with questions regarding my repeat prescription medication - I was shocked and tried to explain why I had been prescribed various drugs that were on there. He was very aggressive towards me and argumentative. He then accused me of being controlling and a strong woman. I felt upset and stressed by this point - this is totally the wrong way to deal with a patient - I was under attack!! I constantly had to remind him why I had come because of the pain I had and what was he going to do about it. He then organised various blood tests and an ultrasound.

He then discovered I had not had a blood pressure test for 2 years even though the last recorded test had been high and my cholesterol levels were also high.
Without hesitation he announced that everything on my repeat prescription was cancelled. This man doesn't know my history or reasons why I'm on those drugs. I think this is a very dangerous way to behave. By this time I was extremely upset! I got the impression that the GP was only interested in cost of medication rather than me as a patient. I no longer have any confidence in that GP and don't want to ever see him again."

In this particular case the patient wanted to make a complaint and they were referred to NHS Complaints Advocacy and advised to consider moving to a different GP practice.

Patient De-registration

During this quarter we heard from a number of patients about GP practices who were de-registering “out-of-area” patients. This included a vulnerable patient with mental health issues and a husband and wife in their 80s, who both had multiple long-term conditions and had been registered with their current GP for the past 50 years.

Evidence suggested that these patients were randomly selected, rather than it being a uniform process applied to all “out-of-area” patients. It was also apparent that the correct NHS England procedures had not been adhered to, as patients were notified in a terse letter, given an arbitrary notice period, and were not supported to find an alternative GP Practice.

Healthwatch Hillingdon raised these incidents and the increased occurrences with NHS England and Hillingdon CCG, who spoke to the practices in question to ensure they acted within the law and followed best practice.
We are pleased to note that since this intervention reports to us of “out-of-area” de-registration has stopped.

The failure to plan the de-registration of the patient with mental health issues has been very expensive and resource intensive for the NHS. They went into crisis after receiving the de-registration letter and had several interactions with health professionals, including London

Ambulance Service, NHS 111 and Hillingdon's A&E. This is particularly disappointing as the individual contacted us shortly after receiving their letter and the GP Practice would not listen to our requests for a planned handover. We have now supported the patient to register with another GP practice that can meet their needs.

In the case of the husband and wife, Healthwatch Hillingdon supported the couple to find and register with another GP practice that had good disability access. The couple have since fed back to Healthwatch Hillingdon that they are "really happy with the new GP practice, it is much better than their previous GP practice and we should have moved years ago!! Thank you for your help".

Treatment Refused for Being a Hillingdon Resident

We were contacted by a mother whose son had been refused an assessment for autism at Northwick Park Hospital because they did not live in Harrow. Their GP had correctly offered the mother a choice of hospitals for the assessment and the family had chosen Northwick Park Hospital however the Consultant had written back to advise "Unfortunately, this child does not live in Harrow and would need to be referred to Hillingdon Hospital".

The mother was very worried about the delay in referral as son is missing out on school and wished to know whether her son had a choice to which hospital to be referred to and if they did, how the family could exercise their son's right to choice.

Healthwatch Hillingdon wrote directly to NHS Hillingdon CCG - who commission the service - to request that the child's right to choose hospital for the first outpatient appointment is delivered as set out in the NHS Constitution. Within 2 weeks the child was offered an appointment at Northwick park Hospital and the family were very grateful for Healthwatch Hillingdon's prompt intervention to ensure that the rights of their child were protected.

Poor Discharge

A patient with bowel cancer was admitted to Hillingdon Hospital with a bowel blockage. Following treatment, nurses promised the family that they would make sure that a home care support package would be put in place on the day of his discharge. However, patient was discharged at 10pm and sent home by ambulance, without a package. The patient's wife contacted the hospital but could not reach anybody who knew about the care package and contacted ourselves. We were able to support the family to ensure the appropriate care package is now in place. This however is further evidence that serious consideration be given to a proposed single point of access for discharge, as we recommended in our hospital discharge report.

Wheelchair Service

We have continued to hear from people about long delays in the wheelchair service. This has been raised with NHS Hillingdon CCG and Opcare, who provide the service for Hillingdon residents. As a result the delays are being actively addressed by the service provider.

During this period NHS England also published new NHS Wheelchair Service Specifications for commissioned wheelchair services, amid national data (Q4 2016/17) that showed around 25% of children are waiting over 18 weeks for a wheelchair and 17% of adults. We will be looking at how these specifications can be embedded in the current contract to improve the quality of service delivery locally.

4. STRATEGIC WORKING

4.1. Children and Young Peoples Mental Health (CYPMH) Transformation Plan

Healthwatch Hillingdon are disappointed by the results of the co-production work announced at the recent conference. Concerns had been raised by ourselves and partners at the Children and Young Peoples Mental Health and Wellbeing (CYPMHW) Steering Group, that this work could potentially duplicate previous engagement. We therefore found it extremely frustrating that the reported findings and the subsequent recommendations were virtually the same as the Healthwatch Report published in July 2015.

Since the findings were revealed, we have been approached by a number of the voluntary sector organisations and the parents involved in the work. They have all expressed their disappointment and their concern, that not only was the work a duplication, but as it came to the same conclusions as the Healthwatch report, a realisation that early intervention services are the same as they were 2 years ago when the Healthwatch report was published. This concern was exacerbated by the discussions held at the conference, which outlined that to be able to implement the early intervention services identified, funding would need to be released from the Acute CAMHS Service.

It is Healthwatch's view that with demand increasing for CAMHS, and treatment within 18 weeks of referrals running at 57% in July, the redistribution of funding to early intervention seems very unlikely in the short term. Healthwatch Hillingdon have therefore made a recommendation to commissioners to undertake an evaluation of the membership of the CYPMHW Steering Group, to strengthen the governance and put in place a new Year 3 plan, which clearly identifies:

- the required workstreams and actions
- the appropriate time scales
- the responsible officers
- the agreed funding for each workstream

We believe this recommendation is in the best interest of all partners and the delivery of the CYPMH Transformation Plan.

4.2. Healthwatch Hillingdon Reports

This year Healthwatch Hillingdon have presented 2 reports to the Health and Wellbeing Board, Safely Home to the Right Care and Expecting the Perfect Start.

Healthwatch strategically monitor the recommendations made within these reports to determine if they have been adopted by health and care partners and where implemented, the progress being made.

We have recently submitted a report to the NHS Hillingdon CCG on the progress being made on the recommendations and submit it to the Board for Members information. (APPENDIX A) Additionally, we would advise that both reports have been presented at the Hillingdon External Services Scrutiny Committee. In April we presented our discharge report to The Hillingdon Hospital NHS Trust Board at their Board seminar and on 25 May 2017, we presented our maternity report to the NWL Quality Safety Group (QSG).

The Report was warmly and widely welcomed by the QSG and there were many comments on how balanced the report was and that we had taken the time to involve midwives and consultants in the project.

The report was acknowledged “as best practice” in undertaking a review of people’s experience of maternity services.

The NWL QSG Chair noted the “great recommendations” in the report and highlighted that they will expect that all the Healthwatch Hillingdon recommendations be implemented and monitored.

The London Maternity Clinical Networks (NHS England) were very keen to provide us with an opportunity to present our report to them and we have subsequently been invited to present on engagement at the London Maternity Voice Partnership Event.

We have also accepted an invitation to present the discharge report to the NWL QSG at a later date.

5. ENGAGEMENT OVERVIEW

This quarter we directly engaged with 220 residents and patients through 13 community events, talks, presentations and information days attended by over 900 people.

Throughout the period, Healthwatch Hillingdon attended a number of community events and groups across Hillingdon. They included the Alzheimer's Cafe, the Older People's Assembly, Parent Carers Group, Hillingdon Carers Fair and a Dementia awareness event hosted by Yeading Library.

Events such as the Older Peoples Assembly and Hillingdon Carers Fair are regular fixtures in the Healthwatch Hillingdon events calendar and during this quarter’s events we reached out to over 50 members of the public.

By attending these events we had the opportunity to inform the public of our work and of the services we offer, however the format of these events, made it quite difficult to gather individuals feedback about experiences of services.

Our attendance at the Alzheimer's Cafe at Hayes & Harlington Community Centre and the Dementia Awareness event at Yeading Library, although comparatively smaller in terms of the attendees, proved to be more conducive. With the groups being smaller it allowed for more interaction, open group discussions and an opportunity to talk to a member of the Healthwatch team about their concerns or issues in a quiet and confidential setting away from the main event.

For instance, at the Alzheimer's Café we spoke in some length with a local resident who had waited several months to get the right prescription from her GP. The delay had negatively impacted on her health. She also informed us of the difficulties she had encountered with her local Tesco pharmacy as they continued to prescribe her with medications she no longer wanted. Despite their error they refused to accept the medicines back which she considered to be very wasteful.

As with most months; the main themes to come out of this quarters engagement included access to GP appointments, dental care and difficulty obtaining repeat prescriptions. This quarter we also heard from several visually impaired residents about the barriers they faced when accessing services. Several complained about missing their GP appointments because they were not informed by the GP receptionist when it was there turn to be seen because their surgeries only used digital boards to display resident’s names.

Volunteering

Healthwatch Hillingdon volunteers gave around 540 hours of their time this quarter and volunteered in a variety of roles including governance, inspection, outreach and engagement, social media and website redesign.

During April/May 2017 we were represented on the patient meal procurement panel at Hillingdon Hospital by an experienced member of our PLACE Assessor Team, as the Trust went out to tender for a new patient meal provision.

In June, we were delighted to welcome Alison Nieves to the team who has been tasked with revising the content for our revamped website. Alison has several years of editorial experience which makes her an excellent choice for this role.

To mark this year's National 'Volunteers' Week, we hosted two Open Day events in Hillingdon to recruit volunteers for Ambassador and Board Member roles. The events gave anyone interested in volunteering the opportunity to come along for an informal chat with staff and existing volunteers. These events generated quite a bit of interest from members of the public and we had at least 2 local residents express an interest in joining the Healthwatch Hillingdon Board.

Digital Engagement

We continue to use our existing social media channels to promote the work of Healthwatch Hillingdon, engage with the public and get involved in the local community.

This quarter, we used our social media platforms to publicise both our Maternity Care Report and Annual Report plus key news stories. We engaged with the public to participate in the CCG's consultation regarding the planned merger of Hayes Town Medical Centre and the Orchard Medical Practice and we have been promoting our engagement events via these channels.

6. ENTER AND VIEW ACTIVITY

PLACE Assessments

April and May are a busy time for our PLACE Assessors. They worked over 4 days at Hillingdon Hospital to help assess 10 Wards, 6 Outpatients, the A & E, communal internal areas, external grounds and undertake 3 ward food assessments.

They also worked with Central North West London NHS FT to assess the mental and community health care environments at Colham Road and the Riverside and Woodlands Centres.

7. FINANCIAL STATEMENT

Quarter 1 - 2017-2018

Income	£
Funding received from local authority to deliver local Healthwatch statutory activities	41,563
Bought forward 2016/2017	6,531
Additional income	0
Total income	48,093
Expenditure	
Operational costs	1,210
Staffing costs	28,276
Office costs*	7,231
Total expenditure	36,717
Surplus to c/f	11,376

*Rates and Insurance paid in month 1 for whole year.

8. KEY PERFORMANCE INDICATORS

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 2017-2019.

The following table provides a summary of our performance against these targets.

KPI no.	Description	Relevant Strategic Priority	Quarter Target 2017-18	Q1			
				2014-2015	2015-2016	2016-2017	2017-2018
1	Hours contributed by volunteers	SP4	525	692	550	637	**540**
2	People directly engaged	SP1 SP4	375		354	434	**220**
3	New enquiries from the public	SP1 SP5	175	124	232	177	**208**
4	Referrals to complaints or advocacy services	SP5	N/A*	19	9	12	**24**
5	Commissioner / Provider meetings	SP3 SP4 SP5 SP7	50	68	49	93	**62**
6	Consumer group meetings / events	SP1 SP7	15	62	22	16	**26**

7	Statutory reviews of service providers	SP5 SP4	N/A*	0	0	0	**0**
8	Non-statutory reviews of service providers	SP5 SP4	N/A*	5	7	3	**5**

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

APPENDIX A

UPDATE ON HEALTHWATCH HILLINGDON PUBLISHED REPORTS 2016-17

Graham Hawkes, Chief Executive Officer

Summary

Healthwatch Hillingdon published 2 reports in 2016/17, Safely Home to the Right Care and Expecting the Perfect Start. These looked at discharge from hospital and maternity care respectively.

The following report gives an overview of the recommendations made in these reports and where they have been adopted by health and care partners, the progress being made in implementing them.

Safely Home to the Right Care

Introduction

The Healthwatch Hillingdon Discharge Project engaged with older people who had recently been discharged from Hillingdon Hospital. We followed their journey from hospital back into the community, to gain a better understanding of the discharge process and the care and support provided to patients when they are back home.
In February 2017, we published the results of the engagement with 172 patients, carers, family and staff from over 20 organisations, in our report – **Safely 'Home' to the Right Care** [1].

Based on the evidence attained we made 9 recommendations to commissioners and providers on how the patient experience could be approved.

