NHS
Hillingdon
Clinical Commissioning Group

Commissioning Intentions 2016-17

October 2015

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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. To help us achieve this we will be focusing on supporting people to care for their own and their families health needs more independently so that people in Hillingdon remain healthy and independent for as long as possible and reduce the demands placed on health care services.

**The population of Hillingdon includes all patients registered with a Hillingdon based GP and unregistered people resident in Hillingdon. Some elements of health care is commissioned by the London Borough of Hillingdon (LBH) and, particularly for Primary Care, others 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 will for the first time share responsibility for commissioning GP Based Services in Hillingdon). The CCG will further develop this work in 2016/17.*

Section 1b: Aim of the Commissioning Intentions

The aim of these Commissioning Intentions is to provide an overview of Hillingdon CCGs plans to purchase (commission) high quality health care to improve the health outcomes for Hillingdon patients for the Financial Year 2016/17 (FY16/17) and to set the scene for how we envisage services developing over the next 3 years.

To develop these Commissioning Intentions we have engaged our patients, carers and the wider public along with our member practices and other providers and have drawn on a wide range of sources of information and feedback as shown on the next page.

The Commissioning Intentions for 16/17 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 North West London.

Section 2: Delivering HCCG's Vision for 2016/17

Hillingdon CCG's (HCCG's) 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 to keep Hillingdon people healthy, independent and enjoying a better quality of life."

In this section we explore how HCCG will deliver its stated vision through four specific aspects: Quality, Value, Our Commissioning Principles and Transformation.

Section 2a: Delivering HCCG's Vision (Quality)

Quality is at the heart of the work of Hillingdon CCG. We remain committed to improving the quality of care delivered by providers of health care services in Hillingdon and aim to ensure quality is embedded into the services we commission for our local population. Hillingdon CCG's Vision for Quality is to deliver excellent health and wellbeing outcomes and great services for the people of Hillingdon that are delivered in the right place and within budget. This includes the requirement that robust assurance systems are in place so the public can have confidence that high quality standards are set within the services we commission and are regularly monitored.

Hillingdon CCG is closely associated with the CCGs in Harrow and Brent and together form the BHH (Brent, Harrow & Hillingdon) CCG Federation covering the outer part of North West London (NWL) where we share a number services to reduce costs and ensure consistency across our numerous providers. This shared resource includes the Quality Team who are managed centrally but have a local presence in Hillingdon CCG (as well as in Harrow and Brent).

Hillingdon CCG, with the support of the Quality Team, will continue to manage quality within our commissioned services through the following:

- Conducting regular detailed analysis of hard and soft quality data and information is used to triangulate the quality of services.
- Gathering data from all of our commissioned services. This analysis allows for continuous monitoring to identify good practice as well as areas where quality standards are not being met which initiates a deeper dive.
- Maintaining good working relationships with our providers and continuing to hold monthly Clinical Quality Group (CQG) meetings with our main providers. These are formal meetings held with the provider where there are open discussions in relation to performance and quality with the use of data and reports.

- Where we are not the lead commissioner, but we have commissioned services, we will continue to work closely with the Lead CCG to receive assurance that services are being delivered to the highest standards possible.
- Focusing on improving patient safety, patient experience and clinical effectiveness and will continue to share learning from serious incidents, never events, safeguarding cases, complaints and any associated reviews with providers to enhance services to patients.
- Working with regional and national initiatives and partners such as the "Sign Up To Safety" initiative and continuing our work with Imperial College Health Partners for the Foundations of Safety Programme.

Section 2b: Delivering HCCG's Vision (Value)

HCCG operate within a financial budget. Historically the CCG has been financially challenged but has worked hard to ensure that the services we commission both meet the changing needs of our population as well as the financial constraints we work with. This work has ensured that in Financial Year 14/15 the CCG was able to achieve financial balance and in delivering our vision for 16/17 we must ensure this situation continues. To do this we need to consider the increasing population within Hillingdon that need to be supported and how best we can achieve this whilst at the same time continuing to reduce our overall costs so that we meet our financial obligations to make savings.

Hillingdon CCG will continue to ensure that we offer value for money within our commissioned services through the following:

- Benchmarking all services against local (North West London), London Wide and National Metrics to identify areas for improvement.
- Monitoring spend patterns and identifying where efficiencies can be made.
- Working with patients, carers, partners and providers to identify different models of service delivery to achieve the same or better levels of quality and outcomes for patients whilst offering improved value for money for the tax payer.
- Selectively testing the market for services to determine whether other providers can offer a more cost effective solution to the delivery of high quality services.

Specific areas where HCCG will focus on during 16/17 to ensure that we are delivering value for money include:

- Ensuring that we provide alternatives to attending hospital for patients with an unplanned care need (whether physical or mental health) where the need is not urgent or does not require the facilities of an acute hospital and helping those that do need to attend to avoid an unplanned admission where possible.

- Helping to support patients safely going home more swiftly should they be admitted including ensuring the Out of Hospital facilities effectively support Patients.
- Working to prevent disease or illness and empowering more patients with Long Term Conditions to enable them to better manage their own health and reduce exacerbations.
- Monitoring performance and variation across our providers and seeking to integrate services more effectively between organisations to achieve efficiencies.

Through the above and other actions outlined within these Commissioning Intentions, HCCG will ensure that we provide high quality services that offer value for money.

Section 2c: Delivering HCCG's Vision (Commissioning Principles)

In commissioning high quality services that offer value for money HCCG will continue to utilise the following Commissioning Principles:

We will:

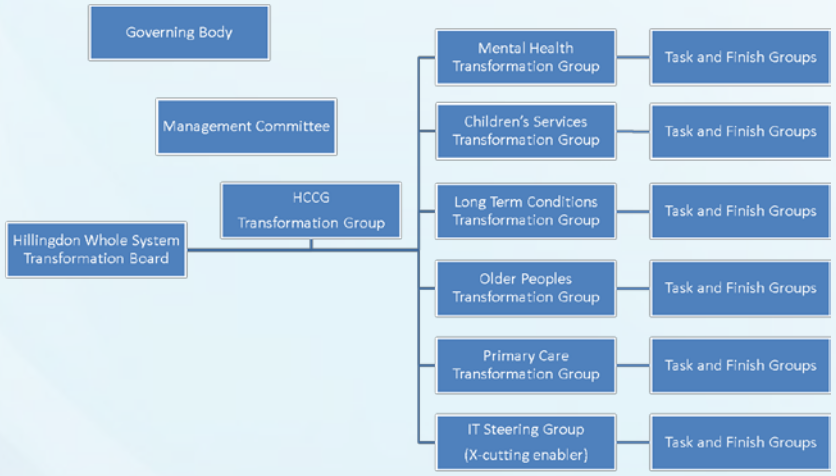
- Commission high quality, clinically effective care with a robust evidence base.
- Demonstrate and evidence equality and consistency in access to services and health outcomes within Hillingdon that continues to reduce health inequalities.
- Work with other commissioners where integrated commissioning will deliver innovative and effective healthcare solutions in line with the commissioning strategy.
- Work with providers, patients and carers to co-design an affordable integrated care system with an increased focus on Out of Hospital care.
- Develop patient and public engagement that ensures meaningful public involvement in commissioning.
- Achieve financial balance and a viable local health economy within existing and future resources with particular emphasis on robust contract monitoring across the entire contract portfolio.
- Commission care in line with health needs as identified within the JSNA and in line with the Joint Health & Wellbeing Strategy.
- Commission services that continue to move toward outcome-focused care, driven by the NHS Outcomes Framework with a key quality focus on the care and treatment of vulnerable adults.

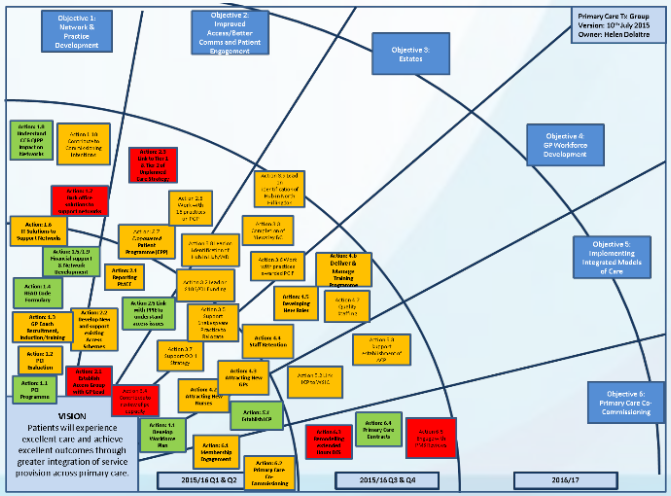
Section 2d: Delivering HCCG's Vision (Transformation)

The last of the four aspects of our Vision is concerned with Transforming Services. Hillingdon CCG, along with other CCGs in London, is committed to supporting the NHS London Transformation Programme and will ensure that the work being undertaken at a London Wide and North West London wide level is aligned with our own local transformation work.

In the increasingly complex world in which we operate we need to be clear on how we want to transform services over the coming years in the face of changing needs, changing commissioning models, developing partnerships and the use of existing and emerging technologies. The Transformation element of our Vision is concerned with six primary areas, each of which has an established Transformation Group involving different partners that varies depending on the transformation group each of which are; Mental Health, Older People, Children & Young People, Long Term Conditions, Primary Care and IT.

Each Transformation Group aims to have an up to date strategic Transformation Map that looks 2 to 3 years into the future and also to have a corresponding implementation plan and a dashboard of measures that enable each transformation group to monitor the impact they are having. A picture of the overall Transformation Group structure is shown below along with an example Transformation Map.





Section 3: The Health Landscape in Hillingdon

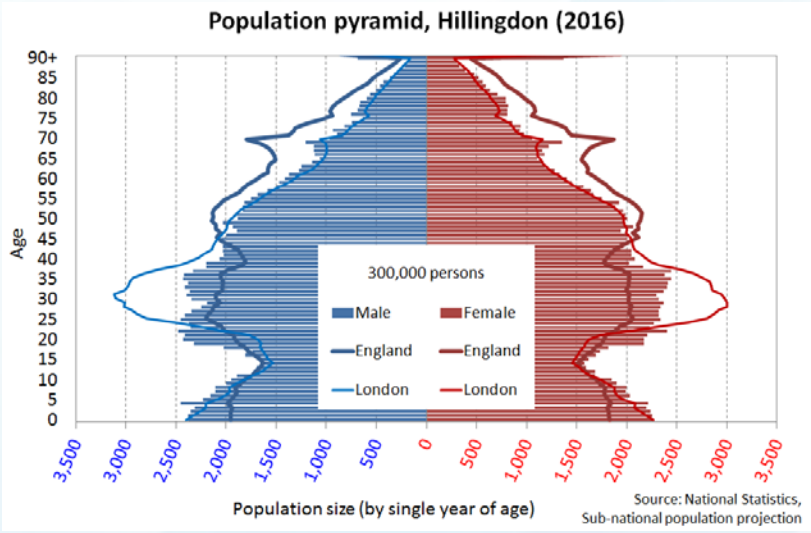
Section 3a: Demographics

Hillingdon has the second largest area (116 km^2) of London's 33 boroughs (strictly, 32 boroughs + City of London) with the 12th largest population. The overall size of the population for the London Borough of Hillingdon is shown in the following table.

• **National Statistics, 2012-based sub-national population projections (SNPP)**	**2016**	300,000
• **Greater London Authority (GLA) 2014 round short-term projection**	**2016**	301,000
• **Hillingdon Clinical Commissioning Group (CCG) GP registered population**	**2015**	301,000
• **Hillingdon CCG GP registered population that actually resides in Hillingdon**	**2015**	283,000

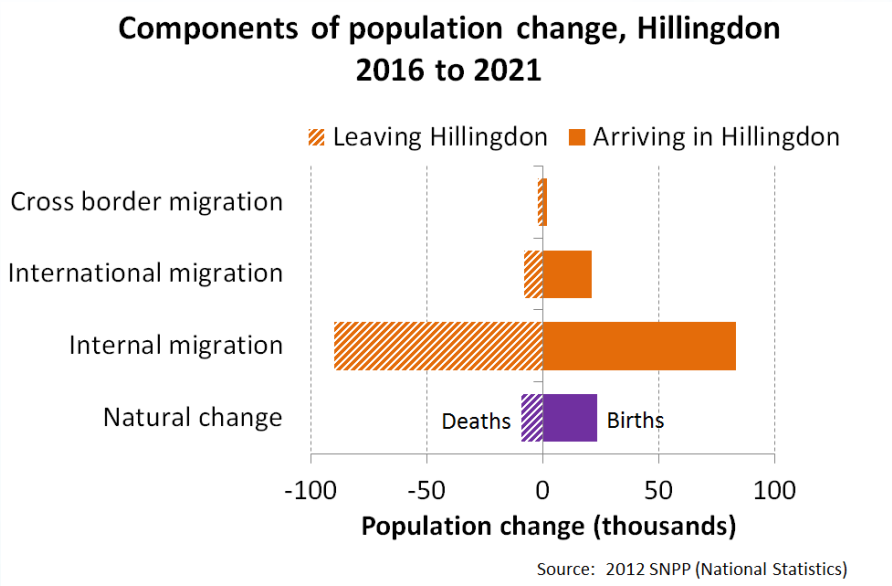
The population pyramid shows the population of Hillingdon by age band and gender and contrasts it with the population of London and the population of England as a whole. The populations for England and London are scaled so the proportion of the population in each age band can be compared with Hillingdon.

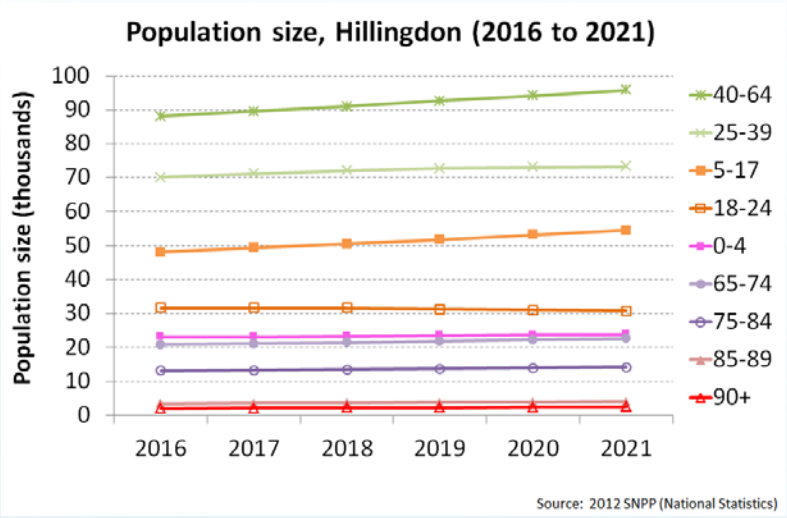
The age structure of the population in Hillingdon is intermediate between that for London and that for England, with, for the most part, a distribution that is slightly older than London as a whole but younger than England. Among children and young adults however, there is a larger proportion resident in Hillingdon than for both London and England.



