NORTH WEST LONDON 5 YEAR PLAN

Hillingdon CCG Summary

The North West London Five Year Strategic Plan sets out ambitions and objectives for health care across the eight CCGs (Clinical Commissioning Groups) of North West London, of which Hillingdon is one. It is drawn up in partnership with NHS England who directly commissions a number of services, including primary care and specialised services. The plan sets out how and where we will be working with our local partners and other CCGs in North West London to deliver changes.

The plan describes key changes we want to make in order to achieve our ambitions for improved care, patient experience and health outcomes in Hillingdon. Our vision is to ensure that the residents of Hillingdon can access high-quality, evidence-based care in a setting appropriate to their needs by transforming the way care is delivered.

In summary these areas of change are:

1. Health Promotion, Early Diagnosis and Early Intervention.

The priorities drawn from Hillingdon's Health and Well Being Strategy include improving health & wellbeing and reducing inequalities, prevention and early intervention, developing integrated, high quality social care and health services within the community or at home and creating a positive experience of care.

This covers

a. Giving every child the best start in life and helping vulnerable families
b. Empowering communities to take better care of themselves
c. Improving mental wellbeing throughout life
d. Working together to support the most vulnerable adults in the community
e. Structured health improvement activities, reducing alcohol harm, tackling obesity, immunisation, children's mental wellbeing and teenage pregnancy rates.
f. Improved prevention programmes for
    - Falls
    - Dementia – early diagnosis and early intervention pathway
    - Improved uptake of screening and immunisations (NHSE)

2. Out of Hospital Strategy including Primary Care Transformation.

Our Out of Hospital strategy responds to needs set out in Hillingdon's JSNA and priorities set out in the Health and Wellbeing Strategy, and will deliver

- **Accessible care**: care that is responsive to patients' needs and preferences, timely and accessible,

- **Proactive care**: proactive planned care that is easy to access, convenient and able to utilise specialist skills where appropriate

- **Co-ordinated care** (including rapid response and supported discharge): care that is patient-centred, co-ordinated and offers continuity of care to high need patients.

In Hillingdon this covers:

- Strengthening out of hospital services to meet growing demand for care that can be delivered in primary and community settings, rapid response to urgent needs and appropriate time in hospital.
- Development of primary care to offer a flexible range of out of hospital services via service hubs in each of the 3 Hillingdon localities
- Better care closer to home, with outpatient and planned care services provided in the community (e.g. cardiology, ophthalmology, MSK and gynaecology)
- Improved access, responsiveness and consistency of high quality primary care
- Transformation of the wider primary care team to support an increase in the range of services provided out of hospital. This is underpinned by the development of GP Networks in Hillingdon. Specific networks will focus on children, care homes , elderly , mental health and long term health conditions
- Development of information sharing with information available to patients and carers to inform their choice and ability to self-manage

3. Integrated Care in Hillingdon. This covers:

- Hillingdon's Better Care Fund Plan will enable residents of Hillingdon to plan their own care; with professionals that work closely together. These professionals will understand the needs of those in their care and their carers ensuring services deliver what is important to everyone.
- We will deliver 11 schemes within our Better care Fund Plan that will focus on improving health outcomes for residents who are 75 years and over with one or more health condition or care need.
- Better and earlier identification of susceptibility to disease or exacerbation alongside joined up management of conditions.
- Better coordination of services including a much stronger focus on case management and prevention.
- Reducing the need for older people to go to hospital – and reducing the lengths of stay where they are admitted.
- Bringing greater coherence to our present pattern of service initiatives: especially in enabling older people to be treated at or close to their home wherever possible.
- Hillingdon's Whole Systems Integrated Care early adopter will focus on the same population cohort, developing more anticipatory care with GPs at the centre of care, working in very different ways with other care providers across all organisational boundaries including third sector
- Care will be more anticipatory in nature, prevent people from escalating to higher levels of dependency or crisis point and support more personalised, self-management of long term conditions, including people with risk factors such as social isolation and dementia
- The WSIC will be able to test the effectiveness of a proactive approach to care, and build on current case management approaches for this group of residents within two North Hillingdon GP networks.