8 of the recommendations have been adopted by health and social care partners and now form part of the Better Care Fund Plan 2017/19[2] and the Discharge Improvement Programme within Hillingdon; which are monitored by both the Health and Wellbeing Board and A&E Delivery Board.

Recommendations

1. The Hillingdon Hospitals NHS FT (The Trust) has a booklet titled 'Working together'. This was a trust wide initiative which commenced in September 2014 with the aim of issuing this booklet to all admitted patients. The booklet would then be filled in during the inpatient stay, and would be completed on discharge complying with many of the details listed in the NICE requirements.

   We recommended that this booklet be reviewed and updated to produce a 'Patient Journey' booklet that keeps patient/carer fully informed during the inpatient stay and outlines the details of the follow-up care and support arranged.

[1] http://bit.ly/2vzlMBy
[2] http://bit.ly/2wkO2a0

This would then act as a clear method of communication between patient/carers and professionals in hospital and in the community.

We worked with Health and Social Care Partners to redesign the 'Working together' booklet[3] to include the areas patients and their families told us were required. In March 2017 a final draft was agreed and 35,000 copies were produced. The booklet was rolled out across the Trust in June 2017.

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2. We would recommend that patient/carers are provided with written information about social care and continuing health care assessments in line with the Care Act. This should clearly outline, entitlement, assessment process, financial implications and support and information to make decisions on the selection of private care.

Summary information and useful reference points were included in the 'Working together' booklet.

Further provision is being developed to ensure consistent independent advice and support is given to patients. Once in place this will outline the options available for both public funded and self-funded post discharge and ensure patients can make informed choices.

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3. We recommended that where an individual has substantial difficulty in being involved in the assessment process and their onward care provision, that an independent advocacy should be provided.

There are a number of actions being currently proposed for this recommendation and it is hoped these will be in place towards the end of 2017.

These look to develop an independent advocacy service for patients who have capacity. Ensuring patients have access to appropriate provision and are supported. Early scoping work is currently being undertaken and implementation is likely to be late 2017.

To ensure patients interests are represented and there choice is protected, where applicable, staff at THH will also be undertaking training on the provision of Independent Mental Health Advocacy and Independent Mental Capacity Advocacy.

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4. We recommended that the hospital looks to standardise the discharge process across all wards. A compulsory uniform process could provide many benefits to improve the patient and staff experience.

It has been acknowledged by the Trust that discharge processes need to be uniform across their wards. The Trust is working closely with all partners and have invited support from the NHS Emergency Care Improvement Programme (ECIP).

[3] http://bit.ly/2wu3svt

A standard discharge approach has been adopted called Red2Green. This will be fully implemented across the Trust by October 2017. This approach is used to reduce internal and external delays as part of the SAFER[4] patient flow bundle and expected to make a real difference by reducing unnecessary delays.

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5. We recommended a review of the discharge lounge be carried out, to assess how effective it is in meeting the needs of patient/carers who are waiting there. Without any pre-emption of this assessment, we suggested that the scope included looking at facilities/amenities available to patients, food and drink, and timely information on their medication or transport.

The Trust acted swiftly to address the issues we had found in the discharge lounge. They now provide hot food, and water for waiting patients and are reducing the amount of time that patients wait for their transport.

There has also been a review of the use of the discharge lounge and whether it could be relocated to optimise its use. This work is ongoing and no time scales have been set.

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6. We recommended that in addition to written instructions for those patients being prescribed multiple medications, that the hospital also looks to provide Dosette boxes, or blister packs. This will mitigate against possible unintentional overdose, improve patient safety and could avoid some readmissions.

To date there has been no progress on this recommendation. The Trust are unable to provide Dosette boxes and it remains the responsibility of the GP to prescribe. Further work is required to understand the processes and look at possible solutions.

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7. We recommended that when discharging an older person that it becomes standard practice to proactively refer to Hillingdon Carers for further support.

This recommendation has been adopted and is incorporated into the Better Care Fund Scheme 2 (An integrated approach to supporting Carers). Processes are in place at the Trust to identify carers and they are publishing a new carers strategy to ensure carers are supported at admission and discharge.

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8. We recommended that serious consideration is given to the proposed '*single point of access for discharge*'.

It has been agreed by partners that having a single point of access for discharge would improve communication between partners.

[4] http://bit.ly/2vBdWoO

A single point of access is being developed for end of life services and conversations have taken place to look at expanding this as a possible solution for discharge. There are also options being discussed to utilise the community health contact centre and the possibility of an information hub for discharge.

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9. We recommended an evaluation of the Integrated Discharge Team. To review membership and effectiveness.

A full review of the integrated discharge function was completed in July 2017. Space was found for social care staff at the Trust and it is planned that the numbers present be increased by October 2017.

The Home 2 Access programme is currently being piloted. This work will enable partners in the integrated discharge function to work closer together. Embedded as Scheme 4 of the Better Care Fund, it is hoped that by October 2017, a Joint Discharge Policy will be ratified by all partners, joint discharge procedures will be in place and trusted assessor arrangements established.

Expecting the Perfect Start

Introduction

Ealing Hospital's Maternity Unit closed in July 2015 under the NWL Shaping a Healthier Future reconfiguration programme. It was expected that an additional 600 women from Ealing would give birth at Hillingdon Hospital's Maternity Unit in 2016-17. Healthwatch Hillingdon decided to measure the impact of the closure of the Ealing Maternity Unit on the experience of women giving birth at Hillingdon Hospital.

During our engagement we spoke to with 251 women who were using the hospitals maternity services, or had given birth since the change, and collected the views of midwives, children centre staff and doctors.

In March 2017 we published our report **'Expecting the Perfect Start'**[5] which outlined the very positive feedback we had received and gave an in-depth understanding of Hillingdon's Maternity Services.

We made 8 recommendations to help further improve the care provided and enhance the experience of women and their families. All have been adopted and an action plan put in place to address the areas identified for improvement. This will be reviewed at both the Maternity Services Liaison Committee (soon to be Maternity Voice Partnership) and the Borough's Children's Strategic Transformation Group.

[5] http://bit.ly/2nroLFP

Recommendations

1. We recommended that a review be carried out on how women were given information, as a number of women indicated that in addition to written literature they would have also preferred a verbal explanation.

Staff were reminded that they are required to ensure women understand the literature that has been given to them. Staff do now explain literature they give out and this is being further enhanced through the introduction of the "baby buddy" app, which contains all the information a woman will require throughout their pregnancy and motherhood.

2. We recommended a review be undertaken of interpreting services to support women who do not speak, or have little understanding of English, to meet Clinical Maternity Standards[6].

Interpreter services are available both face to face and over the phone. Staff are ensuring that women who require translation are being informed of its availability.
The Trust are also reviewing interpreter services to determine their future requirements.

3. We recommended a review of the continuity of care between women and their health professionals to meet the expectations of The National Maternity Review, 'Better Births'[7].

The Trust are part of the North West London Maternity Transformation Programme Early Adopters pilot. This will look to test the new models of care outlined in Better Births, which includes providing continuity of care throughout pregnancy and post birth, through small teams of dedicated midwifes.
The Programme has only recently started and will be fully implemented during 2018.

4. We recommended there be a review of the referral process between the hospital and The London Borough of Hillingdon who provide a smoking cessation service.

The Trust are reporting that 100% of women are informed about smoking cessation and that all who request it are referred to LBH. There is a perception that there are delays in women receiving appointments from LBH, which is contrary to the data. This is a similar position to our initial findings and the organisation will be working together to fully understand why the referral process is not working effectively.

[6] www.rcog.org.uk/en/guidelines-research-services/guidelines/standards-for-maternity-care/
[7] www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

5. We recommended the hospital considers introducing a pager system in the antenatal department to allow women the choice of waiting elsewhere during their appointments.

The Trust feel it would not be practical to operate a pager/messaging system. To accommodate the increase in activity, the capacity of the building needs to be increased. This is planned, but will not be completed until the funding under the Shaping a Healthier Future Strategic Outline Business Case part 1 is approved.
It is unlikely the building reconfiguration will be completed before 2019. The Trust are investigating alternative options and are looking at the possibility of providing clinics at Mount Vernon Hospital.

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6. We recommended there was a review of the referral pathway for Ealing residents to the Ealing perinatal mental health service; and that the Hillingdon Clinical Commissioning Group (CCG) review the perinatal mental health service in Hillingdon to see how future provision can be met.

There has been further CCG investment into the Perinatal Mental Health Service in NWL and services were expanded in June 2017 to meet future provision. The service is providing a wider range of interventions and referral pathways have been strengthened to ensure women are referred to the appropriate service.

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7. In the feedback that we received, over 50% of women indicated that they were not given choices of where to deliver their baby. In most cases this was GPs routinely referring them to Hillingdon Hospital.
We recommended that women are better informed about the choice they have of where they can deliver their babies.

This has been raised at a Hillingdon CCG Operational Development session. The actions required to inform GPs of the right to choice under 'Better Births' is yet to be established.

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8. We recommended Hillingdon Clinical Commissioning Group work with The Shaping a Healthier Future team and Hillingdon Hospital to review the provision of antenatal and postnatal clinics in Ealing.

The service provision is already in place, with a consultant clinic at an Ealing Hospital hub and 4 community based clinics at Children's and Health Centres in Ealing. How this provision is being communicated to Ealing women still requires review. The Ealing CCG Commissioner has been invited to the Children's Strategic Transformation Group but the post is currently vacant and a representative from Ealing CCG has not attended.

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healthwatch Hillingdon

Shining A Spotlight on Your Experience of Care

Healthwatch Hillingdon
Annual Report 2016/17

Contents

Message from our Chair

Welcome to the fourth Annual Report from Healthwatch Hillingdon. I am delighted to be able to report that we have continued our excellent progress during 2016/17 in helping to achieve real improvements in local health and social care services, although there is much still to be done.

Our aim is to give Hillingdon residents a voice to influence local change and to continue to highlight those services which fail to meet expectations.

I am particularly pleased that we can highlight several areas where the organisations that run our local Health and care services have acted upon our representations and made improvements to services as a result.

One of our main responsibilities is to listen to residents of Hillingdon so that we understand the things that are most important and the extent to which services are currently meeting your needs or expectations. We use this information to illustrate where patients and service users want to see changes, provide as much evidence as we can to support the need for improvement and we monitor progress being made by the appropriate agency. We are not always successful in obtaining the changes wanted by residents but we will continue to robustly represent your views and needs.

This report highlights many examples of areas where Healthwatch Hillingdon has been instrumental in achieving change, but one area that does warrant special mention is services for discharge for those aged over 65, from Hillingdon Hospital. We have been able to show that local services are often quite poor and those over 65, have not been receiving the support they need.

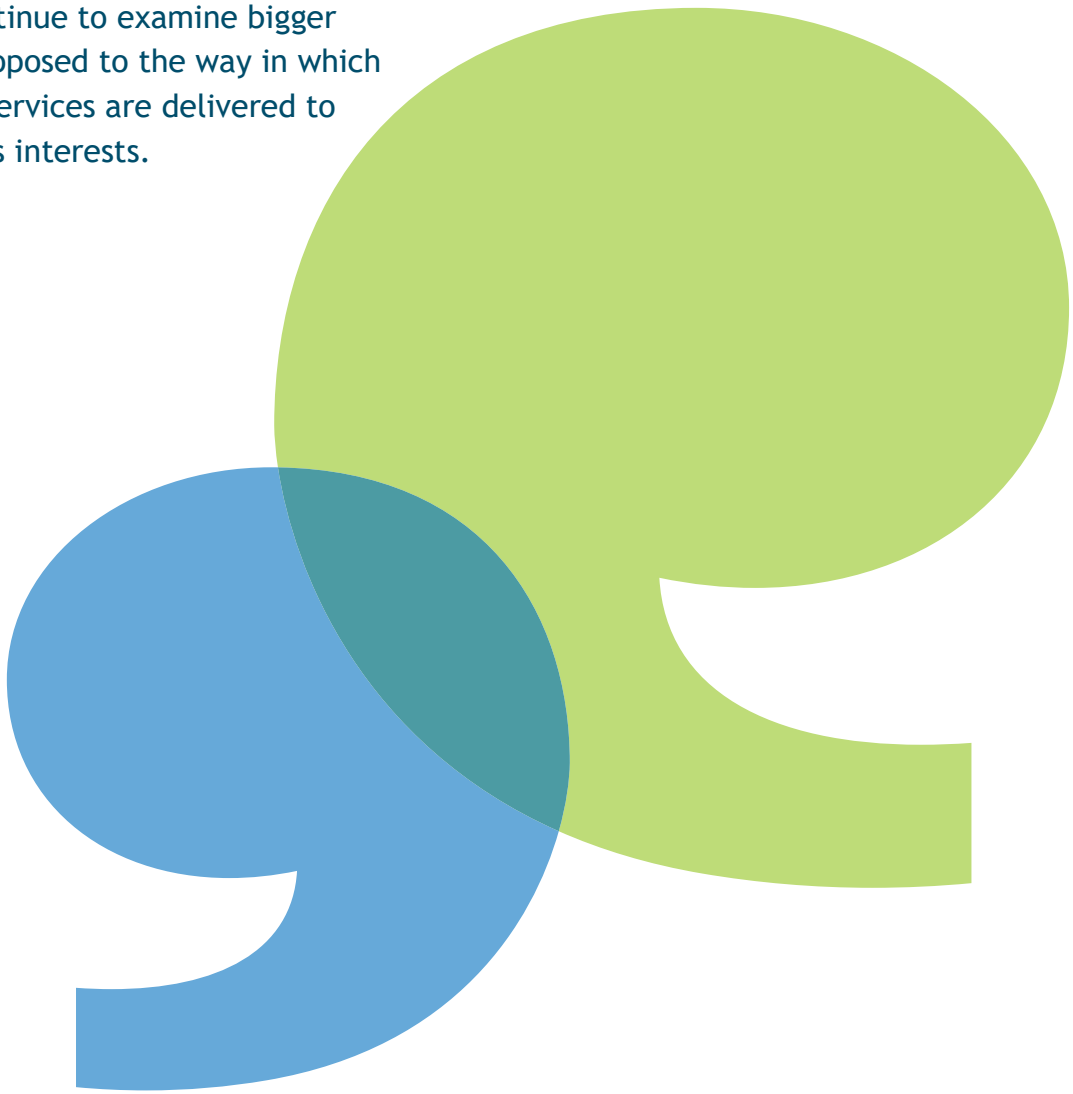
Pressures on Accident & Emergency are a national issue but we do believe that local services can be improved and we are still waiting to see tangible improvements in Health outcomes for people in our area and we will continue to watch for progress.