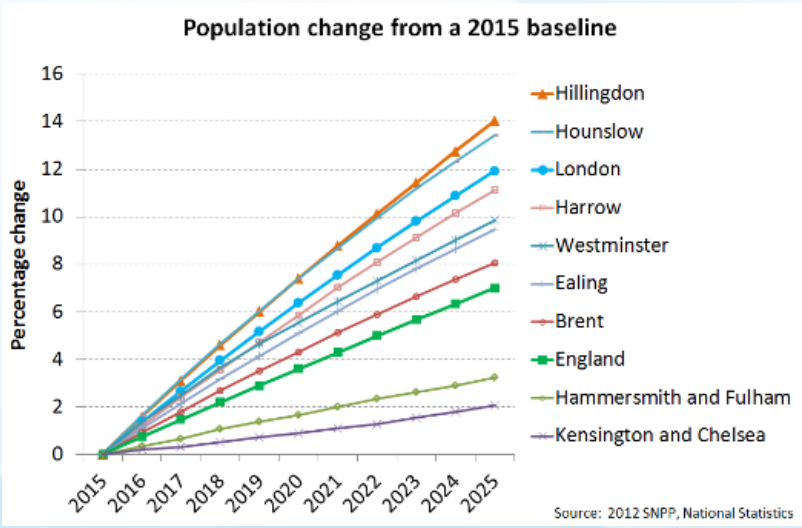
Section 3b: Population Growth Projections

The population increase in Hillingdon over the next 5 years is expected to be 7.1% (around 1.4% year on year). The corresponding 5-year increase in London is 6.1% and in England overall is 3.5%. The main driving force behind the increase in the population between 2016 and 2021 is natural change, i.e. 14,800 more births than deaths. Net migration is expected to account for around 6,600 persons over the same period.





The number of people in the following age bands are expected to increase in the next 5 years: 5-17, 25-39, 40-64 and 65-74. All the other age bands are expected to increase only slightly or remain flat until 2021.

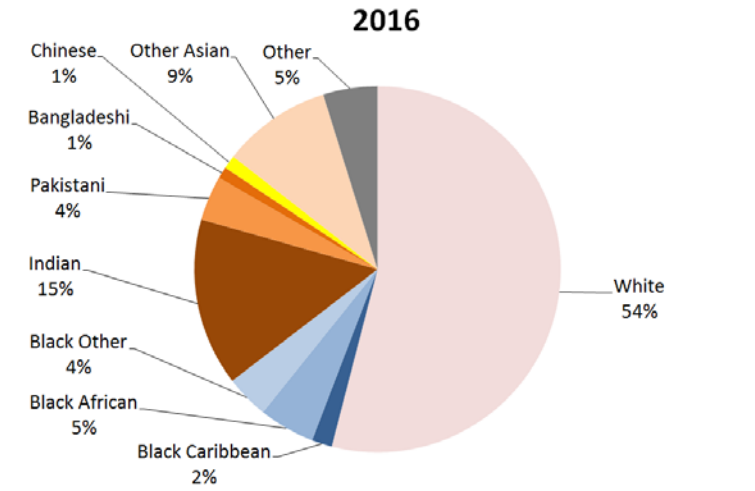


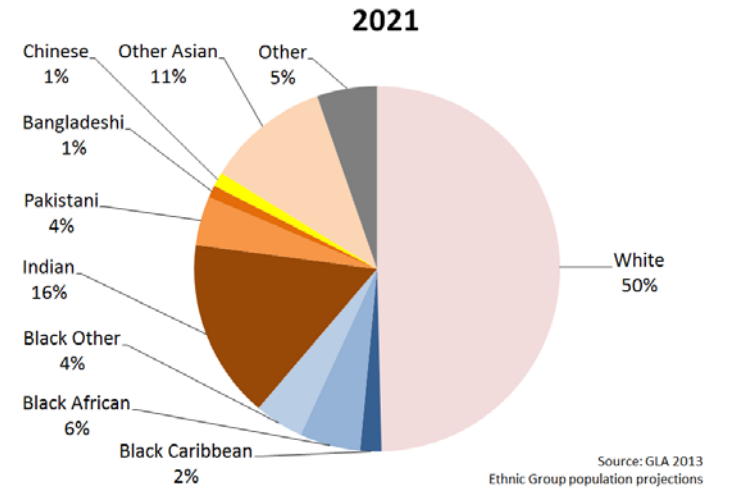
Comparatively, the population growth in Hillingdon is projected to be higher than any other North West London CCG (Hounslow being the possible exception) and will be above both the average for London and England. The projected size of the population (numbers) to calculate the cumulative percentage population increase (plotted in the graph opposite) are shown in the table below.

Total Population By Year (Thousands)								
	2015	2016	2017	2018	2019	2020	2021	2022
England	54,613	55,020	55,415	55,812	56,198	56,582	56,962	57,338
London	8,641	8,759	8,871	8,982	9,088	9,192	9,293	9,392
Brent	322	325	328	331	334	336	339	341
Ealing	351	355	359	362	366	369	372	376
Harrow	251	254	257	260	263	266	268	271
Hillingdon	296	300	305	309	314	318	322	326
Hounslow	272	277	281	285	288	292	296	299

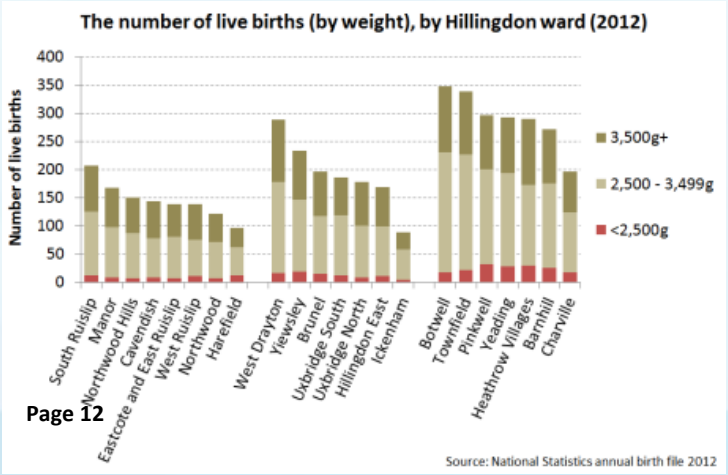
Cumulative Percentage Population Increase From 2015								
	2015	2016	2017	2018	2019	2020	2021	2022
England	100	101	101	102	103	104	104	105
London	100	101	103	104	105	106	108	109
Brent	100	101	102	103	104	104	105	106
Ealing	100	101	102	103	104	105	106	107
Harrow	100	101	102	104	105	106	107	108
Hillingdon	100	102	103	105	106	107	109	110
Hounslow	100	102	103	105	106	107	109	110

Section 3c: Ethnic Breakdown





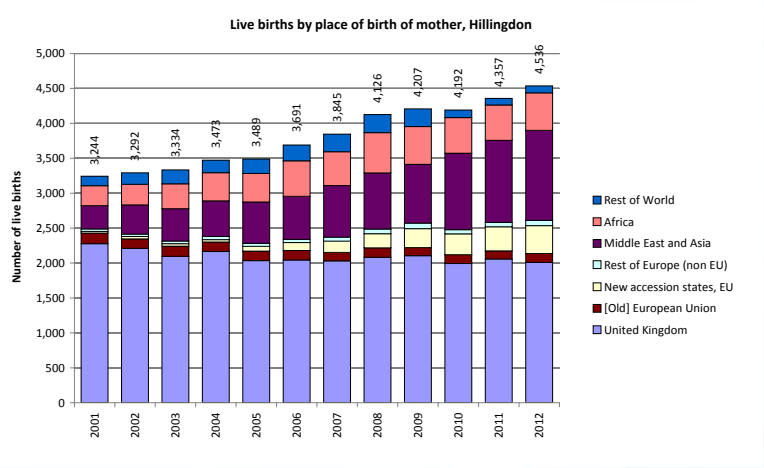
The ethnic group population projections for 2016 and 2021 are shown in the pie charts above. The Black, Asian and Minority Ethnic groups (BAME is defined as all the Greater London Authority ethnic groups except the GLA White group) are all projected to rise in number and proportion between 2016 and 2021. Given that prevalence of long term conditions like diabetes, cardiovascular disease, dementia and cancers varies across different ethnicities, this may have implications for future demands on health care.



There are over 76,000 children and young people aged 0-19 living in Hillingdon which represents 26.2% of the total population, slightly higher than the London proportion of 24.4%. 59.4% of school children are from a minority ethnic group. Generally the wards in the south of the borough have greater numbers of young people who make a higher proportion of the overall population.

Between 2006 and 2012 there has been 23% increase in annual births in Hillingdon (more than 800 births per year) with a total of 4536 births in 2012 compared to 3691 in 2006. There is wide variation between Hillingdon wards in the numbers of births annually, ranging from just over 100 per year in Ickenham to over 330 per year in Botwell and with more births in the South of the borough than the North.

In 2001 over two-thirds of births in Hillingdon were to mothers born in the UK but by 2012 this had fallen to less than 50%. Compared to England, fewer mothers in Hillingdon were born in the UK, and more were born in the Middle East and Asia and in Africa.



Section 3d: Influencing Factors

There are a number of influencing factors that need to be considered in planning health services for the people of Hillingdon and these are expanded upon below.

Language Barriers: There are some wards where the number of people (aged 3+) who *cannot speak English* or *cannot speak English well* number more than 2,000; these are Townfield (7%), Barnhill (7%), Pinkwell (6%) and Botwell (6%). The implication being that additional translation support may be required when patients from this demographic present for treatment. However, it is also likely that the younger patients in these areas will develop bilingual capabilities sooner rather than later.

Infant Mortality: The 2011-2013 the infant (before the 1st birthday) mortality rate in Hillingdon (3.7 per 1,000 live births) was lower than, but not statistically different from, the average for London (3.9 per 1,000 live births) and England (4.1 per 1,000 live births).

TB: The TB rate (2013) in Hillingdon is 35.5 per 100,000 population, this similar to London (36 per 100,000) and higher than the England rate (15 per 100,000). While 83% of individuals with TB in 2013 were born outside the UK, TB rates decreased in the non-UK born London population. The most common country of birth of non-UK born TB patients was India followed by Pakistan, Somalia and Bangladesh. Out of all the TB cases in London, 9% were recent entrants to the UK (entered within the previous two years).

Cervical Cancer Screening: Cervical cancer screening coverage for 25-64 year olds is lower in Hillingdon (74%) than either London (75%) or England (78%). There is no evidence from the 2013/14 national report that this is a reflection of lower uptake from certain ethnic groups.

Injuries Due To Falls: Metrics regarding injuries due to falls in Hillingdon in 2013/14 are similar to those for London, however, the rate of injuries due to falls in females aged 80+ years is worse in Hillingdon (7.5%) than England (6.2%) and London (6.4%).

Other lifestyle factors and risky behaviours contribute enormously to long-term (and short-term) health. The most significant of these in the Hillingdon area are shown below:

- **Excess Weight & Obesity:** In Hillingdon in 2012, 67% of the adult population is estimated (loosely) to be overweight or obese; this is similar to England (64%), but higher than London (57%).
- **Physical Inactivity:** In Hillingdon in 2013, 30% of adults age 16+ are estimated to be doing less than 30 minutes of moderately intensive physical activity (in bouts of at least 10 minutes) per week; this is similar to London (28%) and England (29%).
- **Smoking:** In Hillingdon in 2013, 16% of adults age 18+ were estimated to be current smokers; this is similar to London (17%) and England (18%)
- **Alcohol:** In 2014, the rate of alcohol-specific hospital admissions in Hillingdon (121 per 100,000 population) is similar to the England average (117 per 100,000).
- **Conceptions:** The rate of under 18 conceptions continues to decline. In 2013, the conception rate in females aged <18 years in Hillingdon (23 per 1,000 females aged 15 to 17 years) is similar to London (22 per 1,000) and England (24 per 1,000).

There are some illnesses or conditions where Hillingdon may be performing less well than other areas, these include:

- **Communicable diseases:** Mortality from communicable diseases among Hillingdon residents has fallen consistently since 2003-05. In 2011-13 the standardised mortality rate from communicable disease in Hillingdon (70 per 100,000 population) was similar to London (64 per 100,000), but higher than the rate for England (62 per 100,000).
- **Depression:** In Hillingdon in 2013/14, 5.2% of adults age 18+ were recorded with depression on GP registers; this is higher than London (4.8%) and lower than England (6.5%).
- **Dementia:** Epidemiological models suggest that there will be around 2,800 Hillingdon residents living with dementia in 2016; in 2013/14 local GP registers have recorded around 1,200 people (0.39%) which is the same proportion as London (0.39%), but lower than England as a whole (0.62%).

Section 4: National Strategic Context

In developing our local Commissioning Intentions, Hillingdon CCG (HCCG) needs to consider the national strategic context. The on-going financial restraint requires public organisations to reduce costs and whilst the health budgets are 'protected' there are knock on effects that increase the pressure on healthcare services when budgets are cut elsewhere in the public sector. The national strategic context is laid out in the NHS document "The Five Year Forward View" which recognises the complex nature of health and social care needs experienced by older people and those living with Long Term Conditions including those with multiple health problems. The CCG created a 5 Year Strategic Plan before the publication of the "Five Year Forward View" that set the direction of travel for the CCG's Recovery Programme and which is broadly aligned to the newer national strategy.

The National Strategic Context within which HCCG has to operate is laid out most clearly within the Five Year Forward View and highlights from this document are provided in the following section.

Section 4a: Executive Highlights from the NHS Five Year Forward View

Highlights from the NHS Five Year Forward View include the following:

Improvements achieved over the last fifteen years: Cancer and cardiac outcomes are better; waits are shorter and patient satisfaction much higher despite a global recession and austerity.

However, many challenges still exist including: quality of care can be variable, preventable illness is widespread, health inequalities deep-rooted, needs are changing and we face particular challenges in areas such as mental health, cancer and support for frail older patients.

The responses to these challenges that are outlined in the NHS Five Year Forward View include:

- New options to permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care through a **Multispecialty Community Provider**.