4. **Transforming Mental Health Services. This covers:**

- Enabling more people with stable mental health conditions to be supported in the community, by GPs, care navigators and specialists as required.
- Psychiatric liaison services to ensure timely access to urgent mental health care in acute hospitals.
- Widening access and increasing capacity for people to enter into psychological talking therapies (IAPT), whilst ensuring good recovery outcomes
- Jointly reviewing the provision of local child and adolescent mental health services with health and social care partners, and reviewing out of hours and need for specialist admission with other CCG and NHSE partners
- Improving services for people with learning disabilities in line with annual self-assessment across health and social care and the Winterbourne review recommendations
- Improving access to community based care for people with dementia
- Reviewing perinatal services
- Rolling out standardised urgent referral pathways with other NWL CCGs

5. **Shaping a Healthier Future. This covers**
   - Ensuring that there is high quality and sustainable acute health care in North West London that is organised in a way that maximises the clinical and estates assets available in the area; centralising where necessary and localising where possible. Hillingdon Hospital remains a fixed point within this programme of work.
   - Meeting the London quality standards, which include the national standards for 7 day services, based on the review by the Medical Director of NHS England, Sir Bruce Keogh, for urgent care, which seek to reduce the variation in patient outcomes which occur at the weekends and out of hours. This initiative is included as an enabler within Hillingdon's BCF plan.

6. **Improved quality and safety of care. This covers:**
   - The plan further sets out the need to maintain a focus on essentials during this period of significant change across health and care services. In particular there will be a focus on maintaining quality, access and performance through ensuring that the CCG responds effectively to:
     a) the Francis, Berwick and Winterbourne View
     b) the need to improve patient experience
     c) the need to empower service users to take control of their own care
     d) ensuring compassion in practice values are embedded in all services that deliver care
     e) maintaining staff satisfaction
     f) ensuring high quality safeguarding services
     g) the need for better access to care
     h) ensuring progress to ensure parity of esteem between physical and Mental health care

Measuring our Success

The way we will measure our success will be based on the targets we have set for improvement within our outcome ambitions, which are national measures that have baselines and a target for improvement:

- People living longer and not dying prematurely
- People with Long Term Conditions maximising their quality of life
- People recovering from illness or injury resuming their lives
- People having a positive experience of care

- Treating and caring for people in a safe environment and protecting them from avoidable harm (i.e. people experiencing a safe care environment)

In addition, the plan demonstrates how the financial challenge arising from the following will be managed over the 5 year period in the light of:

a) Population growth
b) Increased care needs associated with an aging population with chronic health conditions
c) Physical condition of health buildings/estates

Summary-HCCG Finance Overview

- In 2013/14 Hillingdon CCG inherited an underlying deficit from the PCT and had an agreed deficit plan of £12.25m as part of a three-year recovery plan to restore underlying financial balance.
- The CCG's13/14 actual outturn was a reported deficit of £5m, which was £7m better than plan. However its underlying deficit at year end was an underlying deficit of £15.4m (on the assumption that the CCG's 2.5% headroom is treated as a recurrent commitment).
- In December NHSE confirmed that Hillingdon CCG was assessed as 9% under its target allocation, and as a result it has therefore received a larger than average increase in allocation in 14/15 and 15/16 of 4.3% and 4% respectively.
- The 14/15 financial plan (pre NWL strategy and assuming full application of NHSE Business Rules) would be a deficit of £25.6m. The agreement of the NWL financial strategy enabled the CCG to submit a balanced plan to be produced as follows:

Total	£25.6m
Funding to negate repayment of 13/14 deficit	(£5.0m)
Funding to support14/15 planned deficit	(£7.7m)
Assumed retained 2.5% non-recurrent headroom	(£7.6m)
Funding to support Out of Hospital investment	(£5.3m)
Total (revised)	0

- Within the balanced plan above, the CCG's 14/15 underlying deficit position is forecast to be c£7m (including the 2.5% headroom). Consequently the CCG plan in 2014/15 does fully not meet NHSE Business rules criteria as there remains an underlying deficit at the end of the year and there is also the absence of a 1% surplus.

- Agreement of the NWL strategy is essential to the delivery of the balanced plan in 2014/15 – it should be noted however that all aspects of the NWL financial strategy are subject still to NHS England agreement as part of their review and sign-off of 14/15 Operating Plans for all CCGs.
- The key assumptions embedded in the plan for 14/15 are as follows:-
- Prudent budget setting assumptions – e.g. allowance for demographic and non-demographic growth
- QIPP of £10.4m, equating to 3.6% which compares to recovery plan forecast of 4%, 13/14 actual of 3.1% (13/14 plan = 3.8%)
- Investments – includes plans for investment of £1.5m to ensure tailored care for older People (£5 per head) and also investment in schemes to reduce readmissions to hospital.
- In 2015/16 the CCG anticipates it will be able to deliver a balanced position (but not a 1% surplus until 2016/17). As a result it will not fully comply with NHSE Business Rules until 16/17. This is dependent on a number of key assumptions in particular:-
- **Better Care Fund is resource neutral;**
- **QIPP of 4% is achieved in both years, if the CCG delivered only 3% QIPP per annum, this would result in c£3m less per annum**.
- **Transition support for the THH continues to be available from NWL Financial Strategy, not the CCG.**