Our overriding priority for the future is to continue our successful work in helping to obtain local improvements in services. In addition to following up issues in any service, we are doing some work in specific areas.

We shall also continue to examine bigger changes being proposed to the way in which health and care services are delivered to protect resident's interests.

Finally, I would like to offer a huge thank you to Graham Hawkes, his team, the volunteers and the Board Members for their hard work, effort and support which have resulted in a successful year for Healthwatch and a first year for me as Chairman.

Stephen Otter
Chairman
Healthwatch Hillingdon



Message from our *Chief Executive*

It only seems like yesterday that we were starting Healthwatch Hillingdon and here we are publishing our 4th Annual Report. I do hope that you enjoy reading about our work, as you take a look at this snapshot of our year.

It has been a busy, interesting year, but most importantly, a year where we have continued to shine a spotlight upon people's experiences of local care.

Through our particular focus on hospital discharge, maternity services and fertility treatment, we have ensured decision makers know exactly what people feel about the service they have received and what is required to improve them.

It is really pleasing to see that the information collected in these comprehensive pieces of work is already changing services. Proving again how important it is for those who plan and run our care services to listen to the public they serve.

Healthwatch Hillingdon has represented the public at nearly 300 meetings this year. Being able to take real examples of the lived experience of patients to meetings, is key to ensuring the public voice is not only heard, but is influencing decisions made at the strategic table.

This year for the first time we surveyed the stakeholders we work with to see what they thought about how Healthwatch is working in Hillingdon. The results were very encouraging and I would like to think a positive endorsement of the way in which we independently operate, with the public at the heart of everything we do.

An aspect of our work, which has remained a focus since 2014, is children's mental health. It was specifically satisfying this year to see a publication[1] about the new community eating disorder service and how it had changed the lives of Leah and her family. It is very heartening to know that all our efforts are making a tangible difference.

[1] http://bit.ly/2kQyDfg

On another front, our shop remains a vital focal point for our signposting, advice and information service with over 70% of the 900 people we have seen contacting us through the shop. On so many occasions this year information received from one person has resulted in many people with the same issue being helped by a change in the way a service is delivered.

It takes a real team effort to achieve the work which is outlined in this report and I would like to personally thank everybody who has made a contribution to Healthwatch Hillingdon this year.

- The public, who have told us their stories, experiences and views;
- Our volunteers who have donated 2166 hours of their time and expertise, to make a difference in their community;
- The Healthwatch Hillingdon Board who have governed impeccably, providing guidance and support;
- The staff team, Raj, Pat and Charmaine, who are dedicated to helping people and the purposes of Healthwatch.

I express my sincere gratitude to Stephen Otter for accepting the position of Healthwatch Hillingdon Chair in October 2016. He has already shown great leadership in developing our vision, and continuing to maintain our well-respected position within Hillingdon and the wider Healthwatch Network.

I also thank Turkay Mahmoud who re-joined the Board in 2016, and as Vice-Chair is ably assisting Stephen to bring a renewed focus and drive to the executive team.

I would like to give special mention to Shirley Clipp and Christianah Olagunju who joined our staff team this year to deliver our work on discharge and maternity. These projects have been a major part of our success this year, and this would not have been possible without all their enthusiasm and efforts. Thank you!

Finally, I am going to unashamedly finish my message in exactly the same way as last year and ask for your help.

Our work has proved that armed with the evidence of your lived experience of care, we can improve services.

We need to hear from you, your family and your neighbours. Tell us your story! Together we can make a difference in our communities.

Graham Hawkes
Chief Executive Officer
Healthwatch Hillingdon

Forward – Councillor Philip Corthorne

I am delighted to welcome you to Healthwatch Hillingdon's latest annual report which, once again, sets out clearly the valuable work Healthwatch undertakes on behalf of residents and the difference that the "voice of the customer" can make.

I congratulate the Healthwatch Hillingdon team: the voluntary Board of Trustees under Stephen Otter's leadership, to Graham Hawkes and the small staff team and to the number of volunteers who have made the research, enquiries and representation possible.

I am also grateful to the public who have taken the time to tell their story, to engage and discuss so that their voice can be heard. I encourage everyone to continue to do so.

We now move forward with national programmes influencing and transforming health and social care. In doing so, Hillingdon Council will always put our residents first and act to support those locally. In Healthwatch Hillingdon we have an established and trusted partner and I look forward to our continued collaboration.

Councillor Philip Corthorne MCIPD
Cabinet Member for Social Services, Housing, Health and Wellbeing London Borough of Hillingdon

Highlights from our year

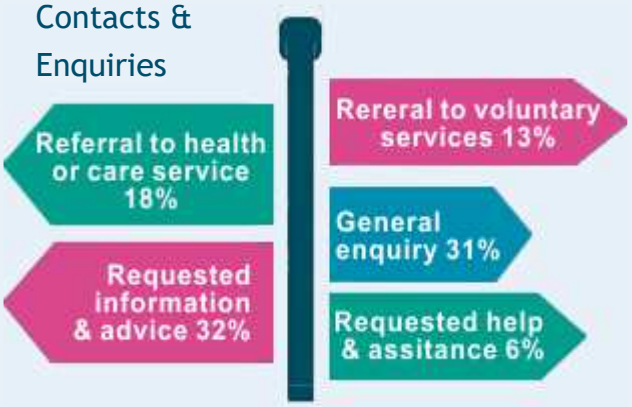
Listening to people who use health and social care

Our reports have focussed on Fertility, Discharge and Maternity

Engagement and Feedback

Giving people advice and information

Contacts & Enquiries



Top 5 Areas

Representation

Our People - Volunteering

Who we are

Healthwatch Hillingdon is completely separate from the NHS and the local authority. We represent the views of everyone who uses health and social care services in the London Borough of Hillingdon. We make sure that these views are gathered, analysed and acted upon, making services better now and in the future.

We exist to make health and social care services work for the people who use them, and we monitor local services to ensure they reflect the needs of the community, and where necessary, use statutory powers to hold those services to account.

Everything we say and do is informed by our connections to local people. Our sole focus is on understanding the needs, experiences and concerns of people of all ages who use services and to speak out on their behalf.

As part of a network of local Healthwatch from every local authority area in England, we are also uniquely placed to raise issues nationally through Healthwatch England.

Our vision

Our vision is to become the influential and effective voice of the public.

We want to ensure that local decision makers put the experiences of people at the heart of their work, giving adults, young people, children and communities a greater say in - and the power to challenge - how health and social care services are run in Hillingdon. This vision is founded on the strong belief that services work best when they are designed around the needs and experiences of the people who use them.

Our priorities

The focus of our work for 2016-17 was set by our Board in 2015 after undergoing an in-depth analysis of the data and intelligence gathered from our residents during the previous year.

The key areas for 2016-17 were:

Discharge from Hillingdon Hospital

This project engaged with Hillingdon Hospital patients over 65 who had recently gone through the discharge process to gain a greater understanding of their experience, ascertaining what worked well and where improvements could be made.

Maternity in Hillingdon

With 600 additional births expected in Hillingdon, this project investigated the potential affect that the closure of Ealing's maternity unit could have on the quality of care that women and their families were receiving.

Fertility treatment

In our 2016 report "IVF: Is Variation Fair?" we highlighted the inequality in access that women and couples face to access NHS fertility services. This report has acted as a catalyst for significant national debate on

the issue, as well as recognition from NHS England and the Department for Health that the current situation is unacceptable. We are pleased that the Department of Health have agreed to take forward many of the suggestions made in our report.

Our Work Plan 2015-2017 can be viewed at: http://bit.ly/20QJAcy

Our Shop

The Healthwatch Hillingdon shop in Uxbridge continues to be a major focal point for our work and we must again sincerely thank the Pavilions Shopping Centre for making this possible.

With **8,351,678** people recorded as passing through the Pavilions in 2016, it is an ideal location for us to reach and help as many people as possible.

We continue to provide our signposting service and give information, advice and support to our residents from an easily accessible central location.

Being directly open to the public, Monday to Friday has enabled us to talk to hundreds of residents and has been a rich source of information about the services provided in Hillingdon.

The shop is not just a Healthwatch Hillingdon vehicle; it's a community hub enabling us to engage with some diverse groups and communities. We have the added value of being able to offer other organisations within Hillingdon a venue to deliver their services.

This year we have continued to support REAP (Refugees in Effective and Active Partnership), the Pukaar Hillingdon, EACH Domestic Violence Counselling Service and The Hillingdon Learning Disability Team providing the facility for weekly sessions. The space has also been used by VoiceAbility as a place to meet clients.

We are also able to support the National Childbirth Trust's Little Bundles initiative programme through allowing them continued storage in our basement.

Listening to People…The Healthwatch Hillingdon Team….

Charmaine Goodridge

Dr Tarlochan (Raj) Grewal

Pat Maher

Your views on health and care

Listening to local people's views

How we've worked with our community

This year we recorded direct engagement with **2579** members of the public. That is up by **25**% on last year!

We spoke to residents at **59** community engagement and **413** were engaged through our discharge and maternity projects. Some of the events attended included the Older People's Assembly, the Disability Assembly and Brunel Universities Volunteers' Fair. As always, these large-scale events provided an excellent opportunity to promote the work of Healthwatch.

Healthwatch has attended 17 drop-in sessions, and has held surgeries at 15 of Hillingdon's 17 libraries. This has given us a presence in the community, and helped to raise our profile.

At the Oak Farm library, an elderly lady informed us of her late husband's frustration of having his haematology appointment cancelled 11 consecutive times at the Hillingdon Hospital.

She also expressed her own frustration at having had her hospital appointment cancelled on several occasions.

During this year, we also spoke at coffee mornings held by organisations such as the Salvation Army, Hillingdon Carers, Parkinson's UK and the Alzheimer's Society. As we anticipated, the number of attendees at these events was relatively small (on average 15-20 people) however this allowed for group discussions, and comprehensive feedback.

The key concerns highlighted by residents who attended the coffee morning events included access to GP appointments, not seeing the same GP at appointments (lack of continuity), repeat prescriptions and dental charges.

The coffee mornings have overall proved to be a very effective way of gathering targeted feedback and we will continue to incorporate them as part of our future engagement activities.

We were also at Hillingdon Age UK's 60 + Fair, Uxbridge Fresher's Fair, Hillingdon Health Conference, Parkinson's Information Day and Hillingdon Carers Health MOT day amongst others. These events were targeted towards different segments of the community and so presented an excellent opportunity to gather experiences from diverse audiences.

Our attendance at Uxbridge College Fresher's Fair was one of the highlights of our engagement activities this quarter as we were able to connect with a younger audience (16-24) who very rarely share their experiences of health and social care services. We were accompanied by 2 of our younger volunteers to assist on our stall as we felt the students would respond better to their peers.

This proved to be a positive approach as during the two-day event we spoke to over 50 young people and handed out our literature.

During 2016/17 we introduced a new feedback form called 'Have Your Say'. The form is used at public events to capture individual experiences – both positive and negative of accessing services.

During 2017 we also want to resume our presence at the Hillingdon Hospital by having a monthly stall in the entrance.

We will also reach out to Hillingdon's faith groups including mosques, churches and temples and youth organisations to capture the views and experiences of those who are seldom heard.

Promotion and Communication

To advertise and encourage people to talk to us we have promotional materials in GP practices, hospitals and libraries. Our details are in every edition of Hillingdon People and we regularly have articles published in the local paper, where we call for people's experiences on specific conditions and issues. (See later in the report).