- A further new option will be the integrated hospital and primary care provider – **Primary and Acute Care Systems** – combining for the first time general practice and hospital services, similar to the Accountable Care Organisations/Partnerships (ACPs) now developing in other countries too.

- Across the NHS, **urgent and emergency care** services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services.

- **Smaller hospitals** will have new options to help them remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services.

- Midwives will have new options to take charge of the **maternity** services they offer.

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

- Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years.

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

- The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.

In order to provide the comprehensive and high quality care the people of England clearly want, Monitor, NHS England and independent analysts have previously calculated that without efficiencies the NHS will need an additional £30 billion a year by 2020/21. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts – manage demand, achieve efficiencies and allocate funding appropriately. Less impact on any one of them will require compensating action in the other two areas.

Section 4b: Highlights from the NHS Outcomes Framework 2015/16

Whereas the NHS Five Year Forward View document sets the strategic direction for all NHS organisations, HCCG also need to consider the NHS Outcomes Framework which provides a national overview of how well the NHS is performing. The Outcomes Framework was first developed in December 2010 and has been updated annually since then which enables it to remain a tool which reflects the current landscape of the health and social care system. In preparing HCCG's Commissioning Intentions for 2016/17 we therefore need to consider the latest edition of the Outcomes Framework (2015/16) and the indicators that are outlined within it.

The NHS Outcomes Framework requires NHS organisations, including Hillingdon CCG, to consider performance indicators that are grouped together into the following five domains:

Domain 1: Preventing people from dying prematurely.

Overarching Indicators:

- Potential Years Life Lost (PYLL) from causes considered amenable to healthcare
- Life expectancy at 75
- Neonatal Mortality and Stillbirths

Improvement areas under Domain 1 include focusing on Cardiovascular Disease, Respiratory Disease, Liver Disease, Cancer, Mortality in Adults with Serious Mental Illness, Infant Mortality and reducing mortality rate in adults under 60 with a Learning Disability.

Domain 2: Enhancing quality of life for people with Long Term Conditions (LTCs).

Overarching Indicators:

- Health-related quality of life for people with Long Term Conditions (LTCs)

Improvement areas under Domain 2 include focusing on the proportion of people who feel supported, employment of people with LTCs, reducing time spent in hospital by patients with LTCs, enhancing the quality of life for carers, those with mental illness and those with dementia as well as those with multiple LTCs.

Domain 3: Helping people to recover from episodes of ill health or following injury.

Overarching Indicators:

- Emergency admissions for acute conditions that should not usually require hospital admission.
- Emergency readmissions within 30 days of discharge from hospital.

Improvement areas under Domain 3 include improving outcomes from planned treatments, preventing lower respiratory tract infections in children from becoming serious, improving recovery from injuries and trauma, stroke and fragility fractures, helping older people to recover their independence after illness or injury and dental health.

Domain 4: Ensuring that people have a positive experience of care.

Overarching Indicators:

- Patient experience of primary care.
- Patient experience of hospital care.
- Friends & Family Test.
- Patient experience characterised as poor or worse (primary and hospital care).

Improvement areas under Domain 4 include improving people's experience of outpatient care and accident and emergency services, improving hospitals' responsiveness to personal needs, improving access to primary care services, improving women and their families' experience of maternity services, improving the experience of care for people at the end of their lives, those with mental illness, for integrated care and for the experience of healthcare for children and young people.

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidance harm.

Overarching Indicators:

- Deaths attributable to problems in healthcare.
- Severe harm attributable to problems in healthcare.

Improvement areas under Domain 5 include reducing the incidence of avoidance harm (such as deaths from venus thromboembolism (VTE) events, incidence of healthcare acquired infection (HAI), hip fractures and category 2, 3 or 4 pressure ulcers), improving the safety of maternity services and improving the culture of safety reporting.

Section 4c: 8 High Impact Actions for Urgent & Emergency Care

In addition to the NHS Five Year Forward View and the NHS Outcomes Framework, Hillingdon CCG also needs to consider the 8 High Impact Actions for Urgent & Emergency Care that have been recommended by NHS England, Monitor and Trust Development Agency. These 8 Actions have been reviewed and agreed by the Hillingdon System Resilience Group (SRG) and are summarised below:

1. No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive Out-Of-Hours services.

2. Calls categorised as Green calls to the ambulance 999 service and NHS 111 should have the opportunity to undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS 111, ambulance services and out-of-hours GPs should be considered.

3. The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.

4. System Resilience Groups (SRGs) should ensure the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services

5. Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support the management of falls patients without conveyance to hospital where appropriate.

6. Rapid Assessment and Treatment should be in place, to support patients in A&E and Acute Medical Units to receive safer and more appropriate care as they are reviewed by senior doctors early on

7. Daily review of in-patients through morning ward or board rounds, led by a consultant/senior doctor, should take place seven days a week so that hospital discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.

8. Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

Section 5: North West London Strategic Context

Hillingdon CCG is one of eight CCGs that cover the boroughs of North West London (NWL). Hillingdon, along with Brent and Harrow, are responsible for health care in the outer region of NWL whilst the five CCGs of Chelsea & Westminster, West London, Hammersmith & Fulham, Hounslow and Ealing, cover the inner region of NWL. Much collaborative activity occurs across the eight CCGs and there are a number of shared functions between the organisations that help reduce the overall cost of commissioning for NWL.

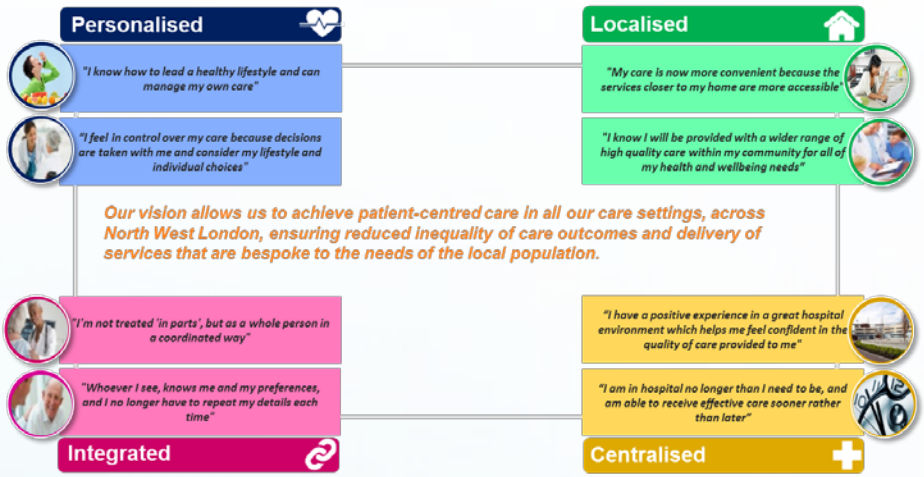
The CCGs in NWL are working together on programmes such as the Whole Systems Integrated Care (WSIC) Programme, Mental Health Transformation and also on our collective activities as part of the Better Care Fund (BCF). However, the major element of the strategic context for NWL is covered by the Shaping a Healthier Future (SaHF) programme, details of which are given in the following section.

Section 5a: Shaping a Healthier Future (SaHF)

North West London (NWL) is changing. We are undertaking a historic transformation of the healthcare system that will dramatically improve care for over two million people. We are on the cutting edge of healthcare innovation, pioneering new ways of integrating care, transforming access and reconfiguring hospitals.
All eight of NWL's Clinical Commissioning Groups and partner organisations are continuing to work together in a collective way to successfully plan and implement this change. Our vision is to deliver care which is:

- **Personalised** – Enabling people to manage their own care themselves and to offer the best treatment to them. This ensures that care is ***unique***.
- **Localised** – Localising services where possible, allowing for a wider variety of services closer to home. This ensures that care is ***convenient***.
- **Integrated** – Delivering care that considers all the aspects of a person's health and is coordinated across all the services involved. This ensures that care is ***efficient***.
- **Centralised** – Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures that care is ***better***.

Our vision is centred on the needs of the NWL population, developed from the patient views on their requirements of healthcare. These views then formed as the ambitions of our strategy and vision for the healthcare transformation in North West London.



We are already delivering this transformation through the Shaping a Healthier Future (SaHF) portfolio. This work will continue during 2016/17 through local activity within the individual boroughs and within the following major programmes being run on a pan- NWL level:

- Acute Reconfiguration;
- Primary Care Transformation;
- Whole Systems Integrated Care;
- Mental Health Transformation.

Acute Reconfiguration: *Improved hospitals delivering better care 7 days a week, and ensuring there are more services available closer to home.*

In NWL, we have recognised the changes in population demographics and lifestyles, and, as such, are changing the way we organise our hospitals and community health services. By making these changes, we can ensure that the highest standards of care are met; that our hospitals have the specialist doctors and facilities in place to deal with your specialist needs round-the-clock, and out-of-hospital services are on hand to treat your everyday health needs as quickly and conveniently as possible, either closer to or within your own home. Acute Reconfiguration aim to deliver:

- 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;

- The concentration of acute hospital services in order to develop centres of excellence which are able to achieve higher clinical standards and provide a more economic approach to the delivery of care.

In 16/17 the focus will be to:

- Deliver a revised Implementation Business Case for approval by the NHS and HM Government, allowing for capital investments to be made to transform NHS estates in NWL;
- The delivery of the transition of paediatric services from Ealing Hospital by June 30, as agreed by Ealing CCG Governing Body (on behalf of all other Governing Bodies in NWL) earlier this year;
- Planning for the transition of other services from Ealing and Charing Cross Hospitals as we continue to transform these sites to their future state.

Primary Care Transformation: *Placing Primary Care at the heart of whole system working, and improving access to GP services*

Primary Care, and in particular General Practice, is at the centre of the NWL vision. However, the model of general practice that has served Londoners well in the past is now under unprecedented strain. There are significant challenges that must be addressed, including increasing demand and projected shortages in workforce. Patients' needs are changing and the systems that are currently in place need to evolve to ensure that they are still fit for purpose in light of this change. The implementation of Shaping a Healthier Future (SaHF) will deliver a vision where patients can benefit from:

- Improved health outcomes, equity of access, reduced inequalities and better patient experience;
- Services that are joined up, coordinated and easy to use;
- More services available, closer to homes;
- High quality out-of-hospital care;
- More local patient and public involvement in developing services, with a greater focus on prevention, staying healthy and patient empowerment.

This will then enables us to provide accessible, coordinated and proactive care, as set out in the London-wide Strategic Commissioning Framework.
To ensure the vision is successfully realised and these benefits become tangible and sustainable, the model of Primary Care needs to be transformed so that it can become the strong and sustainable for Whole Systems Integrated Care (WSIC).
As we move through this year, our priority areas in 16 / 17 are as follows:

- Approving the new model of primary care through the joint co-commissioning committees in common and implementing this across NWL and ensuring that this is a fundamental part of an integrated care offer for patients;
- Working to ensure that all necessary enablers are in place to support the new model of care rollout (including workforce, technology and contracts);
- Putting the right support in place to nurture and grow GP federations so they are able to deliver sustainability in the long term as part of Accountable Care Partnerships (ACPs);
- Progressing with the primary care estates strategy that takes into account the development of out of hospital hubs across NWL. Currently, 19 sites are in the pipeline. Once delivered these will provide significant additional space to deliver primary and integrated care.

Whole Systems Integrated Care: *Coordinating care across commissioning bodies and provider, centred around the patient.*

Across NWL we are approaching year three of a five year journey towards delivering the Whole Systems Integrated Care (WSIC) vision. The characteristics of WSIC (outcome-based models of care, accountable care partnerships, capitated payments and system-wide risk and reward sharing) have been reinforced through national policy as articulated by the "Five Year Forward View".

Full implementation of WSIC will require a multi-year transition towards:

- Jointly commissioned population level outcomes that span health and wellbeing;
- Accountable care partnerships (ACPs) delivering co-produced models of care and managing the clinical and financial risk for their registered populations;
- During 16/17 Early Adopters will begin the transition to WSIC through the roll out of new care models, the development of shadow ACP boards and the roll out of key enablers such as shared analytics, joint governance (commissioner-commissioner, commissioner-provider, provider-provider) and the testing of new approaches to payment and risk/reward sharing.

Therefore the focus for WSIC in 16/17 is to:

- Roll out, review and refine new models of care that reflect the WSIC vision of person-centred care, supporting people to direct the care they need in their homes and local communities;
- Embed new ways of working, culture and behaviours to underpin the system changes required;

- Support and engage with shadow ACP boards as they develop;
- Shape an approach to assurance that will ensure WSIC provides the best quality and best value care for the population of NWL;
- Monitor the new models of care against a shadow population-level capitated budget;
- Introduce a ring-fenced element of real risk share where appropriate;
- Continue to embed co-production throughout ways of working;
- Share learning and best practice across and beyond NWL.

Mental Health Transformation: *Improving mental and physical health through integrated services.*

NWL is committed to collaborating with key partners to co-produce a mental health and wellbeing strategy which will improve outcomes and value. Across the system we have agreed to ensure that there is:

- Support for people who have experienced mental health problems to live well in the community;
- Promotion of recovery, resilience and deliver excellent health and social care outcomes including employment, housing and education;
- Development of new high quality services in the community, focusing on community based support rather than inpatient care so that people can stay closer to home;
- Services that provide urgent help and care which are available 24 hours a day 7 days a week for people who experience or are close to experiencing crisis.

As part of our commissioning intentions we would want providers to be proactively involved in transformation work and in implementing the outputs of transformation work. Specifically in 2016/17 we want to focus on:

- Implementation of new urgent care pathways and compliance with national target waiting times;
- Implementation of Future in Mind, the national strategy for children and young people to respond to local needs;
- Work with local specialist Mental Health and Learning Disabilities providers to implement local pathways to enable people to be cared for within NWL;
- Work collaboratively to implement the emerging outputs of the Like Minded strategy.

Section 6: Local Strategic Context

Whilst Hillingdon CCG achieved financial balance for the year there remains an underlying deficit. Demand for health care services continues to increase in both planned and unplanned care services. The previous sections have outlined the National and North West London Strategic Context that Hillingdon CCG need to operate within and locally we are committed to working in partnership with the Council for the London Borough of Hillingdon to deliver the Better Care Fund (BCF). The local context is also shaped by recent CQC (Care Quality Commission) visits to our two main trusts (The Hillingdon Hospital NHS Foundation Trust and Central & North West London NHS Foundation Trust) and the CCG is committed to working with both organisations to help them implement the actions plans that were raised following these visits.