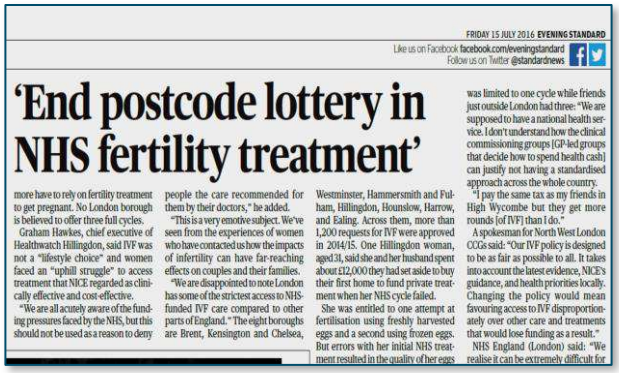
Social media has become an excellent way to raise our profile and reach members of the public. We continue to maintain a healthy online presence on Facebook and Twitter by regularly posting news stories, information and events on health and social care and encouraging our online communities to converse with us and share their views. We use popular Instagram to regularly post images of our outreach and engagement activities, and followers engage with us by commenting on or liking our posts.

Focus - reaching out to residents through local media

Fertility Treatment

As mentioned earlier in this report our 2016 report "IVF: Is Variation Fair?" highlighted the inequality in access that women and couples face to access NHS fertility services. This report has acted as a catalyst for significant national debate on the issue as well as recognition from NHS England and the Department for Health that the current situation is unacceptable. The Department of Health has given careful consideration to our report and we are pleased that they have agreed to take forward many of our suggestions.

This made headlines in the Evening Standard on July 15th 2016.



FRIDAY 15 JULY 2016 EVENING STANDARD

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'End postcode lottery in NHS fertility treatment'

more have to rely on fertility treatment to get pregnant. No London borough is believed to offer three full cycles.

Graham Hawkes, chief executive of Healthwatch Hillingdon, said IVF was not a "lifestyle choice" and women faced an "uphill struggle" to access treatment that NICE regarded as clinically effective and cost-effective.

"We are all acutely aware of the funding pressures faced by the NHS, but this should not be used as a reason to deny people the care recommended for them by their doctors," he added.

"This is a very emotive subject. We've seen from the experiences of women who have contacted us how the impacts of infertility can have far-reaching effects on couples and their families.

"We are disappointed to note London has some of the strictest access to NHS-funded IVF care compared to other parts of England." The eight boroughs are Brent, Kensington and Chelsea, Westminster, Hammersmith and Fulham, Hillingdon, Hounslow, Harrow, and Ealing. Across them, more than 1,200 requests for IVF were approved in 2014/15. One Hillingdon woman, aged 31, said she and her husband spent about £12,000 they had set aside to buy their first home to fund private treatment when her NHS cycle failed.

She was entitled to one attempt at fertilisation using freshly harvested eggs and a second using frozen eggs. But errors with her initial NHS treatment resulted in the quality of her eggs was limited to one cycle while friends just outside London had three. "We are supposed to have a national health service. I don't understand how the clinical commissioning groups [GP-led groups that decide how to spend health cash] can justify not having a standardised approach across the whole country.

"I pay the same tax as my friends in High Wycombe but they get more rounds [of IVF] than I do."

A spokesman for North West London CCGs said: "Our IVF policy is designed to be as fair as possible to all. It takes into account the latest evidence, NICE's guidance, and health priorities locally. Changing the policy would mean favouring access to IVF disproportionately over other care and treatments that would lose funding as a result."

NHS England (London) said: "We realise it can be extremely difficult for

Domiciliary Care

We worked with Healthwatch England to uncover allegations made against a domiciliary care agency as shown on the Channel 4 program 'Dispatches'[2].

Healthwatch worked very closely with the family, Social Service colleagues, and the Care Quality Commission as a thorough investigation was undertaken. We also gave

a statement to Get West London for their published article

"Elderly, blind Uxbridge woman 'left in her own faeces' by Hillingdon Council-funded carers"[3]

What we've learnt from visiting services

Healthwatch Hillingdon has decided not to carry out enter and view as described in law. We are able to do this due to working closely with colleagues within the Local Authority Contracts Monitoring Team and Care Quality Commission, this relationship works really well as shown below. In 2016/17 volunteers invested over 260 hours in 10 Patient Led Assessment of Care Environment (PLACE)[4] assessments.

Major safety issue

During May 2016, 8 of our assessors committed 115 hours to volunteering to complete assessments in Hillingdon Hospital, Woodlands and Riverside sites.

At Riverside the assessors highlighted what they saw as a major safety issue. This was immediately reported to senior

[2] http://bit.ly/2sasddW
[3] http://bit.ly/2s3ESPh
[4] https://www.england.nhs.uk/ourwork/qual-clin-lead/place/

management and swift action was taken by the Trust to carry out repairs. Healthwatch was invited by Central North West London to inspect the repairs as part of the assurance process.

Hospital Wards

Our assessors carried out 2 (PLACE) assessments in October and November 2017 at Mount Vernon and Hillingdon Hospital respectively.

One of our most experienced assessors is now attending the hospital PLACE steering group for Healthwatch. This group monitors the delivery of the improvement plan.

Actions on the improvement plan include:

- Review tidiness and storage issues where identified and ensure a neat environment.
- Replace bins where needed. Address bin labelling issues.
- Repair/ replace damaged or stained seating.
- Review the buildings and grounds maintenance programmes and resource to take account of the PLACE findings re staining and damage, and ensure improvements are made.
- Review PLACE dementia signage requirements and implement solutions to improve privacy in reception areas & wards.
- Prioritise colour, texture and design of flooring programme to take account of the PLACE findings regarding dementia patients.

Care home

We were asked by a resident of a Hillingdon care home and their family to accompany them to a family meeting, arranged to discuss current issues within the home.

Due to our concerns with the standard of care being outlined by residents and their families we immediately contacted Social Services, who attended the home the following working day.

This resulted in the provider putting a plan in place to address the issues and return care to appropriate levels, which we both continue to monitor with Social Services.

This is a great example of how our close working relationship with Social Services is benefitting residents and we would especially thank the officer involved for their prompt action.

Helping you find the answers

How we have helped the community access the care they need

Helping people get what they need from local health and care services is what we are all about

At Healthwatch Hillingdon we provide a comprehensive information, advice and signposting service to our residents, through a number of different ways:

- Our shop within The Pavilions Shopping Centre
- Stalls at events and fairs across the borough
- Our website and social media
- Taking telephone enquiries and receiving emails

The shop is used as a main information hub. We have a wide ranging array of leaflets and posters to inform residents.

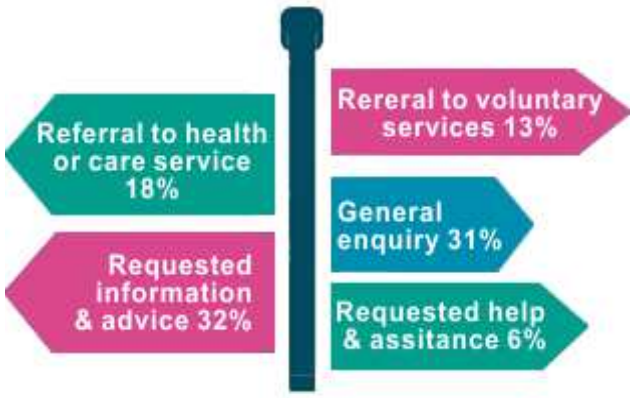
Our website also features similar information and has been visited over 1.1 million times this year.

We signpost people to NHS, Care and Voluntary Sector Organisations.

Where possible we look to empower people by providing them with the information and advice to make their own choices.

Where required, we intervene for residents and on a few occasions, have provided intensive one to one support.

2579 residents contacted our information, advice and signposting service in 2016/17



The reasons that people contact us are very varied. They range from simple enquiries, to some very complex issues.

Our experienced team have an excellent knowledge of health and social care and the services that are provided locally.

As these examples show, this means that when approached we can offer residents advice and support that best meets their needs:

- Mrs P asked us for help. She was over 65 and looked after her husband who suffered with dementia. She was struggling with a number of things including some DIY.

We were able to signpost her to Age UK, Hillingdon Carers and the Alzheimer's Society for a range of solutions.

- An individual visited our offices in September in a highly distressed state. They had been referred to ARCH (Addiction Recovery Community Hillingdon) by their GP, as although they had been previously prescribed methadone and co-codamol for 20 plus years by a GP, their current GP was not now authorised to prescribe methadone. The patient informed us that following a review by ARCH, the co-codamol was withdrawn which were for her back pain. The patient explained that they were in severe pain and had been unable to contact their key worker and had been told she would not be able to see the ARCH clinician for a further 3 weeks.

We contacted ARCH who provided further support to help the individual. We feel it is so important that whenever medication is withdrawn that this is done in a controlled and supported manner to reduce the impact on the individual and prevent them from going into crisis.

ARCH is service in Hillingdon, provided by Central North West London NHS Foundation Trust (CNWL). When working with the above individual we noted that the new ARCH website did not provide details of their PALS Department, or how a patient can make compliments, or a complaint. We contacted CNWL who rectified this, to ensure all residents using the website now have these details.

- We were contacted about an elderly Hillingdon resident, who suffers from mental health issues and numerous physical long term health conditions.

  They live alone and for many years have received a jointly funded care package, which included the regular reapplication of compression bandages for their lymphoedema (chronic swelling of limbs).

  However, without any notice, the family were informed that the care agency will no longer be providing this service and that the care package had been withdrawn by social services. This was very concerning for the family as the resident had previously had a life-threatening leg infection due to their lymphoedema.

We contacted Social Services who immediately investigated the case and reinstated the care package to ensure the resident received the care they needed.

We also received reassurance that the reason for the error had been identified and a process had been changed immediately to stop it happening again.

- Mrs D was due to have a hip replacement in October 2016. She had attended a pre-operation class. She did not want to complain and had found the class interesting and useful, but in the discussions about discharge after the operation, she did not feel she was listened to. She was very concerned about going home after the operation as she felt she was being discharged too soon and was not confident that she would be able to look after herself.

We contacted the hospital and a member of the MSK team contacted Mrs D to listen to her concerns and put a discharge package together that met her needs.

- One of the worrying contacts for us related to a vulnerable patient who has a history of alcohol and drug dependency. They wanted advice on how they could get their doctor to prescribe more sleeping tablets as they didn't want to keep buying them.

  We discovered that in order to safeguard them, their GP prescribes the sleeping tablet, Zolpidem, on a restricted basis by 1 week prescriptions. However, this patient was freely and cheaply purchasing Zolpidem, which is a Class C Controlled Drug, without prescription on the internet.

We raised our concerns regarding patients gaining access to restricted, prescription-only medication via online platforms. We raised our concerns with the Medicines and Healthcare Products Regulatory Agency, as well as Healthwatch England and the Care Quality Commission. We were delighted to see that the appropriate regulators and professional bodies have jointly begun to take enforcement action against those online suppliers which are UK-based, and begun a joint high-profile public awareness campaign to highlight to the public the inherent risks/dangers that offshore online suppliers may pose.

- M had hearing and speech impairment but was able to use British Sign Language (BSL). M had an outpatient appointment the same day at Hillingdon Hospital but there was no BSL support provided. M found the appointment extremely stressful, as she was not able to properly communicate with clinical staff.

  M had another appointment at Hillingdon Hospital at end of March for an operation and M was very concerned and stressed that Hillingdon Hospital made no effort to arrange BSL support for the next appointment/operation even though she made it clear that she needed BSL.

Healthwatch Hillingdon contacted the Outpatient department at Hillingdon Hospital to ensure that BSL support would be made for the operation. Comment: NHS Accessible Information Standards had not been followed.

Making a difference together

How your experiences are helping influence change

Safely Home to the Right Care

On Thursday 23rd February 2017 we published a new report – Safely 'Home' to the Right Care – outlining the personal experiences of older people who had recently been discharged from Hillingdon Hospital.

The report was the culmination of a 6 month engagement programme which saw us engage with 172 inpatients at Hillingdon Hospital, 52 patients post discharge and the professionals and staff from over 20 organisations.

The intelligence collected during our research provided us with a valuable insight into older people's experiences of being discharged from Hillingdon Hospital, and the care and support provided to them in the community.

Evidence suggests uniform processes, better information for people and improving communication between patients, care staff and the component organisations, will be key to the discharge pathway being improved.

We have seen a positive response to the report from commissioners and providers.

There has been an acknowledgment that improvement is needed and a number of recommendations outlined in the report have already been implemented.

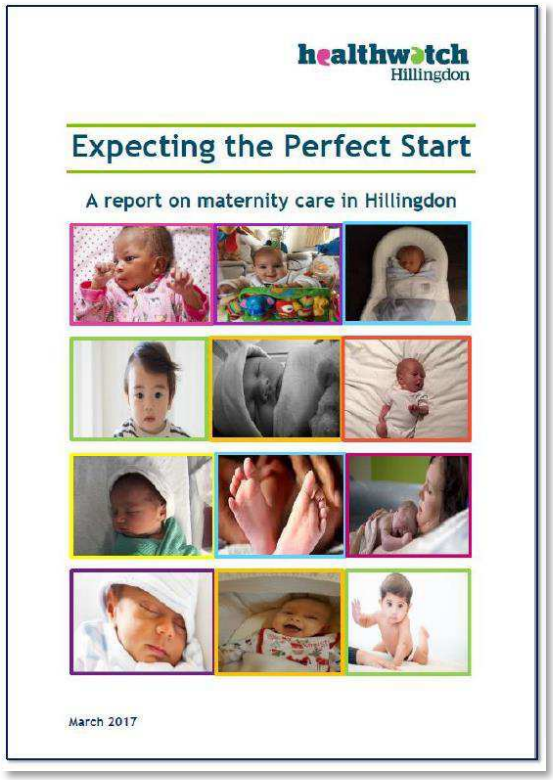
Our evidence has also informed the Better Care Fund and additional actions have been added to the delivery plan monitored by the Health and Wellbeing Board.

We will also look to monitor progress against our recommendations with all partners through the Older People's Services Delivery Group.

Healthwatch Hillingdon has produced a short film of patient's lived experiences to accompany this report. This can be viewed at: http://bit.ly/2qJfyP0

Expecting the Perfect Start

Our other major project was assessing the impact of the closure of Ealing's Maternity unit on the maternity services provided at Hillingdon Hospital.

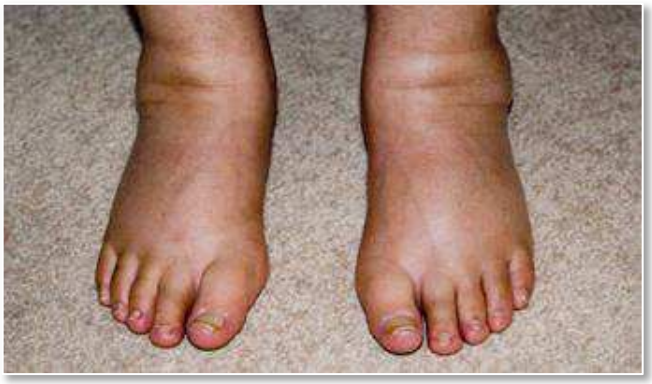


The Expecting the Perfect Start report, which draws on the experiences and views of over 250 women, their families and maternity staff, outlines the comprehensive feedback we have received and gives an in-depth understanding of Hillingdon's maternity services.

More of which is outlined later in this report.

Lymphoedema Service

The lack of primary (non-cancer related) lymphoedema services in Hillingdon was brought to the attention of Healthwatch by several suffering residents. As a result,



Healthwatch investigated the initial findings which showed that there does not seem to be primary lymphoedema services commissioned in Hillingdon, and that differing providers are taking responsibility for caring for individuals in the community.

We raised this with Hillingdon CCG as our assumption appears to be verified by a recent report by the Healthy London Partnership[5].

We are pleased to confirm that the NHS Hillingdon CCG have now launched a new Lymphoedema service that will provide access to all Hillingdon patients with a need for Lymphoedema care and support. This is very welcome news, and we applaud the NHS Hillingdon CCG for investing in this new service for the benefit of our local residents. The new service means that secondary Lymphoedema patients (cancer-related) will be under the care of the Mount Vernon Cancer Centre; whereas patients with secondary Lymphoedema will be able to access care from Harlington Hospice.

Adult Autism Diagnosis

Healthwatch were alerted to long delays for assessment, experienced by some patients

[5] http://bit.ly/2fLbXt0

who had been referred by their GP to the Autism diagnosis service. We were originally highlighted to this in March, and raised this with Hillingdon CCG. It turned out that the problem lay with a contractual disagreement with the local service provider.

Under the NHS Constitution a CCG has a legal duty to ensure that residents have access to appropriate timely treatment and must refer them to an alternative provider, outside of the area, if one is not available locally. As this issue had not been rectified by May, we were concerned for these vulnerable residents and urged the CCG to find a solution.

We are pleased to note that as a temporary solution an alternative provider was commissioned and the Hillingdon CCG then procured a permanent autism assessment service for the borough's residents.

Syringe Disposal

A few patients with diabetes, who were managing their condition at home, contacted Healthwatch in relation to the disposal of the needles (sharps) they use for their insulin injections. There seemed to be confusion amongst professionals and a lack of information for patients on where clinical sharps are disposed.

On investigation, we found that the national policy for the disposal of "domestic clinical waste" provided by the Department for Environment, Food & Rural Affairs advises that: "Local authorities have a duty to collect household waste including healthcare waste from domestic properties."[6]

In Hillingdon there is a sharps service provided by both the NHS and the Council for substance misuse. But for diabetes patients the disposal service is provided by a select number of pharmacies and a few GP practices and these are not readily publicised for patients.

Further clarity and clear information to the public on who to contact to arrange the safe removal of clinical waste (including sharps) from domestic property is necessary.

Healthwatch has lobbied Hillingdon CCG and the Council to publish a list of the pharmacies and GP practices that provide the sharps disposal service on their websites.

Fertility Treatment

During 2016-17 we have continued, as part of our work on access to IVF services, to highlight to the NWL CCG Collaborative that NHS providers should not be charging patients for costly IVF "add-on"[7] treatments as part of their NHS funded care, especially where there is limited evidence of effectiveness.

[6] www.gov.uk/guidance/healthcare-waste

[7] http://bit.ly/2fFbDYQ

We have been assured by NHS England that they will speak to providers to remind them of their legal obligations not to charge NHS patients for add-on treatments available as part of their IVF treatment.

In February 2017, following a cross-party debate on IVF in parliament, Healthwatch Hillingdon wrote to, Nicola Blackwood MP the Department of Health's Parliamentary Under Secretary of State for Public Health and Innovation. We thank the Under Secretary for her encouraging response:

"It is the Government's view that infertility is a serious medical condition and those suffering from infertility, which meet the criteria in the NICE fertility guideline for NHS funded treatment, should be able to seek treatment on the NHS"

We anticipate that once NHS England has completed this work in 2017/2018, that this will address the main summary of our 2016 Fertility report:

"Healthwatch Hillingdon believes that commissioning fertility services at scale across England, with a fixed national NHS tariff, incorporating nationally agreed outcome measures… will be more cost effective for the NHS."

This once again, demonstrates how Healthwatch Hillingdon has acted as a catalyst for national debate and change at both a local and national level.

GP Access

In August 2016 we were contacted by a resident whose mother had been discharged from hospital following a difficult life-changing illness. They told us they had found a lovely care home where they knew their mother would be safe, but were horrified to find that the home were having extreme difficulties in registering their mother with a GP practice.

On speaking to the home we found that they had 7 new residents that the local GP practices had refused to register. Due to current pressures the GP practices were reluctant to register these patients although it was their legal duty. Even after we involved NHS England, the practices continued to put up administrative barriers, which resulted in the home having to take 3 of these frail elderly residents physically to the GP surgery to enable registration.

Residents of the nursing home are all currently registered but with only 15% of the current home's capacity taken up this will be an ongoing issue. We continue to work with NHS England and Hillingdon CCG to ensure residents are registered and a long-term solution can be found, to benefit all parties.

How we work with other organisations

Healthwatch Hillingdon has very strong operational relationships locally with NHS, Council and Voluntary Sector organisations.

We are seen as independent, an equal partner and a valued "critical friend" within health and social care.

These important relationships enable us to have considerable strategic input into the shaping of local commissioning and the delivery of services.

This year Healthwatch Hillingdon attended **289** health and social care meetings and **53** voluntary sector and community meetings, covering a wide range of subjects.

Our involvement keeps us well informed on all matters and gives us the opportunity to challenge and seek assurances on behalf of our residents.

It also ensures that the lived experience of our patients and public are clearly heard and are influencing decisions and improving health and social care in Hillingdon.

Our strong relationships ensure that whatever element of our work we are engaged in, we are able to directly communicate with all organisations from operational to executive level.

- At the **Health and Wellbeing Board** (HWB) we have used our statutory membership to continue to raise issues and concerns on behalf of the public. We bring a focus to the delivery of the Children's and Adolescent Mental Health Transformation Plan and through formal submission of our reports ensure the recommendations we make for service change are reflected at the highest level.

- Working with **Hillingdon Clinical Commissioning Group** is a key relationship. We have an independent seat on a number of their strategic committees, groups, and wider work streams including the:

  - CCG Governing Body

- Sustainability and Transformation Plan (STP) Steering Group
- Quality Safety and Risk Committee
- Co-Commissioning Committee
- Transformation Committee
- Procurement Panel
- A&E Delivery Board
- GP Access Group

These strong avenues of communication have allowed us to regularly raise quality issues and challenge commissioning decisions.

High on the agenda this year has been ensuring the voice of the public was not excluded from the conversations that took place around STPs, our work on hospital discharges for the elderly, maternity services in Hillingdon following the closure of Ealing Maternity Unit, access to GP services – especially in the south of the borough, mental health care, fertility treatment and the unprecedented activity at Hillingdon's A&E.

- At the Local Authority we meet with **Hillingdon Social Services** and **Public Health** to input into a number of areas, such as, delayed discharge from hospital, care homes, domiciliary care, The Autism Strategy and Suicide Prevention Strategy.

We represent the public on both the adult and children's safeguarding boards, and were instrumental in supporting the recruitment of members of the public, to sit on those boards.

Hillingdon LSCB local safeguarding children board

We also closely support the Council at the Older people's, Carers and Disabilities Assemblies.

- We work in similar ways with both **The Hillingdon Hospitals NHS FT** and **Central West London NHS FT**. We share information and work closely together to gain a wider understanding of service quality and how their patient's experience the services each organisation provides.

Healthwatch has a duty to respond each year to the Trusts Quality Statements and we work with each Trust throughout the year to make sure that quality is continually addressed and those areas which require the most focus are seen as a priority. We support both Trusts by providing volunteer PLACE

Assessors to carry out inspections of the care environment and this is resulting in improvements to their condition, cleanliness and to the provision of food.

This year we would specifically thank The Hillingdon Hospitals FT for its assistance in our project work. Their 'all area' patient access enabled a rich source of patient experience data to be collected, which is leading to positive service change.

We also worked with Central West London NHS FT as they reconfigured the way in which they delivered the podiatry and multi-skeletal services.

Our involvement ensured that not only were patients views taken into consideration through the change, but that they also received valued support and information during the transition period.

- We continue to work closely with Hillingdon 4 All (Age UK, DASH, Hillingdon Carers, Harlington Hospice and MIND), Alzheimer's Society, Parkinson's Group, Refugees in Effective and Active Partnership (REAP) and other local voluntary sector and community groups. Supporting residents together, through the sharing of information and signposting to each other's services.

Hillingdon Health and Care Partners

- Health and care work-streams across the country are becoming increasingly more integrated. Organisations are joining forces to develop accountable care partnerships. Throughout 2016 the Hillingdon Health and Care Partners (HCCP) have been preparing to launch in shadow form from 1st April 2017 to pilot the service. Healthwatch Hillingdon has now been invited to sit on the HCCP Board, which again is ensuring patients are represented at the forefront of change.

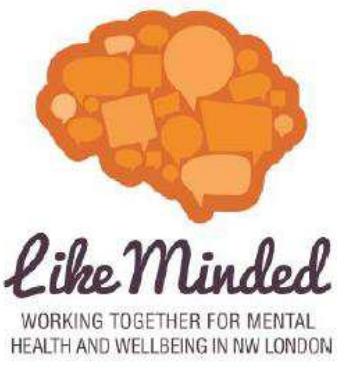
- We represent Hillingdon at regional meetings for change programmes which are being planned and implemented across North West London, such as:

Shaping a Healthier Future - the reconfiguration of acute and community services – which has already seen maternity and acute paediatrics transfer from Ealing Hospital.

Sustainability and Transformation Plans - health and social care working together to

build services around the needs of the local populations

Like Minded - the reconfiguration programme for mental health services in North West London.



- Our relationship with Healthwatch England continues to grow.

Our regular attendance at the London Healthwatch Network meetings provides a valuable opportunity to share intelligence and good practice with others in the London Healthwatch network.

We have continued to work strategically with Healthwatch England to help influence change at a national level.

Our work on IVF is a prime example of this and we were recognised by the Healthwatch England Committee at their March 2017 meeting for our contribution to the development of a national tariff and national guidance for IVF.

- Healthwatch Hillingdon regularly shares anonymised feedback and intelligence on providers with the Care Quality Commission (CQC).

We hold meetings with the CQC where we discuss common concerns and areas of improvement with the regulator. In particular this year we collaborated with inspectors on 3 specific areas of joint interest.

Stakeholder Survey 2016-17

To reflect upon our work in 2016-2017 Healthwatch Hillingdon carried out a stakeholder survey, based on areas within the local Healthwatch Quality Statements, set out by Healthwatch England.

- **Strategic Context and Relationships**
- **Community Voice and Influence**
- **Making a Difference Locally**
- **Informing People**

These quality statements are intended to help local Healthwatch, their commissioners and other stakeholders develop a clearer understanding of the impact that their local Healthwatch has made, its strengths and areas where further development might be required.

We had 42 returned surveys including responses from, CNWL, Hillingdon CCG, Hillingdon Council, Hillingdon Hospital, the wider voluntary sector organisations and other patient representatives.