Section 6a: Delivering the SaHF Vision in Hillingdon

Hillingdon CCG's Strategic Response to each of the 4 aspects of the SaHF Programme are detailed in the table below.

NWL Priority	Benefits to Patients	HCCG Strategic Response Area (Duplicates in Italics)	HCCG Actions Arising (Duplicate Actions Not Included)
Personalised	A1. "I know how to lead a healthy lifestyle and can manage my own care."	**Supporting Patients to easily access information & essential advice.**	• Deliver the Empowered Patient Programme (15/16) • Develop a Mental Health Single Point of Access (TBD) • Work with NWL CCGs on the NHS 111 Procurement (15/16) • Implement Patient Champions in Urgent Care Centre (15/16) • Improve Access to Online Advice (16/17) • Expand Community Outreach Programme (15/16) • Improve Cancer Information (As Per National Cancer Patient Experience Survey)
		Commissioning programmes to support Patients to self-manage.	• Expand Medication Reviews in GP Practices with Pts (15/16) • Re-Run the Parent Education Programme (15/16) • Implement Remaining Cancer Stratified Pathways (14/15-15/16)
		Developing the capabilities of our Practices & GP Networks	• Rollout Primary Care Education Programme (14/15-16/17) • Implementing the LTC Strategy: *Cardiology (Heart Failure) (15/16), Respiratory (COPD/Asthma) (15/16), Diabetes (15/16), Cardiology Phase 2 (16/17), Cancer Phase 2 (16/17)* • Align Community Services to Networks (14/15-16/17) • New Planned Care Pathways into Primary Care (ENT, Headaches etc) (16/17)

Personalised		**Commissioning services that provide advice as well as treatment.**	• Implement Remaining Cancer Stratified Pathways (14/15-15/16) • Implement Cancer related 'Direct Access Diagnostics) for GPs (16/17). • Review/Implement the Hillingdon For All (H4All) Business Case (15/16-16/17).
		Investing in technology to support Patient care.	• Develop 'Shared Patient Record' across providers (14/15-16/17). • Integrate our Urgent Care 'Out of Hours' System (16/17). • Improve access to specialist advice for GPs (14/15-16/17). • Implement ESP2 (Electronic Prescription Service) (15/16).
	A2. "I feel in control over my care because decisions are taken with me and consider my lifestyle and individual choices."	**Engaging Patients/Carers in the design of services in Hillingdon.**	• Embed Co-Production Workshops as 'the norm' (15/16). • Enhance Patient/Partner/Carer engagement in Commissioning (15/16-17/18). • Work with partners to access feedback from patients and service users together – ask the questions once.
		Focusing on addressing the residual health inequalities in Hillingdon.	• Update our Equality & Diversity Objectives (15/16). • Map Residual Inequalities (including Cancer) & Produce an Action Plan (15/16). • Enhance our Equality Impact Assessment Process (15/16).
		Transforming community and mental health services.	• Review/Update all Community Service Specifications (15/16-16/17). • Selective Market Testing where appropriate (15/16-16/17). • Use BCF and WSIC to drive increased integration across health providers and health and social care providers. • Embed Integrated Care Planning Programme into Primary Care (15/16).
		Developing fully integrated services where appropriate.	• Develop Pathways for Long Term Conditions (See above). • Implement Older People Integrated Care (including WSIC) (15/16-16/17). • Implement Intermediate Care 'In Reach' from Community/Third Sector (16/17). • Review of Homesafe Programme (Early Supported Discharge) (16/17). • Expand Integrated Discharge Planning (15/16-16/17).
		Giving Patients/Carers direct control of their own health care.	• Progress the implementation of Personal Health Budgets (PHB) (16/17).

Localised	B1. "My care is now more convenient because the services closer to my home are more accessible."	**Developing fully integrated services where appropriate.**	• Refresh Planned Care Strategy (15/16). • Undertake selective market testing (15/16-16/17). • Undertake Cancer "Chemo Closer To Home" Strategy Review (15/16). • Increase number of services delivered from a community site.
		Promoting the use of alternative 'point of contact' for advice/care.	• Rollout Hillingdon-Wide Comms programme (15/16-16/17). • Undertake audit & monitor access point uptake (16/17).
		Making advice more easily available electronically.	• Explore the possibility Remote Monitoring for Cancer Pts (16/17). • Implement Connect to Support (in partnership with Local Authority) (16/17).
		Improving access to Primary Care & OOH Services.	• Explore and if possible implement the concept of a Virtual Practice (15/16).
		Working toward a fully compliant '7 Day' Service.	• Expand Integrated Discharge Planning (15/16-16/17).
	B2. "I know I will be provided with a wider range of high quality care within my community for all of my health and wellbeing needs."	*Developing the capabilities of our Practices & Networks*	*See actions above.*
		Transforming community and mental health services.	*See actions above.*
		Developing fully integrated services where appropriate.	*See actions above.*
		Developing fully integrated services where appropriate.	*See actions above.*
		Working in Partnership with the Local Authority.	• Develop Joint Commissioning Intentions (16/17-17/18). • Develop Cancer Plans (16/17). o Screening o Early Diagnosis o Prevention & lifestyle Promotion

Integrated	C1. "I'm not treated 'in parts', but as a whole person in a coordinated way."	*Transforming community and mental health services.*	*See actions above.*
		Developing fully integrated services where appropriate.	*See actions above.*
		Promoting the use of alternative 'point of contact' for advice/care.	*See actions above.*
		Making advice more easily available electronically.	*See actions above.*
		Committing to the concept of 'parity of esteem' for MH conditions.	• Undertaking a 'Parity of Esteem' review (15/16-16/17).
	C2. "Whoever I see, know me and my preferences, and I no longer have to repeat details each time."	*Supporting Patients to easily access information & essential advice.*	*See actions above.*
		Investing in technology to support Patient care.	*See actions above.*
		Transforming community and mental health services.	*See actions above.*
		Developing fully integrated services where appropriate.	*See actions above.*
		Working in Partnership with the Local Authority.	*See actions above.*
Centralised	D1. "I have a better experience in a great hospital environment which helps me feel confident in the quality of care provided to me."	*Investing in technology to support Patient care.*	*See actions above.*
		Engaging Patients/Carers in the design of services in Hillingdon.	*See actions above.*
		Developing fully integrated services where appropriate.	*See actions above.*
		Working toward a fully compliant '7 Day' Service.	*See actions above.*
		Developing a 'Planned Care' strategy that is 'future fit'.	• Refresh Planned Care Strategy (15/16).
	D2. "I am kept in hospital for as long as I need to be, and am able to receive effective care sooner rather than later."	*Transforming community and mental health services.*	*See actions above.*
		Developing fully integrated services where appropriate.	*See actions above.*
		Increasing access to Primary Care & OOH Services.	*See actions above.*
		Working toward a fully compliant '7 Day' Service.	*See actions above.*
		Developing a 'Planned Care' strategy that is 'future fit'.	*See actions above.*

Section 6b: Commissioning Priorities for 2016/17

Our Commissioning Priorities for 2016/17 are grouped into four areas which are detailed below:

Priority 1: Ensuring Services Meet the Needs of Our Population

We will achieve this priority by:

- Engaging patients, carers and others in the design of services.
- Focusing efforts into addressing the health inequalities that exist.
- Reviewing, redesigning and selectively investing in Mental Health services as part of our commitment to the concept of 'Parity of Esteem'.
- Seeking to commission services based on 'clinical effectiveness and outcomes' rather than activity alone.

Priority 2: Reducing Unnecessary Demand for Highly Stressed Services

We will achieve this priority by:

- Empowering patients to self-manage elements of their care and providing them with better information and support.
- Promoting alternative 'points of contact' for advice/care where appropriate.
- Enabling providers to share information and advice about access and support more easily.

Priority 3: Moving More Services Out of Hospital

We will achieve this priority by:

- Working with GP Practices and Networks to develop their skills, capabilities and capacity to support the CCG's Out of Hospital Strategy.
- Working with all providers and partners to integrate services particularly focusing on Older People and those with Long Term Conditions.
- Enhancing our work with our Local Authority (London Borough of Hillingdon) on both the WSIC and Better Care Fund (BCF) programmes.
- Continuing work to develop three "hubs" within Hillingdon where services can be co-located.

Priority 4: Delivering Value for Money

We will achieve this priority by:

- Supporting providers to share information to improve the quality of care and reduce the duplication of activities.
- Selectively testing the market on services with a particular focus on Community and Mental Health services and those other services where we can realise significant value for money improvements or where we cannot achieve the scale or pace of transformation we are seeking.
- Enhancing our contract management processes to ensure we get the performance and quality we expect from all providers.

Section 7: A Systems & Outcomes Approach to Health Care in Hillingdon

Hillingdon CCG is committed to commissioning services that work together seamlessly as a coordinated and coherent system rather than as a disparate and uncoordinated portfolio of services. This approach also supports the developing Accountable Care Partnership (ACP) that will bring Provider partners together and will also support an integrated approach to commissioning services with the London Borough of Hillingdon. In addition to commissioning integrated and seamless services/systems, HCCG is seeking to move toward commissioning services based on outcomes rather than outputs and this section provides an indication of the likely KPIs that will be applied to each system although these are subject to change as the CCG's thinking evolves throughout 2016/17.

Description	Expected Outcomes	Indicative Key Performance Indicators
Unplanned Care All services that support patients with an unplanned care need including both acute services such as the Emergency Department (ED), Mental Health Support and Acute Medical Unit (AMU) as well as other services including Urgent Care Centre, GP Out of Hours Services (where commissioned by the CCG), GP and Network Services, Community Services and others including Pharmacies.	• A system that is resilient and can reliably deliver the 4 Hour A&E Standard. • A system that meets the needs of patients with care being offered and delivered in the right setting for the patient's needs. • Patients being routed to the right place of care. • A financially sustainable system. • An integrated system that copes with peaks and troughs in demand.	• GP Urgent Care Slots Availability • GP Out of Hours Performance • Unplanned Attendances • 4 Hour A&E Standard Performance • Ambulance Attendances • Admissions for Ambulatory Care Sensitive Conditions • Unplanned Admissions • Zero Length of Stay Admissions • Average Length of Stay • Readmissions within 2 & 30 Days • Friends & Family Test

Planned Care All planned care services both in acute care (physical and mental health) and in community settings plus all standard primary care services.	A system that continue to deliver the 18 Week Standard and is resilient to demand growth. A reduction in variation in all areas including; referral rates into secondary care, activity in secondary care and productivity of associated community services. A system that is financially sustainable. A system that clearly meets or exceeds best practice standards in terms of activity, outcomes and costs.	• GP Referrals to Secondary Care • Out of Hospital Activity • Outpatient Activity • Day Case Activity • Outpatient Procedures • Elective Inpatient Activity • Average Length of Stay • Readmissions within 2 & 30 Days • Hospital Standardised Mortality Ratio • 18 Week Referral To Treatment (RTT) • Friends & Family Test
Long Term Conditions All services (both planned and unplanned) designed to support patients of any age with one or more Long Term Condition (LTC). This includes increased work to support the prevention of LTCs where possible and all services aimed at improving outcomes for patients with LTCs.	• Better outcomes for patients with LTCs. • More patients self-managing elements of their care. • More care being provided in primary and community health settings. • A reduction in unplanned care needs for patients with LTCs. • Maintenance and improvement in performance around the cancer standards. • A financially sustainable system.	• Registered Patients with LTCs • LTC Patients with a Care Plan • Patients with LTCs (Unplanned Attendances) • Patients with LTCs being Admitted • Patients with LTCs treated 'Out of Hospital' • Patient Reported Outcomes • Patients Feeling Supported • 31 and 62 Cancer Targets • Friends & Family Test

Mental Health All services (both planned and unplanned) designed to support patients with a Mental Health issue.	• Better outcomes and support for patients. • More patients capable of managing elements of their care and knowing how to access services appropriately when needed. • More care being provided in primary and community health settings. • A reduction in unplanned care needs for patients with Mental Health issues.	• Patients with an MH Condition with a care plan. • Patients experiencing unplanned events/crisis. • Patients admitted into inappropriate settings. • Patients supported in Primary Care. • Average Length of Stay.
Older People All services (both planned and unplanned) designed to support older people including those that link to Social Care services.	• Improved outcomes for older people. • Better and more coordinated care for frail elderly people. • Reduced unplanned care needs for older people. • Fewer older people being admitted when they do present with an unplanned care need. • A financially sustainable system.	• Older People with a care plan. • Older People in Care/Nursing Homes with a care plan. • Older People experiencing unplanned events/crisis. • Older People admitted into inappropriate settings. • Older People supported in Primary Care. • Average Length of Stay. • Reduction in Delayed Transfers of Care. • Reduction in Prescribing Costs.
Integrated Care All services delivered jointly between two or more healthcare providers and/or between healthcare and social care.	• Reduced duplication of activity. • Reduced costs of commissioning and a financially sustainable health care system. • Seamless services provided to the Hillingdon population whether their need is social or health care related. • Improved joint decision making.	• These will be determined during 2016/17.

Section 8: Listening to the Voice of Patients & Carers

Hillingdon CCG (HCCG) actively listens to what patients, carers, partners, providers and others tell us they need from the services we commission. Our consultation processes are designed to understand how existing services are being delivered and the changes we need to make to services to ensure they meet the continuing and changing needs of our population. We also consult as part of our statutory obligation to ensure we are meeting our Equality and Diversity objectives which are detailed in the next section.

Section 8a: Hillingdon CCG's Equality & Diversity Objectives (2015)

The current Equality & Diversity Objectives for the CCG are stated in the table below. These objectives have been prepared following extensive consultation as well as analysis of specific areas of inequality in Hillingdon.

HCCG Equality and Diversity Objectives (Revised & Renumbered 2015)
Stakeholder Based Objectives
1. **Hillingdon People:** Enable and ensure all people, patients and carers in Hillingdon (across all nine protected characteristics and intersections) have equal access to engagement processes and are effectively involved the design and quality of HCCG commissioned services.
2. **HCCG Staff:** To reduce health inequalities in Hillingdon and address possible and actual risks of health inequality, support staff to identify, design, commission and procure equitable services for all, including mitigating actions where there is a risk that commissioning or decommissioning services may have a negative impact on any equality population in Hillingdon.
3. **HCCG's Governing Body** will ensure HCCG's work is making progress towards eliminating discrimination, ensuring equal opportunity for all and fostering good relations by ensuring equality analysis and review processes are in place, drawing on sound evidence, and used effectively in HCCG decision-making eg. good quality Equality Impact Analysis (EIA) is used effectively throughout the organisation.
Characteristic / Equality Population Based Positive Action
4. **Identify populations at risk in Hillingdon:** HCCG staff and Governing body together will draw on sound evidence from available sources to identify populations at risk of or facing health inequality in Hillingdon and prioritise positive actions to reduce inequality and mitigate risks of further inequalities that have been identified through EIAs.
5. **Population – BME Children Under 5:** Ensure that Black and Minority Ethnic (BME) children under the age of 5 have improved benefits from taking up appropriate healthcare services and/or self-care management for the treatment of minor conditions and ailments, by empowering and educating their parents and carers to identify and utilise the full range of available services in Hillingdon. (Age/Race).
6. **Population – BME Young People & Adults Mental Health:** Reduce crisis admissions of young people and adults from Black Minority and Ethnic (BME) populations in Hillingdon to acute Mental Health beds under the Mental Health Act. (Age/Race/Disability).
7. **Population – all Carers:** To increase support available for carers of all ages and with all protected characteristics. (Disability-Carers/All).

Section 8b: Significant Consultations Undertaken During 2014/15 and 2015/16

The following is a summary of the major consultations that were undertaken during the 2014/15 Financial Year and up to the end of the first quarter of 2015/16 which is when the Commissioning Intentions start to be produced for the following year:

- Carers Strategy Consultation
- Adult Diabetes Consultation Programme (including feedback from Self-Management Workshops)
- Diabetes (All Age) On-Going Care Consultation
- Wheelchair Service Re-Design & Co-Production Programme
- COPD Consultation Programme (including feedback from Self-Management Workshops)
- Asthma in children (Awareness Sessions in School Assemblies)
- Community Outreach Programme
- Access in Primary Care Consultation Programme
- CCG Membership Feedback (Feedback from the GPs based within Hillingdon)

The feedback we received is summarised in Section 8c below and has been used to help inform the Commissioning Intentions that can be found in Section 10 of this document.

Section 8c: Summary of Feedback

Based on the consultations undertaken during the year as detailed above we have summarised the main feedback received. This feedback has been used to help shape the Commissioning Intentions defined in Section 10 of this document.

AREA	WHAT YOU TOLD US
Carers Strategy Consultation	• Improve respite care to provide breaks from caring. • Reduce bureaucracy in accessing support. • Manage/improve the standard of care provided. • Provide someone to talk to and better access to advice. • Support/training to help carers manage specific issues for the person being cared for (such as incontinence).
Adult Diabetes	• Improve access to information on self-managing diabetes. • Improve support to help diabetics to manage their weight. • Improve education to enable patients to manage medications and the best way to inject their insulin. • Improve access to blood testing in the community rather than at hospital. • Improve health screening for diabetics and improve access to eye screening (diabetic retinopathy).
Diabetes On-Going Care	• Improve consistency of podiatry services provided. • Improve the number of patients receiving regular foot checks. • Provide patient checklist to help them ask the right questions when seeing a GP or other professional who is helping them manage their condition. • Reduce reliance on clinicians supporting care and transfer some responsibility to the patient where appropriate. • Educate patients and enable them to self-manage where appropriate including providing specific support for BME groups. • Increase the number of patients with care plans, particularly for those over 65 with diabetes.
Wheelchairs	• Provide an out of hours emergency helpline. • Enable concerns to be raised directly with the CCG. • Involve service users in the development of the service. • Shorten lead-time from assessment to provision of equipment. • Improve follow-up support for when service user needs change. • Improve access to equipment to enable service users to be discharged from hospital in a timely manner. • Improve advice to Occupational Therapists (OTs) around what accessories are available. • Create a fast-track process for service users with a progressive disorder and those with a terminal illness. • Improve support for children under 2.5 years-olds.

COPD	• Improve signposting and education for patients with COPD to help them better manage their condition. • Improve access to weight management support and supervised exercise. • Ensure follow ups with GPs are planned and undertaken on a regular basis. • Enable patients to self-refer back into specialist care if symptoms return.
Children's Asthma	• Improve awareness in schools and provide better information in a range of settings (ie GP Practices, Pharmacies etc). • Help educate children so they understand how they can use their inhalers more effectively and are more aware of the condition. • Promote the Minor Ailments Scheme. • Improve diagnosis of asthma in children under 6.
Community Outreach	• Improve information concerning NHS 111 and when to use it versus when to use 999. • Improve awareness of other options than going to the hospital. • Review screening process for NHS 111 which can be a lengthy process. • Improve awareness of the skills of local pharmacies in dealing with minor ailments particularly amongst BME communities who may not value a pharmacist's expertise. • Expand the number of patient able (and supported) to self-manage their condition at home.
Access to Primary Care	• Increase registration rates of patients from Eastern Europe with a GP. • Reduce reliance on the Urgent Care Centre by improving access to GP appointments. • Make it easier for specific BME groups to raise mental health related issues with GPs. • Improve access to information for BME groups around mental health and learning disabilities. • Raise awareness of the dangers of sharing medication with family and friends that was not prescribed for them.
Membership Feedback	• Need to reduce the stresses faced by GP Partners within their surgery. • Improve networking and peer support opportunities. • Improve links between GPs, GP Networks and the CCG. • Promote Clinical Leadership. • Make it more attractive to practice in the South of Hillingdon. • Improve use of pharmacists to support prescribing issues. • Deal with the 'retirement crisis' facing GPs. • Join up our IT Systems across Hillingdon. • Engage GPs more effectively in CCG decision making. • Continue to develop a workforce that is 'fit for the future'.

Section 9: 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) and collectively these organisations and settings for what is called '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 2016/17.

9a. Overview of the Current Provider Market in Hillingdon

The Provider Market for Hillingdon consists of a network of organisations working together to deliver the healthcare services commissioned by the CCG as well as those commissioned by others such as NHS England and our Local Authority, the latter also commissioning the social care aspects of our combined health and social care system. This section provides an overview of the current situation of the main aspects of the provider market in Hillingdon.

Primary Care

Primary Care services are predominantly those delivered by GPs in practices and are mostly commissioned by NHS England although this is starting to change with the CCG starting to play a bigger role through the concept of Co-Commissioning where the responsibilities for commissioning, monitoring and assuring primary care services will be shared between the CCG and NHS England. There are currently 46 GP Practices within Hillingdon and these (with the exception of two practices) are organised into four GP Networks which provide opportunities for shared learning, capacity building on a scale greater than an individual practice and also for developing and delivering new services. The vast majority of GP Practices provide their own Out of Hours support to patients with only a very small minority 'opted out' which places the responsibility for provision with the CCG.

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 all other commissioners who use these services. Other aspects of community services, such as the provision of community equipment, is jointly commissioned by the CCG with the London Borough of Hillingdon through a shared funding agreement called a Section 75 Agreement, whilst other aspects such as Pressure Relieving Mattresses, Wheelchairs and Non-Emergency Patient Transport (amongst others) is commissioned directly by the CCG with a range of other providers.

Mental Health Services

CNWL also delivers the bulk of Mental Health Services in Hillingdon. In the case of these services, Harrow CCG is the lead commissioner for the Mental Health Contract with CNWL and Hillingdon CCG is an associate commissioner. Hillingdon CCG is an are active partner in the North West London (NWL) Mental Health Transformation Programme and work with other CCGs in NWL to develop joint standards and explore how we can adopt best practice and improve services locally.

Acute Care

Our hospital based care is provided predominantly by The Hillingdon Hospitals NHS Foundation Trust (THH) where Hillingdon CCG is the lead commissioner. THH provide the Emergency Department and associated services with an Urgent Care Centre operated by Greenbrooks on behalf of the CCG but operating from the main THH site. THH also provide the bulk of all elective or planned care, from such things as knee operations through to maternity services. THH is set to continue as a 'fixed point' within the transformation of acute care services that is occurring across NWL via the Shaping a Healthier Future (SaHF) programme and has already absorbed increased activity following the closure of the maternity unit at Ealing Hospital in July 2015. Work is now underway to prepare for closure of the Ealing paediatric unit in 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.

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.

9b. Our Intentions for 2016/17

This section provides a high level overview of our Commissioning Intentions for 2016/17 in respect to the Provider Market. To meet our strategic objectives and to ensure we can provide a financially sustainable healthcare service that continues to meet the growing and changing needs of our population we are committed to reshaping services.

General Intentions

The following apply to all providers:

- We expect all providers to make full use of e-Referrals and aim to eliminate any referrals issued via other means.
- We expect all NHS providers to utilise EMIS compatible systems to access, update and use the Shared Care Record (SCR) to improve patient care.
- We will implement a schedule of clinical and quality audits guided by anomalous activity, CQC reports, patient feedback or other sources.
- We will seek to develop new contracting models to enable us to respond more flexibly to changes in the health and social care environment.
- We recognise that many service specifications across the board need revision to reflect the current health and social care economy in Hillingdon and whilst these will be addressed with individual providers on a service by service basis as a general point for 2016/17 all service specifications will, as a default position, apply to all patients registered with a Hillingdon GP (whether they live in or outside the borough) and to all patients who are not registered with a GP but who live within the London Borough of Hillingdon.
- We will work with surrounding boroughs and areas to discuss how patients registered with their GPs but living within Hillingdon can be effectively supported.

Integration

- The CCG is committed to the concept of an Accountable Care Partnership (ACP) or similar structure as outlined in the NHS Five Year Forward View and will use 2016/17 to test the concepts and processes for an ACP within the scope of Older People and supporting patients with Long Term Conditions.
- We recognise that the membership of an ACP type structure may need to flex and change to accommodate the other changes we are considering.
- We will be taking a more proactive approach to the integration of urgent and emergency care systems both locally and across North West London.
- 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.
- Primary Care will continue to play an essential part in supporting our Out of Hospital Strategy and an increasingly important role in supporting patients to self-manage elements of their care. To do this we will increase the amount of secondary care advice that is available by expanding the scope of email advice lines and will increase the number of educational opportunities for Primary Care professionals.
- We will continue to develop the Integrated Care Programme that will be delivered through GP Networks.
- We will continue to provide feedback to practices and via Sub-Group Meetings and enable them to access data via the WHYSE Programme. We will be reviewing the effectiveness of the Practice Commissioning Initiative in the light of emerging themes in Co-Commissioning and may change or stop this programme.
- We will take on additional responsibilities for the monitoring on Out of Hours Services in collaboration with the Local Medical Committee (LMC).
- We will continue to seek ways for Primary Care to help us reduce demand for secondary care services especially around unplanned care services.
- We remain committed to supporting Primary Care in areas such as access, premises and workforce development to enable practices to support the CCG's Out of Hospital and QIPP Agendas.

Community Care

- We recognise the need to rapidly transform community services in light of such things as the Out of Hospital Strategy, the transformations underway to support patients with Long Term Conditions and the need to demonstrate value for money for tax payers and achieve the expected quality and safety standards we require for our patients.
- Where we cannot achieve the scale and pace of transformation required we will test the market and procure services either individually, in logical groups or on a wider scale. Specifically for Community Care this covers such areas as: Community Rehabilitation, District Nursing, Podiatry, Rapid Response, Tissue Viability, Twilight Nursing, Community, Paediatricians, Paediatric Speech & Language Therapy and the End of Life Service Portfolio.
- 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.
- We recognise the need to improve the ability of the CCG to manage the contract including improving the amount and quality of data provided so that effective monitoring can occur and effective decisions made.
- We will require providers of Community Services to work more effectively and in an integrated manner with other providers to support the CCG's objectives.
- Specifically, we will seek to move the budget for dressings into the 16/17 Contract with our main Community Provider.

Mental Health

- Much of what has been written above about Community Care in terms of transforming services, testing the market and procuring where appropriate also applies to Mental Health Services as does the elements around improving service specifications, working more effectively as part of an integrated system and improving contract monitoring processes.
- As for Community Care, where we cannot achieve the scale and pace of transformation required we will test the market and procure services either individually, in logical groups or on a wider scale. Specifically for Mental Health Services this cover Primary Care Mental Health Services, Improving Access To Psychological Therapies (IAPT) (aka Talking Therapies), Mental Health Rehabilitation Services and Children & Adolescent Mental Health Services (CAMHS).
- Whilst we will require our Mental Health provider to work more effectively as part of an integrated system we will specifically be seeking to improve the links between Primary Care and the Community Mental Health Teams (CMHTs).
- Decisions around the direction of travel for Mental Health services will take into account the fact that Harrow CCG is the lead commissioner and the need for Hillingdon CCG to align any work done with the NWL Mental Health Transformation Strategy.

Acute Care

- We will improve contract monitoring processes and continue to challenge areas where activity seems anomalous compared to North West London averages. This will include the following areas as a minimum: Respiratory Medicine, Cardiology, Trauma & Orthopaedics, Rehabilitation Services, Paediatric ENT, Geriatric Medicine, Pain Management, General Surgery, Midwifery, Endocrinology, Ophthalmology and Cardiac Surgery.
- We will specifically be seeking to procure a new Community Chronic Pain Service and to either negotiate a new arrangement for Musculoskeletal Services (MSK) or test the market if a negotiated settlement cannot be reached.
- We will seek to establish more high quality and responsive services ‘Out of Hospital’ and increase the number of sites from which services are delivered.
- We will seek to reduce unplanned admissions to the North West London average for our population and will continue to work to create a resilient and integrated unplanned care system.
- We will work to achieve relevant 7 Day Standards in partnership with THH.
- We will be seeking to improve the coding of appropriate co-morbidities with THH so as to improve the ability of the CCG to plan services and access data, particularly in relation to Long Term Conditions such as Diabetes, Cardiology and Respiratory.
- We will also work to control costs and ensure we remain a financially viable healthcare system.

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 ACP where appropriate.
- We will look at alternative ways of contracting with voluntary and third sector organisations that make it easier for them to engage productively with the NHS.

Section 10: Commissioning Intentions

The following sub-sections outline Hillingdon CCG's (HCCG) Commissioning Intentions by area. The areas considered are as follows:

10a. Integrated Care (including Whole System Integrated Care (WSIC) and Better Care Fund (BCF))
10b. Services for Older People
10c. Unplanned Care
10d. Planned Care including Out of Hospital & 7 Day Services
10e. Long Term Conditions
10f. Mental Health (incorporating Learning Disabilities)
10g. Children & Young People (CYP)
10h. Medicines Management
10i. End of Life
10j. Community Services
10k. Primary Care
10l. Continuing Health Care (CHC) & Complex Care
10m. Patient & Public Engagement & Empowerment
10n. IT & Technology
10o. Safeguarding

In addition to the specific actions that are detailed in the following sections there are some generic commissioning intentions that apply to the majority, if not all, services and service areas and these are listed below.