The results:

98% of respondents stating that they agree or strongly agree that Healthwatch Hillingdon (HwH) demonstrates added value through its work engaging local people.

> **"Healthwatch provides a great deal of information and personal stories of how people are affected"**

88% of all respondents agree or strongly agree that Healthwatch Hillingdon brings a distinct contribution to decision making structures in the local system.

"Hillingdon Healthwatch provides extremely valuable scrutiny of local services. The officers are fair in their assessment of services and seek to work collaboratively with commissioners to improve the local offer for residents."

95% of all respondents agree or strongly agree that they understand the rationale behind the priorities of Healthwatch Hillingdon.

"The recent Discharge Report - we as providers were actively briefed on the aims of the project, involved in contributing to the data gathering and de-briefed with constructive feedback. We were also given an opportunity to respond to the findings and how we intend to address these going forward."

94% of all respondents agree or strongly agree that Healthwatch Hillingdon insight and reports are constructive, independent and clear about the rationale for the evidence used.

"Healthwatch Hillingdon are a valuable partner in meeting our ambition to commission high quality care in Hillingdon. We look forward to continuing to work with them."

95% of all respondents agree or strongly agree that Healthwatch Hillingdon brings added value to their work thanks to its unique perspective

"The information that Healthwatch have contributed to CCG discussions has brought a valuable patient perspective to many of our work programmes. The reports into discharge processes and maternity care at Hillingdon Hospital in particular have provided areas of focus and prioritisation both for the CCG and the system more broadly. Contributions are always constructive and focussed on finding consensus and a way forward but provide appropriate challenge where necessary."

What can we do better?

The results from: Community Voice and Influence, Making a Difference Locally and Informing People…

…. show that there is still more work to be done. The number of respondents who agreed local people were actively involved in the delivery of HwH fell to around 76%. The figures for how we involve seldom heard groups and whether respondents felt comfortable to promote HwH, were very similar.

Only 60% felt that the service clearly ensures marginalised groups are heard. A relatively high number of people recorded that they did not have the knowledge or experience to answer, or answered indifferently.

"Unclear how much engagement they do with seldom heard groups but aware they have certainly reached out to older client groups and those with MH issues"

"I am unaware of Healthwatch Hillingdon's Insight reports and can't comment on the extent to which either the hospital, or commissioner, has been involved in their production"

The results in these sections do not come as a surprise as HwH have already recognised that more is required to promote the organisation and the services we provide to a wider audience. This is already in the HwH Workplan and an area we are looking to address in 2017-2018.

We have been very encouraged

The survey provided Healthwatch Hillingdon with the real opportunity to measure how we are delivering local Healthwatch against our core statutory duties and this vision.

Overall the results are very encouraging and endorse the way in which we deliver local Healthwatch. They show that we are seen by our stakeholders in health and social care as an equal partner. We have strong strategic relationships and are adding value to their work. We are ensuring the voice of the public is not only represented and heard, but is influencing change.

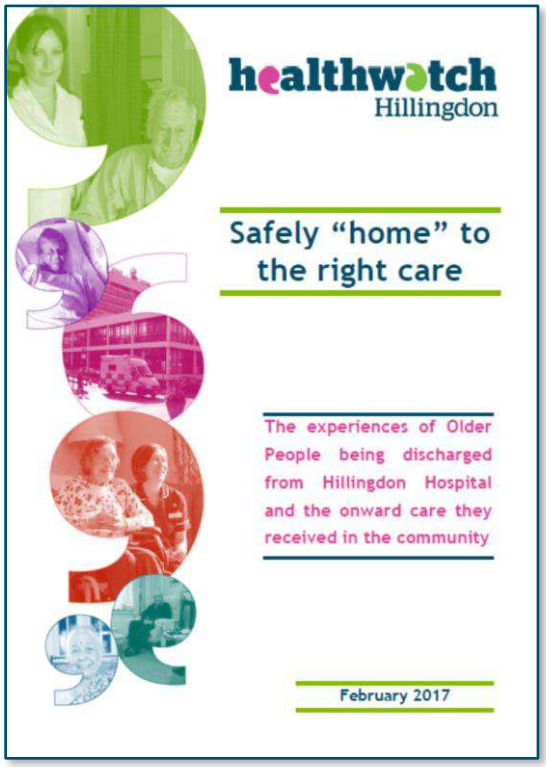
It could be argued that by achieving this we are delivering our vision already. The survey results however show that although we are giving adults, young people, children and communities a greater say, there is still more to do to reach a wider audience before we can truly say we are delivering our vision.

Our achievements and standing gives us a solid foundation to build upon, as we move into 2017-2018.

It starts with you

Talking to you about discharge from hospital

Safely "home" to the right Care



Hillingdon Hospital say: We are keen to work in partnership with Healthwatch, Care Partners and other key stakeholders to progress the very helpful recommendations you have made in this report.

Older patients arriving at Hillingdon Hospital are from a generation who express pride in what they regard as 'their' NHS. They are largely from a generation where they just 'get on with it' and 'don't want to cause trouble or be a nuisance'. They endure, and don't like to complain. They feel vulnerable as many have lost confidence with age. We interviewed 172 patients on various wards and followed up with 52 of them after their discharge from hospital. 81% of patients said that they were either satisfied or very satisfied with the way they were treated overall.

They said staff were caring and trying their best, but wards were very busy, which led to lengthy waits in being attended to, long waits for medication and poor communication. It was no surprise therefore when asked what could be improved, 31% of these said they felt the hospital was understaffed and needed more doctors and nurses.

30% of patients and/or their carers referred to poor communication and lack of understanding about their condition.

Professionals and staff also recognised the need for better communication and explanation for patients and families/carers, but see the need for better processes and management to be able to free up 'firefighting' time in order to invest in the necessary commitment to clearer communication.

Patients and families/carers wanted an understanding of their situation from a member of staff. They were often told they

needed to speak to a doctor for this, but that could mean waiting a considerable time. Professionals and staff also felt there is a need for a communication process consistently applied. Some wards seem to allow an appointments system with doctors, others do not. It seems to be very hard to get any time with a doctor.

Patients sometimes forget, don't hear or get confused about what they have been told. This can lead to the family /carers being uninformed, which leads to family seeking information from staff which is often time consuming and frustrating.

Patients and their families/carers would therefore like information from doctors explaining the current situation and what would happen next, written down.

Staff told us that this would also help them, as much of their time is taken up with enquiries from families, and not all staff roles are aware of the full situation on a patient to be able to effectively give an update.

Patient evidence suggested that there were inconsistent processes and procedures throughout the wards resulting in inconsistent care to elderly patients.

Healthwatch Recommendations

Communication and Information

1. We have recommended that a booklet is produced and issued to all admitted patients which will be filled in during the inpatient stay. This booklet will be completed on discharge complying with many of the details listed in the NICE requirements.

We would recommend that this booklet is reviewed and updated to produce a 'Patient Journey' booklet that keeps patient/carers fully informed. This will then act as a method of communication between patient/carers and professionals in hospital and in the community.

2. We have recommended that patient/ carers are provided with written information about social care and continuing health care assessments in line with the Care Act.

3. We have recommended that an independent advocacy service should be provided for individuals who have substantial difficulty in being involved in the assessment and discharge planning process.

The difference we have made already!

We are pleased that work started immediately on our first recommendation.

Partners gathered to redesign the working together booklet to include the areas patients and their families told us were required. In March 2017 a final draft was agreed and it is expected that following production the booklet will be rolled out and issued to all admitted patients in early June 2017.

This is very encouraging as we feel that this will make a real difference to patients and their relatives/carers. It addresses many of their concerns, particularly lack of communication.

One of the biggest frustrations for patient advocates is seeking information from doctors who are always busy and difficult to make contact with. In this booklet there are contact pages enabling questions to be written down and answered in writing by a professional.

We are very grateful to the Hillingdon Hospital for their prompt action on this, and hope to work together to ensure that it is a success for patients and staff alike.

BREAKING NEWS

ROLL OUT OF THE FIRST 35,000 COPIES OF NEW COMMUNICATION BOOKLETS STARTED ACROSS ALL WARDS AT HILLINGDON HOSPITAL ON 12th JUNE 2017

Processes and Procedures

4. We have recommended that the hospital looks to standardise the discharge process across all wards. A compulsory uniform process could provide many benefits to improve the patient and staff experience.

5. We have recommended a review of the discharge lounge be carried out, to assess how effective it is in meeting the needs of patient/carers who are waiting there.

6. We have recommended that in addition to written instructions for those patients being prescribed multiple medications, that the hospital also looks to provide Dosette boxes. This will mitigate against possible unintentional overdose and improve patient safety.

7. We would recommend that when discharging an older person that it becomes standard practice to proactively refer to Hillingdon Carers for further support, especially when the patient is the sole carer for the patient.

Closer integration and joined up working

8. We have recommended that serious consideration is given to a proposed single point of access for discharge, as a possible solution to providing wrap around and integrated care for the patient/carer.

The difference we have made already!

It has been acknowledged by the Trust that discharge processes need to be uniform across their wards. The Trust is working closely with all partners and has requested support from the NHS

Emergency Care Improvement Programme (ECIP). The Trust has received formal recommendations from ECIP and a steering board is overseeing the delivery of these recommendations.

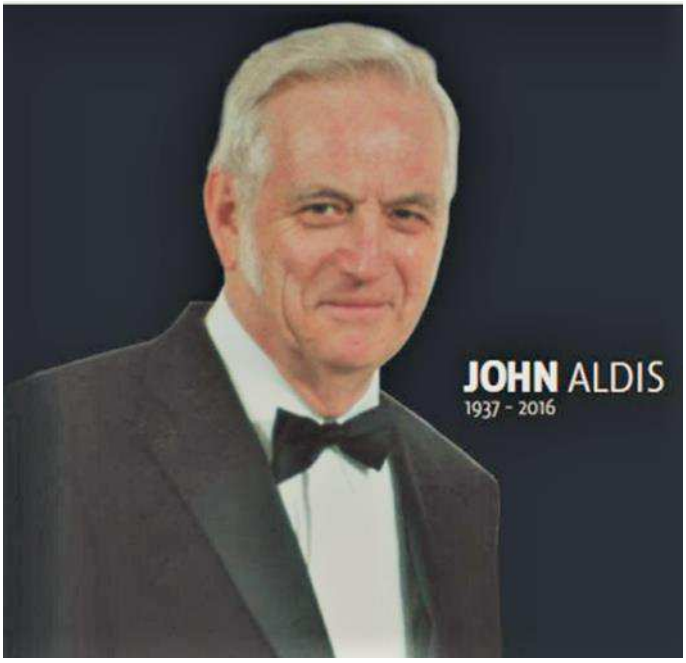
The Trust acted swiftly to address the issues we had found in the discharge lounge. They now provide hot food, and water for waiting patients and are reducing the amount of time that patients wait for their transport.

The patient's story

Stories are of the lived experience of patients and their family members. They are their own accounts and written in their own words. Some names have been changed to protect anonymity.

Alan's Story

My Big Brother John.



Around six years ago, my brother suffered a stroke from which he never fully recovered. This led to mobility issues. He was often having falls inside his home which inevitably led to hospital admissions ...and they were becoming more frequent.

There were also very early signs of dementia setting in. Just after his 79th birthday in January, I suggested to him that he took out a Lasting Power of Attorney for his Health (LPH) naming his only next of kin (me) as his executor. I also asked him did he wish to stay in his own home for the remainder of his days. He replied "Yes".

By April, he was back in Hillingdon Hospital with a urine infection. He was incontinent (mainly because of his mobility) and prone to this kind of infection. By this time Social Services had decided he needed full time care which was duly implemented. 4 visits a day by two carers every day. (one hour a day, Monday to Friday). His mobility was getting worse, so, I had some of the downstairs area cleared and a hospital bed and hoist were installed by the district nurse's department of Social Services. His doctor paid him a visit and diagnosed that he

had rheumatoid arthritis in his hands and arranged for him a visit to the hospital for some time in July.

The rheumatoid arthritis condition made it difficult for him to hold things plus he was pretty much a "dead weight" with his limbs. He never got to that appointment because the doctor's practice (Medical Centre in Ruislip) forgot to mention that he couldn't walk by himself to the hospital transport that had come to pick him up! I contacted the practice to discuss my brother's health and to get the transport changed so he could meet his appointment at a later date.

We are now into late July and I noticed that my brother had an irritable cough, but thought no more of it. Approximately three weeks later I went to visit him again and he still had the cough - but he said he was OK. A few days after that I get a call to say that John was admitted to hospital (Friday 12th August I think) because he had slipped off his chair, and the attending carers noticed that his urine was a really dark colour.

So, he was in Hillingdon Hospital for the urine infection.

The Discharge Fiasco:

The urine infection got cleared up in about four days. On the Wednesday, a doctor who noticed his cough, checked him out and diagnosed that he had the early signs of pneumonia. His throat had swollen up as a result and his diet had to be changed to soft foods. The medical staff at the hospital suggested that he recover in his own home and would be discharged the next day (Thursday) taking with him medication from the hospital pharmacy. Hillingdon Hospital notified Social Services who in turn notified John's carers that they would be "back on" as he was coming home on the Thursday. Well, he never got there. Why? Because pharmacy didn't have the medication that was prescribed.