GENERAL COMMISSIONING INTENTIONS FOR 2016/17
Expand educational support provided by secondary care to primary and community care to support an increase in the number and complexity of patients managed out of hospital.
Improve use of the shared care record by secondary care with the aim of improving the quality of care provided and reduce duplication of tests and other areas.
Expand access to email advice and support available to GPs from secondary care to enable GPs to manage more patients out of hospital.
Expand the use of e-Referrals and introduce Decision Support Tools (DSTs) to Primary Care.
Seek to develop a Common Clinical Record across Hillingdon.
Work with THH to improve the quality of coding particularly coding of appropriate co-morbidities.
Improve the usage of Smart Cards by THH.
Reduce variations across all providers.
Improve the compliance with the NWL Internally Generated Demand (IGD) policy within acute providers.
Audit of the application of THH's access policy within THH and incorporation of any revisions needed into the contract.
Ensure that the CCG is refunded appropriately for Out of Area patients including treatment provided to non-EU patients.
Agree a schedule of clinical audits for 2016/17.
Work with THH and other providers to reduce DNA rates and therefore increase capacity.
Improve the reporting of performance and contract monitoring processes across all providers.
Require providers to work with the CCG on the assurance of their CIP Schemes as a contractual requirement.
Undertake selective demand and capacity studies.
Test the market on areas where negotiation cannot achieve the required service changes to meet current/future needs or identified efficiencies.
Improve the quality, effectiveness and accuracy of all service specifications with a particular focus on Community & Mental Health Services.
Explore the expansion of PHBs to Pts with LTCs (outside of CHC) in line with the NHS Mandate and 15/16 Planning Guidance.
Develop a plan to address the residual health inequalities that exist in Hillingdon.
Service Specifications to apply to any patients registered with a Hillingdon GP irrespective of the borough they live within and will also apply to any person resident in the London Borough of Hillingdon but not registered with any GP.

Section 10a: Integrated Care (including WSIC and BCF)

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Integration
CLINICAL LEAD	Dr Kuldir Johal
COMMISSIONING LEAD	Joan Veysey

OVERVIEW

Hillingdon CCG's (HCCG's) vision for Integrated Care is stated as: *Through clinically focused commissioning, HCCG will be recognised for delivering a high performing, good quality collaborative and cost effective acute and community based health system for the residents of Hillingdon, within available resources in an environment that delivers quality care, supports clinicians and is satisfying for all staff and members.*

The 15/16 Commissioning Intentions for integrated care focused on the development of specific programmes to improve the outcomes and experience of care for frail older people. These programmes included the Better Care Fund (BCF), Whole System Integrated Care (WSIC) and Integrated Care Programme (ICP) that together aimed to deliver care that is coordinated and person centred meaning that people are directly involved in planning their own care and which delivers outcomes that are important to them. The CCG's Integration Commissioning Intentions also enable the development of the commissioning and provider landscape, enabling more integrated commissioning approaches across health and social care via the BCF, development of outcome based commissioning and capitated payment models as part of the whole system early adopter pilot and development of a new provider accountable care partnership in Hillingdon.

The CCG's Integration Commissioning Intentions for 2016/17 will build on these development s in the following ways:

1. The model of care for older people with one or more Long Term Conditions (LTCs) developed through these programmes will be scaled up and taken forward within the Older Peoples' Commissioning Intentions for 2016/17 as a single model of care (see later in this document).
2. The Commissioning Intentions for Integration will focus on the development of the commissioner and provider landscape through:
    - Integrated commissioning with London Borough of Hillingdon (LBH) via the Care Act flexibilities including BCF.
    - Development of provider landscape and new Accountable Care Models Including a possible Accountable Care Partnership (ACP).
    - Development of key system enablers including information sharing and shared care records.

As part of the provider network we will expect clinicians in our local hospital to develop pathways for populations/patient groups that provide more care in the community alongside GPs and other community clinicians.

STRATEGIC OBJECTIVES FOR INTEGRATED CARE	
Objective	**Expected Outcomes**
1. Increase the scale and pace of Integrated Commissioning.	• Agreed arrangements with London Borough of Hillingdon (LBH) for joint commissioning (where appropriate) for health and social care services. • Commissioning for outcomes with a capitated budget on a section of the CCG's portfolio including possibility Older People and those <65 years old with a Long Term Condition. • Decision on the long term full integration model for Hillingdon.
2. Expand the BCF programme with LBH.	• By 2020 residents of Hillingdon able to plan their own care with control over services that matter to them. • Decision made on cohort of patients covered by the Better Care Fund (BCF).
3. Develop an outcomes framework for Hillingdon.	• Delivery of improved system outcomes and patient reported outcomes.
4. Develop a new capitated funding model.	• Increased focus on prevention. • Improved links of outcomes to financial incentives.
5. Support development of new accountable care partnership.	• Agreed governance models with provider for alliance commissioning model.
6. Develop system enablers to support primary care networks to be the coordinating hub of all care.	• Improved coordination of all care for patients whether their health needs are physical or mental. • Improved access to information across the health and social care system.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Expand the BCF and scale up model of care for older people including new aspects such as Mental Health, Dementia, Supported Living and others. • Agree a capitated budget for Integrated Services in 15/16 and prepare to migrate to new contract structure as soon as possible. • Develop plans for how to contract via an Alternative Care Partnership (ACP) via shadow arrangements. • Care Information Exchange (CIE) pilot commenced and PKB (Patient Knows Best) tested across provider partners. • Embed Integrated Care Programme in Hillingdon and evaluate the Hillingdon for All (H4A) gateway provision and agree Phase 2 for programme. • Data sharing agreement strategy developed and rolled out. • Improve integration around Children's Mental Health Services where possible.	

Section 10b: Services for Older People

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Older People's Services
CLINICAL LEAD	Dr Kuldhir Johal
COMMISSIONING LEAD	Jane Walsh

OVERVIEW

The CCG along with its partners has developed a series of aims associated with the Services for Older People that are commissioned in Hillingdon. These aims take into account feedback from patients, residents, and carers, and have been agreed between health and social care providers and commissioners in Hillingdon. The aims for Services for Older People are:

- To integrate the assessment of need and provision of care for older people between health, social care and third sector providers. Care provision will be timely, effective and outcomes based.
- Whatever the care setting, the older person and their family and or carers will be involved in the planning of their care so that they can make informed choices, know who to contact in a crisis and with more general concerns or questions.
- To engage and develop the local workforce and market in order to meet the current and future health and care needs of the population of older people in Hillingdon.

In delivering these aims, the Commissioning Intentions for Services for Older People for 2016/17 has identified six strategic objectives and the associated actions. These strategic objectives are designed to deliver a model of care and associated provision that meets the identified needs of patients and carers in an integrated way between health and social care based on need rather than the source of the funding. This work is intended to transform the way services are able to be delivered and move away from the traditional health and social care barriers to integrated service delivery as well as providing a model of care and provision that is intended to be sustainable both in economic and workforce terms.

STRATEGIC OBJECTIVES FOR SERVICES FOR OLDER PEOPLE	
Objective	**Expected Outcomes**
1. Improve the planning of care and provision of care, including when there is a change in care setting.	• Increased involvement of patients and their families and or carers in the planning of their care so that they are able to maximise their independence and to make informed choices, including on transfer of care setting. • Improved understanding of and meeting the needs of each individual patient. • Better co-ordination between services. • Patients feel better supported and know who to contact when issues arise.
2. Enhance case management.	• A shift from reactive care provision to anticipatory care provision, from crisis management to crisis prevention. • A reduction in unscheduled attendances at A&E and associated admissions to acute care with a corresponding reduction in length of stay when an admission is required.
3. Engage effectively with patients and carers including enabling self-care.	• Local services being developed which take into account patient and carers' feedback and can be accessed as equitably as possible. • Service users, patients and carers feeling involved in the development of care today and for the future.
4. Development of the market to meet current and future needs.	• A provider market with the skills and capability to deliver the needs of our population. • A provider market that provides for a sustainable financial future within Hillingdon.
5. Development of the local workforce to meet current and future needs.	• A workforce that has the skills and capacity to meet the needs of our population.
6. Development of a suite of measures that enable progress and impact to be tracked both in terms of quality and finance.	• A suite of measures capable of demonstrating progress and impact. • A financial environment conducive to a sustainable future for Hillingdon.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Pilot the identification of patients who will benefit from active case management. • Jointly with LBH, scope further integration of intermediate care services and the opportunities for service provision within various care settings. • Start to implement the delivery plan for the carers' strategy and explore opportunities for joint procurement of carers contracts with LBH. • Establish joint contract monitoring processes with LBH and work toward older people having a named contact for coordinating their care. • Jointly with LBH undertake a review of respite care and a review of medical and other support provided to Residential/Nursing Care homes.	

Section 10c: Unplanned Care

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Unplanned Care
CLINICAL LEAD	Dr Mitch Garsin
COMMISSIONING LEAD	Rashesh Mehta

OVERVIEW

Our commissioning intentions for unplanned care are the product of on-going engagement with our clinical community and stakeholders and represent our current planning and preparation for 2016-17. It is paramount that we maintain our focus on improving quality and ensure the future sustainability of our unplanned care system. We are wholly committed to developing a truly integrated system, and accordingly our plans have been jointly developed with our partners.

There are well documented rising pressures in urgent and emergency care nationally and locally, from both volume and acuity. There are challenges associated with helping patients and others chose the right service, making alternatives to A&E available and accessible when appropriate and enabling responsive community services which help avoid unplanned hospital attendance and/or admission where appropriate.

Building on our baseline activity and in planning for growth and changes in the mix of patients presenting, our 2016/17 Commissioning Intentions bring an opportunity to work to reduce attendances at A&E where appropriate, further reduce admissions to hospital through both the expansion of existing schemes and the development of new schemes. There is also a clear commitment to reducing the average length of stay of non-elective admissions and the associated excess bed days that may occur. Commissioners are seeking to 'engineer' a system where stakeholders, particularly providers, are enabled to work together effectively, so that our unplanned care system can cope with increases in demand whether in winter months or surges at other times of the year.

Additional considerations we have taken into account within our 2016/17 Commissioning Intentions for Unplanned Care include the following:

Urgent & Emergency Care System Redesign – Hillingdon CCG will review all services delivering urgent and emergency care services inclusive of NHS 111, GP OOHs, Urgent Care Centres, Mental Health & Community Services, Secondary Care, Social Services and the new/emerging models of care in federated networks for all patients registered with local GPs with the aim of commissioning a safe, high quality, integrated urgent care system which will align the NHS 111 Service with other parts of the Urgent & Emergency Care (UEC) System.

7 Day Working - Commissioners will work with providers on the implementation of 7 day working across the urgent and emergency care system including that providers deliver national and local targets (including the 4 Hour A&E Target) and appropriate quality standards.

Shaping a Healthier Future (SaHF) – The acute reconfiguration programme in North West London (NWL) is redefining how urgent and emergency care is provided across the region. The Hillingdon Hospitals NHS Foundation Trust (THH) (who are commissioned by Hillingdon CCG) remain a fixed point and will also take on additional activity associated with children during 2016/17.

Ambulatory Emergency Care (AEC) - The CCG is conducting an evaluation of the effectiveness of the current AEC services for adults & children and will continue to work with THH to roll out and expand the AEC pathways and capacity during 2016/17.

Robust Contractual Processes - For the NHS 111 Service, GP Out of Hours (where CCG Commissioned) and the Urgent Care Centre at THH, the performance management of these contracts will transition from "light touch" to robust contract monitoring. The CCG is currently reviewing the use of some of these services by frequent users to understand the level to which they are being used as standard primary care facilities. Depending on the outcome of this, the CCG will put in place a protocol to ensure that the services are used appropriately. We require providers to work with commissioners to help manage patient demand, including promoting self-care, and redirecting patients back to primary care where appropriate.

Procurement - Unplanned care services such as NHS 111, GP Out of Hours and the Urgent Care Centre will be subject to a system level review. Current contracts for these services are due to expire at different time points over the next two years. It is unlikely that individual services will be re-procured in isolation but will be subject to a system procurement during 2016/17 or possible early in 2017/18.This is especially true for the NHS 111 Service where the emerging model of care is to integrate this with GP Out of Hours Services.

We will also be taking an all age approach to improving Unplanned Care services for 2016/17.

STRATEGIC OBJECTIVES FOR UNPLANNED CARE	
Objective	**Expected Outcomes**
1. Ensure our Non-Elective (NEL) System is Resilient.	• Ability of our system to cope with both routine/expected growth and unexpected peaks in activity. • A financially sustainable unplanned care system.
2. Deliver National & Local priorities and standards.	• Delivery of all standards including the 4 Hour A&E Target during each month of 2016/17. • Achievement of the QIPP Targets associated with 2016/17 for Unplanned Care.
3. Ensure patients are routed to the correct part of our Urgent & Emergency Care (UEC) System.	• A system that utilises its capacity effectively and correctly to treat patients. • Empowered primary care, community care, mental health services that support patients to manage their conditions more effectively and to further empower patients to take control of aspects of their care.
4. Provide consistently high quality and safe care across all seven days of the week.	• Achievement of appropriate elements of the 7 Day Standard. • Increased support to patients to help them be discharged safely at weekends.

Key Actions For 2016/17

The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17:

- Expand admission avoidance schemes such as Ambulatory Pathways (Adults, Paeds, EGAU and Surgical) and Intermediate Care and agree tariffs.
- Integrate Homesafe and Rapid Response into a single service with joint measures around admission avoidance and reducing LoS.
- NHS 111 Extension decision to be made before the end of 14/15 and working with other North West London CCGs on a procurement.
- Support the new model for NHS 111 that sees it integrating with GP Out of Hours Services.
- Improve the monitoring of and awareness of GP Out of Hours Services.
- Continue to focus on reducing demand for unplanned care services and diverting patients to the most appropriate point of care.
- Map the entire health system and undertake selective audits and deep dives into areas where activity is anomalous to North West London.
- Continue to selectively invest resilience money and readmission credit reserve funds where it will gain the most impact.
- Continue to improve the effectiveness of the System Resilience Group (SRG).
- Work with LAS to improve the triage service and reduce conveyances.
- Develop targeted guidance for key groups with information on how they can self-manage their conditions.