Meanwhile the carers were at the house, but no John. The next day (Friday), pharmacy supplied the medication required. The carers showed up again. However, Hospital Transport couldn't spare anyone until nearly 11pm at night. I was told he should get home around midnight. I said to the ward nurse she must be joking because who was going to get him into the house as there wouldn't be anyone there to greet him. She said OK, it'll have to be Monday now. (I would suggest: that unknown to me, he was getting no antibiotics for the pneumonia condition, because the ward staff saw him just as a patient waiting to go home. It is conjecture, but I 'm putting two and two together and making four.) Of course, there is another scenario - he was getting the medication, but despite him getting worse, they still discharged him because all they were interested in was the availability of his bed - if that was the case then I don't know how the management can sleep at night).

Monday changed everything. Finally, he got driven home by hospital transport, with his medication. John was gasping for breath because he could hardly breathe. It was also the hottest day in August. The driver noticed the difficulties my brother was having and pointed it out to the two waiting carers at his home. They took one look at him and called for an ambulance. The ambulance got there within 30 minutes. The Paramedics took a look at him and were heard to say 'which idiots let this one out?'

They tried to take him back to Hillingdon but were informed there were no beds available.

So they took him to Northwick Park Hospital. He was on near enough, pure oxygen for four days. But a patient cannot stay on pure Oxygen forever. So he was transferred out of there to another ward where he was put on half-oxygen. (Sunday, 28th August).

That was the last time I saw John alive. To be honest he seemed quite cheerful but struggling to speak. I thought 'he's over the worst; he'll get better and through it OK'. I kept in touch with Northwick Park just about every day from that point onwards. Towards the end of that week the staff at Northwick Park were saying that his heart was becoming a problem because of the pneumonia and that if he got into difficulties they would not try to revive him. By the Sunday (4th September) the hospital said he was in pain from breathing difficulties and that they were going to administer Morphine. When hospital staff tell you they are going to administer Morphine, you know it's the beginning of the end but you live in hope.

Thursday 8th September John died at 7am on the morning of Thursday 8th September of Bronchial Pneumonia.

Northwick Park had obviously tried to contact me early in the morning, but I hadn't picked up. So they phoned John's stepson in Wigan. He sent me a text to say that I should call "Vill" at the hospital. I did so about 8.30am to enquire what the problem was with John. He told me "John has expired". I didn't quite catch the last word and asked him to repeat it. He repeated it: "John has expired". That made me so angry, I replied "He's not a Packet of Cornflakes or a robot -he's a human being! Try died, deceased or passed away, not frigging expired!"

> No-one at Hillingdon seems to talk to each other. It's not that they don't care, I'm sure they do, it just seems that no-one is working off the same page. If they had been, my brother would probably still be alive today!

Harry's Story

Harry's Mum Mary, was in Hillingdon Hospital in September 2016, where……

> ……she received fantastic care and attention from the staff there.

She had been in Hillingdon before this incident and had to stay in for an extra 10 days while the care package was sorted out. This was a long time for her to be in there just waiting. In September she went in with fluid on her lungs. While this was addressed, Harry kept asking to speak to a doctor to find out what had been done, and how it could be avoided again.

> It seems the actual Doctors have no intention of speaking to family members and certainly make it

impossible to speak to them, I never got to speak to a doctor, I kept asking but one never updated me with any information.

Harry's Mum was given the Friday as a discharge date. Harry arranged with the hospital that she would be brought home in the hospital transport ambulance at 4pm as she had arranged for 2 carers to receive her at her house.

This was necessary as his Mum could not walk, was very deaf, diabetic, and needed support. For some reason the hospital transport ignored this instruction and took her home at 2pm.

They took the key out of her key safe and let themselves in, dumping Harry's Mum on the bed. They left her alone without a drink or any support. Harry was really not happy about this as his Mum was 80 years old and was disorientated enough coming out of hospital, but to be dumped on a bed and just left is not how she felt an elderly person with multiple health conditions should be treated.

Geoff's Story

Over a period of three years Geoff had been in Hillingdon Hospital twice for operations to remove cancers in his bladder, both operations went extremely well and he couldn't fault the professionalism of the surgeons and the immediate after care staff.

After the first operation he was taken to a ward to recover where he was told to keep drinking several litres of water to flush out blood and clots until his urine ran clear, a doctor who was supervising him at the time advised him to call if his urine turned bloody and painful which it did during the night.

He asked the duty nurse to call for the doctor and after waiting for at least one hour nobody came so he asked the nurse again as he was becoming anxious, after another hour a pharmacist turned up and gave him a bag of medications which was meant for another patient. The pharmacist did apologise for the mix up.

Things gradually became more "normal" over the months but Geoff felt it had been

a very long and tortuous journey which could have been made so much simpler if the correct support had been there from the very beginning.

Three years later due to the same cancer returning, he was again taken to a ward to recover after another operation. He was surprised to be discharged early to return home being told to again, drink lots of water

I suspected the hospital was desperately short of beds.

After being at home for several hours and drinking lots of water he began to experience pain and an urge to urinate but

discovered that even using all his strength he could only squeeze out a few drops of blood.

He rang 111 who called him an ambulance to take him to A&E. He was readmitted where the clots were removed and after an overnight stay he was discharged home wearing a catheter and urine bag for one week supervised by community nurses.

He has since completely recovered. He had this to say:

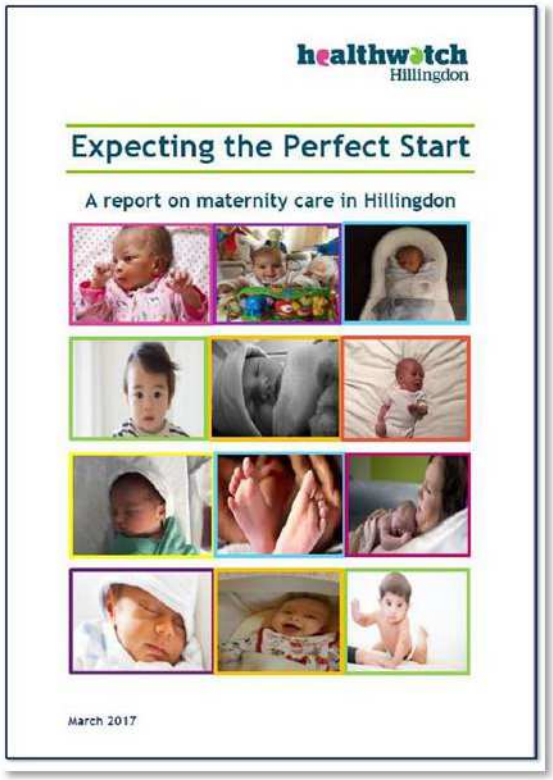
> In my opinion we cannot fault the work of our Doctors and Nurses but it is obvious to us all that they are overwhelmed with work and shortage of beds and staff, even some staff who cannot speak English.

Our insight suggests that it is overwhelmingly clear that better information and communication between patients, care staff and organisations, is key if services are to be developed and improved.

It could be argued that achieving this maybe the most important factor to transforming care services in Hillingdon.

Talking to you about maternity services

Expecting the Perfect Start



Healthwatch Hillingdon spoke to a total of 251 women, 198 from Hillingdon and 53 from Ealing. This included women who were currently using the hospital's maternity service and women who had given birth since the changes.

We also engaged professional staff such as midwives, children centre workers and doctors. The experiences were collected via a range of methods such as one to one semi structured interviews, survey questionnaires and focus groups.

Experiences were collected from women at various locations for example play groups, children centres, antenatal and postnatal clinics, other voluntary organisation programmes, and from feedback collected directly at the Hospital.

Our engagement revealed key themes from the feedback raised by the women and families, which included:

- An overwhelming majority of women stating that they were very happy with the care and service provision at The Hillingdon Hospital at every stage of their maternity care. With many stating that the quality of care given at the hospital is of a very good standard.
- Families were very pleased with the care and empathy provided by maternity staff. In most cases, women described midwives and doctors as informative and helpful.
- Women are very happy with the quality of information they are provided, however quite a few women said they would have preferred to have had a verbal explanation in addition to printed literature.
- Over 50% of women indicated that they were not given the choice of which hospital's maternity service they could use. In the majority of cases this was because their GP routinely referred them to Hillingdon Hospital.

- Over half of the Ealing women who we spoke to described the difficulties with travelling to Hillingdon Hospital and explained a lack of choices/facilities for antenatal and postnatal services in the area.
- From the focus groups targeting women of the BME community it highlighted the need for greater cultural sensitivity.

- The feedback also highlighted the need for language service provision for women with language difficulties.
- Some women explained the need for increased uniformity in breastfeeding.
- information and support from all healthcare professionals.
- 60% of the 40 women who requested smoking cessation did not receive this support.
- Women received mixed experiences of the Triage services, whilst 64% of women were positive about their experiences, 17% highlighted dissatisfaction due to rudeness of staff and the need for a reduction in labouring in triage without adequate assistance.
- Our engagement showed that the perinatal mental health service is under pressure with waiting lists rising. This was partly attributed to Ealing women being referred to the Hillingdon service instead of the Ealing service.
- Both mothers and maternity staff advised us that they felt more midwives were required.

Healthwatch Recommendations

Based on our engagement outcomes, 8 recommendations were put forward to help build upon the hospital's good performance and further improve women's experiences.

1. A review is carried out how information is given, so in addition to receiving printed literature, women are provided with more verbal information.
2. A review is undertaken of interpreting services to support women who do not speak, or have little understanding of English, to meet The Royal College of Obstetricians and Gynaecologists (RCOG) standards: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/standards-for-maternity-care/
3. To review the continuity of care between women and their health professionals to meet the expectations of The National Maternity review.
4. There is a review of the referral process between the hospital and The London Borough of Hillingdon who provide smoking cessation service.

5. The hospital considers introducing a pager system in the antenatal department to allow women the choice of waiting elsewhere during their appointments.
6. There is a review of the referral for Ealing residents to the Ealing perinatal mental health service; and that the Hillingdon Clinical Commissioning Group (CCG), review the perinatal mental health service in Hillingdon to see how future provision can be met.
7. Greater informed choice be given to women as to where they can deliver their babies.
8. Hillingdon Clinical CCG work with The Shaping a Healthier Future team and Hillingdon Hospital to review the provision of antenatal and postnatal clinics in Ealing.

What difference did we make?

This report was published in March 2017 and at the time of publishing we were still awaiting responses from commissioners and providers. However, there is a clear commitment to embed some of the recommended changes, which have all been incorporated into the Strategic Children's Transformation Group work plan. We will be regularly monitoring their progress through our seat on this group and the Maternity Services Liaison Committee.

Mothers told us…

"Because I was in a lot of pain I couldn't really understand everything I was told so it was reassuring that they spoke to my boyfriend and gave him the same amount of detail that they gave me so he knew what was going on with me and the baby"

"They were extremely nice to him and supportive of us both"

"One midwife was really emotionally supportive especially because my baby had jaundice and I was really scared, she really did go above and beyond to put me at ease"

"I felt that my culture (eastern European) was not respected and I was spoken down to"

"Triage were amazing, I came in multiple times throughout my pregnancy and they were great every time"

"I had gestational diabetes during my pregnancy and the team were really helpful with advising me on what to eat and what type of exercises I should be doing so that was helpful"

"I felt that the postnatal care was quite poor especially because everyone would give different information"

"My wife decided that she wanted a home birth and was very happy with the antenatal care we were given by the home birth team"

"Triage were great very informative"

"Given that I had a history of mental health issue (depression, anxiety) I didn't like how I wasn't able to see the prenatal mental health specialist when I said I wasn't coping well with taking care of my baby, they said that they would put me on a waiting list but I never got seen, luckily I was able to find groups to go to on my own but I really don't think this was helpful at all because if it wasn't for the groups I went to I would've had an even worse time than I was already having and the talking therapies line that I was referred to was pretty useless if I'm honest."

"when I went home I was feeling quite a lot of pain in my stitches and when I called into the hospital to ask what to do I felt that I was a bit dismissed and just told to take pain medication, like I hadn't already done that"

Our plans for next year

What next?

The main priority for Healthwatch Hillingdon is to meet the requirements of our contract to deliver local Healthwatch, which is fully aligned with our statutory roles.

As we, involve, represent and protect the rights of, our residents and the users of Hillingdon's health and social care services, we will continue to ensure that their views and experiences are at the forefront of everything we do.

The Healthwatch Hillingdon Work-plan for 2017-19 has been written to reflect the need of the communities we serve. Our operational priorities are built on local insight and people's experience of care. Our main focus in the year ahead will be around General Practice and Care Homes.

Through our strategic involvement, we will continue to oversee and challenge both commissioners and providers, on the delivery of the recommendations we have outlined in our reports on children and young people's mental wellbeing, hospital discharge and maternity services.

We will also continue to have an oversight of the quality and safety of care services in Hillingdon and be strategically involved in change programmes in the borough and across NWL.

The NHS and Social Care are in a state of transition as the Five Year Forward View (FYFV) strategy looks to integrate care and bring about financial balance through Sustainability and Transformation Plans (STP).

As part of the NWL STP Footprint this work is well advanced in Hillingdon. We expect there to be a number of work-streams under the STP, which will propose changes to the current way in which care services are delivered.

One of Healthwatch Hillingdon's key roles this year will be to ensure that the public are not only fully informed and consulted, but that they are an integral part in the design of new services.

In Hillingdon we are already seeing the advance development of an accountable care partnership as outlined in the FYFV. Hillingdon Community Care Partners; an alliance between The Hillingdon Hospitals NHS FT, Central North West London NHS FT, the Hillingdon Primary Care Confederation and the voluntary sector organisation, Hillingdon4All, will be starting in shadow form this year, to deliver services to older people.

Being a new lay member of the Board of Hillingdon Community Care Partners, gives Healthwatch Hillingdon the opportunity to ensure that the public are involved in shaping new services as the accountable care partnership looks to go 'live' in April 2018.

As the results of the 2016-2017 review survey with stakeholders has confirmed there is a need for us to promote Healthwatch Hillingdon to new audiences and to reach out to a greater number of people, especially from those labelled 'hard to reach'. This is captured in the work-plan, but significantly we have aligned this with the need to inform and empower those we engage with. Giving people the knowledge, confidence and capacity to exercise their rights and take control of their own health is going to be very important. Especially with the impending plans outlined in the FYFV.

For the first time we have included a priority in our plan which looks to add to our work, through seeking to deliver commissioned projects. This is an exciting opportunity to build on our now proven track record of delivering strong, independent, evidence based engagement projects, expanding our reach and making a greater difference in our Borough.

Healthwatch Hillingdon is determined that 2017-2018 will be another year in which we are Independent, Influential and Informing.

Our People

Decision making

Our Board as at 31st March 2017

- *Stephen Otter, Chairman*
- *Turkay Mahmoud , Vice Chair*
- *Allen Bergson*
- *Richard Eason*
- *Baj Mathur* MBE
- *Kay Ollivierre*
- *Rashmi Varma*

Healthwatch Hillingdon is a Company Limited by Guarantee and is governed by a Board that consists entirely of lay people and volunteers. Selection and recruitment to our Board is through an open and transparent recruitment process.

Board members act as Directors of Healthwatch Hillingdon under the Companies Act 2006 and as Trustees of Healthwatch Hillingdon under the Charities Act 2011.

Meetings of our Board are held quarterly in public and agendas, minutes and reports of our meetings are published on our website and available upon request.

We have published our 'Relevant Decision Making Policy' on our website, setting out how the Healthwatch Hillingdon Board makes relevant decisions.

This policy is reviewed annually to ensure that the decisions taken by Healthwatch Hillingdon follow national best practice and reflect any guidance from Healthwatch England.

Additionally, Healthwatch Hillingdon have a suite of documents that govern the conduct of our business, which can be viewed on our website.

Our Staff Team

- *Graham Hawkes, Chief Executive Officer*
- *Dr Tarlochan (Raj) Grewal, Operations Coordinator*
- *Pat Maher, Administration & Support*
- *Charmaine Goodridge, Outreach & Volunteers*
- *Christianah Olagunju, Maternity Project Coordinator*

Our Volunteers

Volunteers play an important role in enabling Healthwatch Hillingdon to achieve its core functions. We consider ourselves very fortunate therefore to have a team of dedicated volunteers who bring with them a wealth of skills and experience and a passion to improve health and social care services for local people.

During 2016/17 volunteers undertook a range of activities on behalf of Healthwatch:

Engagement – Manning stalls, attending events

Social Media -Raising the profile of Healthwatch through social media outlets such as Facebook & Twitter, YouTube

Project support – Interviewing patients in Hillingdon Hospital as part of the Safely Home, and Expecting a Perfect Start projects.

Administration – data inputting and office based activities

In all a total of **25** volunteers supported our work, contributing a staggering **2166** hours of their valuable time.

Many of those volunteers received training this year in addition to their core Healthwatch training, by Healthwatch Hillingdon partnering with the training provider 'The Skills Network'. Healthwatch volunteers and staff undertook level 2 courses in: Business Administration, Customer Service, Information, Advice & Guidance and Dementia awareness. On completion of their course, volunteers received a level 2 NCFE certificate, courtesy of the National Skills Council.

It is important that we develop our volunteers increasing their skillsets and enhancing their CVs. Without their contribution, it would be impossible to do all that we do. We value our volunteers and do our best to develop them and provide interesting and challenging experiences for them.

As our pool of volunteers continues to grow we will be in a better position to expand the work we do and reach out to those communities who would otherwise not be heard.

Case Study 1 - Lily Doyle

What was your situation?

After leaving sixth form, I decided that I wanted to get into PR and social media, so I started volunteering and interning with a variety of organisations and charities. After leaving them to pursue my own self-employed career, I came across Healthwatch and I couldn't say no to the opportunity they were offering me.

Where did you hear about Healthwatch Hillingdon and what made you decide to become a volunteer for them?

I found the volunteering opportunity with Healthwatch on Do-It.org. I've had my experience with volunteering and interning, but as soon as I met with them in person, I knew that I wanted to take this opportunity on as it was perfect for the experience I was trying to gain.

What volunteering activities did you participate in whilst volunteering? Are you still volunteering now?

I currently produce graphics and daily content for Healthwatch Hillingdon's social media platforms as well as assisting

with materials for surveys, leaflets and reports. I still volunteer with them now.

What did/do you enjoy most about volunteering with Healthwatch Hillingdon?

I love seeing Healthwatch progress and reach their goals on social media with the help of myself. I've gained a lot of skills and experience through volunteering which has helped me take on other freelance work in the social media sector. More importantly, it's been incredible fun to create new content and graphics for them and I'm very proud that they continue to use what I create.

Why would you recommend volunteering with Healthwatch Hillingdon to others?

They've made me feel super welcome and I've learnt so much from the year I've volunteered with them. They've helped me gain confidence, skills and experience, making me feel more comfortable to share with expertise with others.

"Volunteering with Healthwatch Hillingdon has been one of the best decisions I've made. It has helped me gain skills, experience and confidence, so I now feel more ready to start my career in social media"

Case Study 2 -Mehvish Atiq

What was your situation?

I am 17 years-old and I currently in full-time education as a Sixth Form student studying for my A-levels. Throughout year one of my course, I felt that whilst I was studying, I needed skills that would help me develop in my career and gain some valuable work experience in Health and Social Care.

Where did you hear about Healthwatch Hillingdon and what made you decide to become a volunteer for them?

From ongoing research into different work experience placements, I came across Healthwatch Hillingdon on the Do-it.co.uk website. From this day onwards, I was led to a range of different opportunities from gaining new skills to meeting many different people.

What volunteering activities did you participate in whilst volunteering?

I was an engagement volunteer, raising awareness of Healthwatch services and engaging other local volunteers to the service. I was also taking part in projects. My role in this was to survey local residents' experiences of NHS services and gain valuable skills into finding out the problems faced by residents using these services

What did/do you enjoy most about volunteering with Healthwatch Hillingdon?

The idea about Healthwatch was to promote the service and also gain patient experiences on NHS services available to them. I enjoyed my time at local events

to raise awareness of Healthwatch and also by going into Hillingdon Hospital and children's day-care centres, by talking to the general public about their experience of NHS services

Why would you recommend volunteering with Healthwatch Hillingdon to others?

To me, working with Healthwatch was a new experience, meeting new people and engaging with the public to promote the service. Volunteering with Healthwatch means you have flexible working hours and this enabled me to volunteer during my free time over the course of the year. Healthwatch allowed me to gain new experiences of local services and supported me in anything that I wasn't very confident about. I was given essential training to cover the basics and this allowed me to have an idea as to the kind of events and activities that I wanted to take part in later on.

"Healthwatch Hillingdon was one of the few volunteering placements that allowed me to participate in activities that I was comfortable doing and didn't have age restrictions. I had flexible working hours, attending events and partaking in activities when I had free time and the staff was very supportive and achievements were often recognised. I would strongly recommend anyone to volunteer with Healthwatch Hillingdon if you have an interest in Health and Social Care or would just like to gain valuable experience and new skills that employer's value."

Interested in volunteering?
Contact Charmaine today!

Case Study 3 -Stephen Otter

Being a Trustee

I became a trustee at Healthwatch Hillingdon in March 2013, when Healthwatch was first formed. This meant setting up all the governance, policies and practices for the organisation. Healthwatch Hillingdon is a health watchdog run by and for local people. It is independent of the NHS and the local Council. We are here to help you get the best out of your health and care services, and give you a voice so you can influence and challenge how health and care services are provided throughout Hillingdon.

We can also provide you with information about local health and care services, and support you if you need help to resolve a complaint about your NHS treatment or Social Care.

I am already a trustee at Carers Trust Thames (formerly Crossroads) and have previous experience as the Chair of Governors at East Berkshire College. As trustee's, governance is part of our role and we always strive to be effective.

The main thing for me is to make sure I understand all the rules and regulations of

being a trustee. There is very good guidance about charity governance available online through NCVO, the Charity Commission and organisations like Trustees Unlimited.

Anyone thinking about becoming a trustee should read the guidance first and ensure they understand the responsibility the role entails.

On a day to day level, the role is like my job; you make sure you are responsive to emails and calls, read and consider thoroughly all the materials you are sent and attend the board meetings having prepared for them. Together with keeping up to date with how the health and social care landscape is changing.

It's very satisfying to use my professional skills to help people and to be making an impact on the charity. My HR background has also been helpful and I've enjoyed contributing advice when asked including directing the charity on issues such as recruitment.

The time commitment can be difficult. In addition to trustee meetings there are other activities that we are expected to attend.

Being a trustee is a serious commitment and comes with responsibilities. People need to know it can be demanding. You need to show you really want to do it and will take it seriously. There is no point becoming a trustee unless you can commit the time and energy. This makes it rewarding. I believe trusteeship is a good way to gain board experience, particularly for young professionals who would find it very difficult to do so otherwise. And most importantly, it is very satisfying to feel you are using your skills to help others in a very tangible way.

If you are interested in becoming a trustee, please contact Graham on 01895 272997

Our finances

Financial Statement 2016/17

Income	£
Funding received from local authority to deliver local Healthwatch statutory activities	175,000
Bought forward 2015/2016	20,050
Additional income	500
Total income	195,550
Expenditure	
Operational costs	26,612
Staffing costs	149,683
Office costs	12,724
Total expenditure	189,019
Balance brought forward	6,531

NOTE: The Financial Statement is provisional and subject to the Healthwatch Hillingdon accounts for the year 2016-17, being examined by an independent examiner under section 146 of the Charities Act 2011.

Getting in touch

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Healthwatch Hillingdon

@HW_Hillingdon

Company Limited by Guarantee | Company Number: 8445068

Registered in England and Wales

Registered Charity Number: 1152553

We will be making this annual report publicly available on 30th June 2017 by publishing it on our website and submitting it to Healthwatch England, Care Quality Commission, NHS England, Hillingdon Clinical Commissioning Group, London Borough of Hillingdon, Hillingdon Health and Wellbeing Board and the External Services Scrutiny Committee.

Healthwatch Hillingdon has used the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

To request a hard copy of this report, or in an alternative format, please contact us.

BOARD PLANNER & FUTURE AGENDA ITEMS

Relevant Board Member(s)	Councillor Philip Corthorne
Organisation	London Borough of Hillingdon
Report author	Nikki O'Halloran, Administration Directorate
Papers with report	Appendix 1 - Board Planner 2017/2018

1. HEADLINE INFORMATION

Summary	To consider the Board's business for the forthcoming cycle of meetings.
Contribution to plans and strategies	Joint Health & Wellbeing Strategy
Financial Cost	None
Relevant Policy Overview & Scrutiny Committee	N/A
Ward(s) affected	N/A

2. RECOMMENDATION

That the Health and Wellbeing Board considers and provides input on the Board Planner, attached at Appendix 1.

3. INFORMATION

Supporting Information

Reporting to the Board

The draft Board Planner for 2017/2018, 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 2017/2018 were considered and ratified by Council at its meeting on 23 February 2017 as part of the authority's Programme of Meetings for the new municipal year. The dates and report deadlines for the 2017/2018 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 2017/2018

7 Dec 2017 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Friday 17 November 2017 **Agenda Published** 29 November 2017
	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: Strategic Estate Development (SI)	HCCG / 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	
	Pharmaceutical Needs Assessment 2018	LBH	
	PART II - Update on current and emerging issues and any other business the Chairman considers to be urgent	All	

8 Mar 2018 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Friday 17 February 2018 **Agenda Published:** 28 February 2018
	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: Strategic Estate Development (SI)	HCCG / LBH	
	CAMHS Progress Report (SI)	HCCG / LBH	
	HCCG Operating Plan	HCCG	
	Pharmaceutical Needs Assessment 2018	LBH	
	Annual Report Board Planner & Future Agenda Items (SI)	LBH	
	PART II - Update on current and emerging issues and any other business the Chairman considers to be urgent	All	

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