Section 10d: Planned Care including Out of Hospital & 7 Day Services

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Planned Care (Including 7 Day Services and Out of Hospital Services)
CLINICAL LEAD	Dr Mehboobali Saleh
COMMISSIONING LEAD	Kamran Bhatti

OVERVIEW

Our aim for all services commissioned by Hillingdon CCG is that we ensure we provide high quality, evidence based services that are clinically effective and have a positive experience for patients. Specifically for Planned Care this means providing as much of those services 'Out of Hospital' (OOH) and closer to home with services available 7 Days per Week where it is clinically appropriate and where it offers 'value for money'. When designing how we will deliver our Planned Care Services we need to ensure that they meet all national and local quality and efficiency indicators and that the services avoid duplication.

The CCG is in its final year of a challenging three year recovery programme where the transformation of Planned Care Services has been one of the driving areas. In collaboration with providers we have delivered a programme of pathway development and service redesign. The outcome has been that ENT, Gynaecology and Urology are now delivered as a community service under contract variation with Hillingdon Hospital. In addition, Ophthalmology and Dermatology services are now delivered under community contracts across locations in Hillingdon outside of the Hospital setting.

The 2016/17 Commissioning Intentions for Planned Care build upon the previous work undertaken in the areas listed above and expand the programme across all appropriate specialties. We intend to focus on an increasing the number of services delivered in a community setting as well as exploring the expansion opportunities for additional sites from where services are delivered. This will predominantly continue to be achieved in partnership with our main acute provider (The Hillingdon Hospitals NHS Foundation Trust) through contract variation although we do expect to test the market wherever a negotiated settlement cannot be agreed or where the scale and pace of change required cannot be achieved otherwise.

As Musculoskeletal (MSK) Services are such a large part of our Planned Care Services there is a section below with additional narrative. The Planned Care Strategic Objectives stated below also apply to MSK as a specialty within Planned Care and therefore the MSK Section only lists the appropriate actions along with some narrative.

We will be taking an all age approach to Planned Care services for 2016/17.

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Musculoskeletal (MSK) Services
CLINICAL LEAD	Dr Mitch Garsin
COMMISSIONING LEAD	Russell Foster

OVERVIEW

Hillingdon CCG will reach the end of its three year MSK QIPP plan at the end of financial Year 2015/16. This presents an opportunity to review the successes and learnings of the last three years; look at the National and Local strategic context and decide which approach to MSK services will be of most benefit to Hillingdon patients whilst delivering the CCG's 2016/17 QIPP targets.

The current three year plan clearly delivered QIPP savings of £2.5m in Year 1 (13/14) and £0.938m in Year 2 (14/15). Savings in Year 3 of the programme (15/16) have been more difficult to achieve with increasing MSK first appointment outpatient activity, particularly in Trauma and Orthopaedics (T&O), unexpectedly high activity associated with spinal injections, and delays to the implementation of a Community Chronic Pain Service.

During the remainder of 2015/16 and into 2016/17, Hillingdon CCG will be seeking to bring Spinal activity back to the North West London average, deliver the residual QIPP targets associated with Year 3 and introduce a Community Chronic Pain Service as well as a Community Rheumatology Service. In addition, the CCG is committed to working with our partners at Brent and Harrow CCGs to develop spinal pathways that will apply across all three CCGs.

The Commissioning Intentions for 2016/17 for MSK remain to move patients out of hospital into community care, primary care and self-care where appropriate and to reduce both costs and activity associated with secondary care. As 2015/16 sees the end of the initial 3 year strategy for MSK, it is logical for the CCG to seek to develop a further 3 (or 5) year strategy for MSK given the on-going pressures and costs in this area.

STRATEGIC OBJECTIVES FOR PLANNED CARE	
Objective	**Expected Outcomes**
1. Improve the ability of Primary Care to manage patients effectively 'Out of Hospital'.	• Email and telephone advice available to GPs for all specialties when needed. • Better defined pathways for GPs to follow where gaps exist. • Improved awareness and skills in primary care to support patients 'Out of Hospital'. • Less demand for over-stretched hospital services where clinically appropriate.
2. Improve the quality and effectiveness of acute care services.	• Improved outcomes for patients. • A financially sustainable planned care system for Hillingdon.
3. Reduce variation across Primary and Secondary Care.	• Increased consistency in the way that patients are managed and referrals are made. • Reduced costs for managing patients in secondary care. • Increased conformity to national and local benchmarks.
4. Develop an Integrated Planned Care System.	• Closer alignment between Primary, Community and Secondary Care. • Better information related to activities and costs in Community Care. • A more seamless service experienced by patients.
5. Ensure delivery of the 2016/17 Objectives for 7 Day Services.	• Delivery of Standards 3, 4 and 9 (Phase 2). • Progress toward Standards 6, 8 and 9 (Phase 3).
6. Delivery of the QIPP Targets for Planned Care.	• Demonstrable progress toward a sustainable healthcare economy in Hillingdon. • Achievement of the 2016/17 QIPP targets.

Key Actions For 2016/17

The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17:

- Implement a requirement that all Dermatology activity passes through our Community Service within the 16/17 Contract.
- Decommission further non-2WW Dermatology Services including Patch Testing and other appropriate Tier 4 services.
- Develop a strategy with THH to provide or co-locate services in the community for both existing and new schemes.
- Review the Community Ophthalmology Service and decide whether this should be procured.
- Implement a Community Chronic Pain Service and require all Pain Activity (including Spinal Injections) to pass through this service.
- Implement email advice, the referral return policy and a primary care education programme with THH across all major specialties.
- Implement a series of deep dives and contract challenges where activity is anomalous to that across North West London.
- Deliver 7 Day Standards 3, 4, 9 (Phase 2) and progress 6, 8 and 9 (Phase 3) with THH.
- Create a new MSK Strategy that will realise QIPP Savings and a reduction in secondary care activity, bringing it to within the NWL Average.
- Seek to expand the number of diagnostics that are available in the community and improve selected diagnostic pathways including Ultrasound.
- Improve access to GPs 7am to 7pm recognising that this may not need to be at the patient's normal practice.

Section 10e: Long Term Conditions

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Long Term Conditions
CLINICAL LEAD	Dr Mehboobali Saleh
COMMISSIONING LEAD	Helen Delaitre

OVERVIEW

In Hillingdon, an estimated 91,000 have one or more Long Term Condition (LTC) and the NHS costs associated of managing LTCs is estimated to be between £91 million and £116 million.

Hillingdon CCG has published its strategy for patients with Long Term Conditions (*Healthier Together Strategy 2014-16)* which outlines the CCG's commitment to improving the quality of life for patients with LTCs through better prevention, self-management, integration of services, care planning and patient support that takes into account co-morbidities and related complications.

One of the main priorities for this strategy is to reduce existing inequalities in the borough. Public health data helps us to assess the future demand for the treatment of certain conditions which are more prevalent in specific population groups and work on LTCs will focus on the areas where we can expect higher hospital admissions both to reduce the rate of disease occurrence and also target earlier diagnosis. For instance, ethnicity is closely linked to health status, deprivation, health inequalities and poor health outcomes and the CCG will focus effort in areas with the worst health outcomes.

The LTC Strategy sets out three phases for transformation, in line with conditions which account for the highest inequalities in life expectancy as follows::

- **Wave 1:** Cardiology, Diabetes, Respiratory (including Asthma and COPD), Cancer and Rheumatology.
- **Wave 2:** Stroke (where our acute services are well defined and we need to consider an integrated service) and Inflammatory Bowel Disease (IBD).
- **Wave 3:** Multiple Sclerosis, Epilepsy and Parkinson's.

Wave 1 projects are underway and the CCG will be working up plans for Stroke and IBD in 2016/17. In delivering our LTC Strategy for 2016/17 the CCG needs to consider the following issues:

- **Rheumatology** – This is covered by the CCG's Planned Care Agenda and is covered under MSK Services earlier in this document.

- **Empowered Patient Programme** – This is part of the CCG's Patient Empowerment Agenda covered later in this document.
- **Integrated Care Planning** – This will be delivered through GP Networks for the >75s and we also need to consider the wider Integration Agenda.
- **Primary Care Workforce** – Developing staff and reducing variation in care are priorities both of which issues are covered under Primary Care.
- **Health Promotion** – Through the LTC Transformation Group we will work to align CCG priorities to London Borough of Hillingdon plans.
- **Screening** – Public Health England are responsible for screening but the CCG is committed to helping prevent LTCs and also provide earlier diagnosis.
- **Diagnostics** – Each service area will review the needs from diagnostic services and this will be coordinated through a Diagnostic Services Map.

The Strategic Objectives and Expected Outcomes are stated for all LTCs that the CCG will be focusing on during 2016/17 but we have added a section that provides some narrative and the specific actions for each condition we are focusing on during 2016/17.

We will be taking an all age approach to supporting patients with Long Term Conditions (LTCs) in 2016/17.

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Long Term Conditions – Cardiology
CLINICAL LEAD	Dr Reva Gudi/Dr Diviash Thakrar
COMMISSIONING LEAD	Caroline Davidson (Helen Delaitre, Head of LTCs)

OVERVIEW

Cardiovascular disease (CVD) accounts for 32% of all deaths in Hillingdon (JSNA 2011). The incidence of CVD increases with age. Heart failure rates increase 10% in the over 65s and the risk of developing Atrial Fibrillation (AF) after the age of 40 is 1 in 4. The incidence of AF increases 18% in the over 85s. One in 5 strokes are due to AF rising to 1 in 3 over the age of 80. It is predicted that the number of people in Hillingdon aged over 65 will increase by 9% over the next 5 years and the number of over 85s will rise 22%. Therefore it is important that cardiology services adapt to the needs of an aging population particularly in the north of the borough. 18% of CVD deaths are people aged under 75 (which is higher than the national average) and occur to a greater degree in the south of the borough therefore an integrated cardiology service should also target vulnerable, high risk communities to reduce health inequalities.

Public Health Observatories CVD Health Profiles 2013 profile for Hillingdon indicate that Emergency admissions (2012/13) for Coronary Heart Disease (CHD) and heart failure are significantly higher than the England average. Almost 7000 people in Hillingdon have CHD but it is expected that a further 3000 are undiagnosed and also 27000 people have undiagnosed hypertension. Therefore to reduce A&E attendances and admissions, diagnosis rates in primary care need to improve diagnosis rates.

Patient's conditions are increasing in complexity due to co-morbidities. The National Audit for Cardiac Rehabilitation 2013 found that in 2006, 13% of patients had co-morbidities but in 2012 it was 46% of patients.

There is little capacity within primary care to deliver self-management education to patients and to support them when they are unwell. Therefore patients whose conditions are exacerbating will go to A&E or if over 65, access Rapid Response for support.

The Integrated Cardiology Service will deliver a joined up Adult Cardiology Service for Hillingdon, improving the quality of Cardiology services locally and moving clinical activity from secondary care into primary care to prevent A&E attendances, non-elective admissions, readmissions, outpatient attendances and improve support for patients to self-manage. The developments in the service redesign have been divided into phases to enable a more focused approach to implementation. Phase 1 was implemented in 2014/15 and phase 2 is currently being mobilised. The Commissioning Intentions for 2016/17 are related to initiatives that fall into phase 3.

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Long Term Conditions: Cancer
CLINICAL LEAD	Dr Cherry Armstrong
COMMISSIONING LEAD	Mary Idowu (Helen Delaitre – Head of LTC)

OVERVIEW

It is estimated more than 30,000 people in London receive a cancer diagnosis every year and over 13,000 die from the disease annually making cancer the biggest cause of premature death in the capital. The number of people living with and beyond cancer is more than 200,000 and this is expected to double by 2030. After Cardiac and Respiratory conditions, cancer is the third largest killer in Hillingdon. The *Five Year Cancer Commissioning Strategy for London* sets out key recommendations to improve cancer services, survival rates and patient experience. The recommendations identify the following themes:

- Prevention
- Screening
- Early detection
- Reducing variation
- Living with and beyond cancer (Survivorship)
- End of life care

These objectives mirror the commissioning intentions and also take into account *Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020* which was published in July 2015.

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Long Term Conditions – Respiratory Diseases
CLINICAL LEAD	Dr Nilesn Bharakhada
COMMISSIONING LEAD	Christine Falzon (Helen Delaitre, Head of LTCs)

OVERVIEW

The 2016/17 Commissioning Intentions for Respiratory Diseases aim to consolidate on the work done in 2015/16 for Adult Respiratory (COPD) patients and upscaling the model developed for paediatrics (asthma).

COPD: Chronic Obstructive Pulmonary Disease (COPD) is the 5th biggest killer disease in the UK, killing approximately 25,000 people a year in England. Premature mortality from COPD in the UK was almost twice as high as the European (EU-15) average in 2008 and premature mortality for asthma was over 1.5 times higher. Although, deaths from asthma have plateaued at between 1000 and 1200 deaths a year since 2000, it is estimated that 90% of deaths are associated with preventable factors and could therefore be avoided. Almost 40% of these deaths are in the under 75-age group. Asthma is also responsible for large numbers of hospital admissions, the majority of which are emergency admissions.

The quality standard for Chronic Obstructive Pulmonary Disease (COPD) requires that services should be "commissioned from and **co-ordinated across all relevant agencies** encompassing the whole COPD care pathway. The Pathway will deliver the **integrated approach** to provision that is fundamental to the delivery of high-quality care to people with COPD".

Paediatric Asthma: The **London Strategic Clinical Network for Children and Young People** has recently developed a number of Asthma Standards for Children and Young People. The Standards set out 37 Quality statements that specify how RCPCH, BTS/SIGN and NICE Asthma Guidelines should be implemented into tangible services on the ground. Asthma and allergy frequently coexist, so an asthma and allergy pathway reinforces the concept of a whole airway approach for effective patient diagnosis, management and education, e.g. shared allergic triggers, inter-related symptoms and treatments. This model is deemed particularly relevant to Hillingdon where there is a large number of paediatric A&E attendances for respiratory disease in children aged 0-5.

Tuberculosis: The TB pathway is mandated by NHSE and will be funded by centrally through CCG co-ordination.

Symptom-Based Pathways are a long-term goal that is being considered in other areas and should be developed locally as new best-practice service models emerge in this area.

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Long Term Conditions - Diabetes
CLINICAL LEAD	Dr Patricia Hurton
COMMISSIONING LEAD	Sukeina Kassam (Helen Delaitre, Head of LTCs)

OVERVIEW

There are over 16,000 people in Hillingdon registered with a diagnosis of diabetes. The Hillingdon prevalence for diabetes is 6.4%, which is higher than that of London (6.0%) and England (6.2%). Current prevalence rates put Hillingdon as 4th highest compared with the other boroughs in North West London. It is estimated that if the rise in diabetes continues unchecked, in 5 years' time prevalence will be 9.2% in Hillingdon compared with 8.7% in London and 8.5% in England. This suggests that around 3% of our population will become diabetic within the next 5 years unless programmes are put in place to prevent people from developing this long term condition.

There is also significant variation in the management of diabetes in primary care with the Hayes and Harlington locality seeing the highest prevalence.

It is estimated that one in four people with diabetes in London is undiagnosed which in Hillingdon translates to a hidden demand of 3,750 people. These people are at significant risk of developing long-term complications associated with their undiagnosed and untreated diabetes and could be potential patients that get identified once seen through the unscheduled care route.

Hillingdon CCG aims to deliver an Integrated Diabetes Service which will co-ordinate support for patients at risk of developing or who have already been diagnosed with diabetes and supporting those patients to remain at home or in their chosen care setting with less need for secondary care support (either planned or undiagnosed). It aims to reduce the percentage of patients with diabetes developing severe complications of end stage renal disease, amputation, blindness, stroke and coronary heart disease which are associated with this chronic condition.

STRATEGIC OBJECTIVES FOR LONG TERM CONDITIONS	
Objective	**Expected Outcomes**
1. Integration of Health and Social care	• Improved planning of services that require health and social care input. • Seamless services delivered for patients moving between health and social care.
2. Embed Co-Production with Partners and Patients	• Improved engagement of patients and service users in service developments. • Reduced gap in expectations between what is delivered and what patients say they require.
3. Empower Patients to Self-Manage	• Improved outcomes for patients through better self-awareness and skills to manage elements of their care. • Reduced number of exacerbations, improved confidence and better mental health for patients with LTCs.
4. Empower Primary Care to Support Patients	• Reduced need for secondary care support for patients. • More care provided closer to home.
5. Reduce Unplanned Care needs for Patients with LTCs	• Better outcomes for patients with LTCs needing fewer unplanned care interventions. • Reduced pressure on the unplanned care system in Hillingdon.
6. Deliver the CCG's QIPP targets	• Reduced costs for the local health economy enabling better investment decisions to be made. • Improved support available for new, growing, changing or emerging needs where they are identified.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Improve access to psychological support for patients with a Long Term Condition. • Utilise secondary care expertise to enhance the capability of GPs to manage more patients and more conditions in the community. • Expand the existing Empowered Patient Programme to both increase patient numbers and the number of conditions covered. • Develop plans to strengthen support for patients transitioning from children and adults. • Improve the trust-wide coding of appropriate co-morbidities within the THH 2016/17 Contract. • Introduce the new NWL Chronic Kidney Disease Pathways and a Community IV Diuretic Service. • Develop Multi-Skilled Cardiac Nurses to manage a range of heart conditions in the community such as AF, Hypertension, Angina etc. • Expand the range of primary care based diagnostics available and direct access diagnostics. • Improve the definition of all relevant community service specifications including, where appropriate, undertaking market testing/procurement. • Increase the number of Cancer Risk Stratified Pathways, the use of Holistic Needs Assessments and the number of Pts receiving an early diagnosis. • Develop a Cancer Strategy and establish a Cancer CWG. • Contract with local providers to deliver an Integrated Respiratory and Integrated Diabetes Service. • Develop a Community Based Asthma (including Paediatric Asthma) Service and work with NHSE to plan for TB Services locally. • Work with GPs to improve identification of patients at risk of developing diabetes and focus acute care on the 'Super Six' diabetic conditions. • Implement a Tier 3 Weight Management Programme and align activities for Weight Management with Public Health.	

Section 10f: Mental Health (incorporating Learning Disabilities)

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Mental Health (All Ages)
CLINICAL LEAD	Dr Stephen Vaughan-Smith (Adults) & Dr Cherry Armstrong (Children)
COMMISSIONING LEAD	Joan Veysey, Ian Kent & Elaine Woodward

OVERVIEW

During 2014/15 the Mental Health Transformation Board was established to oversee the implementation of the Hillingdon all age Mental Health Strategy. The Strategy was high level and focussed on the following areas: Health Promotion, Recovery, Improved physical healthcare, Support to users and carers reduction in self-harm reduce stigma and discrimination, Extend services to hard to reach groups, Improve Dementia services, Improve services for people in crisis/urgent care and Suicide prevention. All of these initiatives remain relevant for and underpin the Mental Health Commissioning intentions for 2016/17. During the last quarter of 2015/16 there will be significant changes to Mental Health Services in Hillingdon with the redesign of community mental health services and the introduction of a new Urgent Care Pathway and a Single Point of Entry. The impact of these major developments will need to be assessed and evaluated during the first quarter of 2016/17.

In addition the CCG is looking to enhance joint working arrangements with the London Borough of Hillingdon in line with the principles underpinning the Better Care Fund Initiative something that was recently demonstrated with the appointment of a joint Learning Disability Development Manager. The CCG will work in partnership with the Local Authority to develop the universal public health agenda based on the Mental Health Needs Assessment recommendations with a particular focus on dual diagnosis and suicide prevention. It will also undertake a joint review with LBH of the Recovery Pathway looking at an integrated procurement option in 2017/18. Furthermore 2016/17 will see the impact of the full year effect of Business Cases approved in 2015/16 including those for the Memory Services, CAMHS Out of Hours and Perinatal Services. 2016/17 will also see a potential joint procurement exercise with the outer North West CCGs of IAPT and Primary Care Plus Services as well as the beginning of a 5 year CAMHS Transformation Plan and new National Waiting Times Targets for Early Intervention, Perinatal Services and CAMHS.

Finally the CCG intends to finalise discussions and decide on a way forward concerning whether selective or wholesale market engagement, testing and/or procurement may deliver the transformational pace of change that it is seeking for both community and mental health services or not. The decision on the way forward is expected to be finalised during Q4 15/16.

STRATEGIC OBJECTIVES FOR MENTAL HEALTH	
Objective	**Expected Outcomes**
1. Further develop and improve local Dementia services reflecting the growing needs of the population.	• Ensure all services are working effectively together to jointly identify the local expected prevalence rates for Dementia diagnosis. • Improve early diagnosis rates for Dementia and improve the ongoing support for people living with Dementia and their carers.
2. Ensure IAPT Services remain fit for purpose, are meeting Hillingdon's local needs as well as existing and new national targets.	• Ensure the service meets the new waiting times targets for 2016/17 as well as the current Access and Recovery Targets.
3. Develop an effective MH Urgent Care Pathway and Single Point of Access.	• Reduction in Psychiatric admissions and reduction in admissions via Accident and Emergency. • Potential reduction in bed base across 5 CCGs.
4. Further development and stretch for key MH Services.	• Introduction of an Early Intervention Psychosis Service that meets national standards. • Development of a Perinatal Service that supports women from conception up to 12 months post-partum. • Development of an MH rehabilitation pathway in collaboration with London Borough of Hillingdon.
5. Continue with the 5 year CAMHS Transformation Programme which will begin in October 2015 including consideration of extending CAMHS to age 25.	• Establishment of an intensive community support team for children which will be easily accessible, NICE compliant evidence based treatments. • Reduce the number of inpatient admissions to out of area Tier 4 Services.
6. In partnership with key Stakeholders improve the employment prospects of those with mental health problems.	• Attract European Social and Lottery funding into the Borough to establish a Trailblazer Mental Health Employment support project which will support people with mental health problems into sustainable employment. • The Project will focus on the high need areas of Hayes and West Drayton.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Implement the Dementia Action Plan including developing a Resource Centre and rolling out Level 1 & 2 Training. • Integrate IAPT and Primary Care Plus Services and review key services including CAMHS Eating Disorder, Early Intervention for Psychosis. • Revisit all service specifications for Mental Health and undertake market testing/procurement as appropriate to achieve required efficiencies. • Develop urgent care pathways for both adults and children with mental health needs and a programme to support homeless people with MH needs. • Work with public health to support removing remaining stigma associated with MH conditions. • All service specifications will apply to all patients registered with a Hillingdon GP or those resident in Hillingdon but not registered with a GP.	
COMMISSIONING INTENTIONS 2016/17	

STRATEGIC AREA	Learning Disabilities (All Age)
CLINICAL LEAD	Dr Stephen Vaughan-Smith (Adults) and Dr Cherry Armstrong (Children & Young People)
COMMISSIONING LEAD	Joan Veysey, Ian Kent & Elaine Woodward

OVERVIEW

During 2016/17 the CCG will work in collaboration with the Local Authority to identify a new provider for the Community Learning Disability Service, in addition a Joint Business Case will be developed to put in place a comprehensive Learning Disability Service which is not currently available in Hillingdon. This will involve the development of a whole spectrum of services to care from early years to end of life. The CCG and Local Authority will work to ensure that all Local Providers make provision for reasonable adjustments for people with a Learning Disability entering their services, including the utilisation of the Green Light Toolkit and Contractual levers as required.

STRATEGIC OBJECTIVES FOR LEARNING DISABILITIES	
Objective	**Expected Outcomes**
1. Consideration to be given to extend CAMHS services to age 25.	• Improve the transition of children with a Learning Disability from children's to Adult Learning Disability Services.
2. Continue to implement the CAMHS Transformation Programme which will commence in October 2015.	• Establishment of an intensive community support team for children with a Learning Disability will be easily accessible, based on NICE compliant treatments. • Reduce the number inpatient admissions locally and into out of area placements.
3. Implement the recommendations of the LD/S75 Strategic Review completed April 2015	• Develop a fit for purpose specification for the Community Learning Disability Service based on the service model recommended by the Learning Disability Senate. • Utilise this specification as the basis of a procurement exercise to appoint a new provider by October 2015. • Reduction in out of Borough placements and increased local treatment for those with Challenging Needs.

Key Actions For 2016/17

The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17:

- Procure a fit for purpose Community LD Service and review the extension of the CAMHS service to age 25.
- Develop a joint autism plan with LBH.
- Seek to transform the care services that exist for LD.
- Proactively engage the third sector in supporting the LD Agenda and reduce the number of patients with an LD who are sent 'out of borough'.
- Improve transition support for children with an LD transitioning to become adults.

Section 10g: Children & Young People (CYP)

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Children and Young People
CLINICAL LEAD	Dr Cherry Armstrong
COMMISSIONING LEAD	Anthony Walters

OVERVIEW

Hillingdon CCG aims to ensure children & young people receive the best possible treatment through high quality integrated care. The views and voices of children and young people will be at the centre of how we design and deliver our services for them. A key commissioning priority will be the accessibility and transparency of clinical pathways for our children and young people. The CCG will review and implement clinical pathways for paediatrics with a view to implementing ambulatory care pathways in 2016/17 across acute and community providers. The ambulatory care pathway seeks to facilitate treatment for children and young people as quickly as possible as well as enhancing patient experience.

Hillingdon CCG is aware of its responsibility to ensure all children and young people have equal access to health services. It is committed to working with our partners to deliver key elements of the SEND code of practice- including joint commissioning of Speech and Language Therapy Services.

We will ensure where appropriate that care and support is provided in the community. We believe this will provide better care for our children and young people and avoid unnecessary attendance at acute hospitals. To this end we will work with Paediatricians to encourage joined up working with GP's to provide support in the community.

As Hillingdon CCG is taking an all age approach to commissioning service areas for 2016/17 most of the actions specific to children and young people can be found in the relevant sections such as Planned Care, Unplanned Care, Mental Health, Long Term Conditions etc.

STRATEGIC OBJECTIVES FOR CHILDREN & YOUNG PEOPLE	
Objective	**Expected Outcomes**
1. Reduce the number of unplanned attendances and admissions associated with children and young people.	• Fewer children admitted following an unplanned attendance. • Better health outcomes for children with an unplanned care need especially for those with a Long Term Condition.
2. Improve the planned care system for children and young people with Long Term Conditions.	• Less demand for acute care services where appropriate. • Fewer unplanned care needs arising for children with Long Term Conditions. • Better long term health outcomes. • Improved patient experience of care.
3. Improve support for Vulnerable Groups.	• Better health outcomes (both physical and mental health) for vulnerable children. • Better support for vulnerable people as they transition from children to adults.
4. Reconfiguration of acute services to better meet the needs of children and young people.	• Improved care provided in acute care. • More services provided closer to home across health and social care. • A financially sustainable system for Hillingdon.
5. Improve early intervention for children and young people.	• Better coordination of services across health and social care. • Fewer children developing Long Term Conditions. • Better health outcomes for children and young people.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Implement Ambulatory Pathways and/or a ZLOS Tariff for Paeds. • Undertake a deep dive into paediatric activity associated with planned care and plan for the potential increase in births following the closure of Ealing Maternity Services. • Develop/deliver a parent education programme in matters such as managing common self-limiting childhood illnesses. • Explore joint commissioning with LBH of speech and language therapy services and develop a common approach to implementing an autism strategy. • Improve service specifications for relevant services and explore market testing/procurement of children's services as appropriate. • Undertake a review of the support for children arriving in Hillingdon as an unaccompanied minor. • Improve coordination of care for Children and Young People between acute care and community services.	

Section 10h: Medicines Management

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Medicines Management
CLINICAL LEAD	Dr Mayur Nanavati
COMMISSIONING LEAD	Vasundra Tailor

OVERVIEW

The purpose of the Medicine's Management Team (MMT) is to work with practices to help them improve medicines usage, get the best out of the medication they prescribe and ensure that budgets are optimised and spend minimised wherever possible.

A key focus for the MMT is to promote integrated and coordinated working between providers.

Priorities for 16/17 include supporting practices through Independent Pharmacy Prescribers (IPP), reducing polypharmacy issues (including improving safety and reducing incidents) and working with practices to control budgets including defining the Medicines Management Local Improvement Scheme (LIS).

STRATEGIC OBJECTIVES FOR MEDICINES MANAGEMENT	
Objective	**Expected Outcomes**
1. Achieve GP engagement through a named advisor.	• Medicines optimisation advice and guidance is followed and appropriate changes to prescribing made by GPs. • Quality and safety of medicines use is improved. • Medicines waste is reduced and both cost savings and prescribing budgets are achieved.
2. Incentivise GPs to prescribe efficiently, safely and cost-effectively.	• Independent pharmacists working in practices will support their GPs in making appropriate prescribing decisions as recommended in the MM LIS. • Increased use of Scriptswitch which will result in reduced expenditure in prescribed drugs.
3. Increased number of reviews in Care Homes.	• Medication errors related to polypharmacy are significantly reduced. • Patient experience with their medicines and medicine usage is improved.
4. Increase joint working with health professionals across the interfaces and with NWL and London-wide Pharmacy Networks.	• **THH:** Medicines initiated in hospital are appropriate for continued use in the community. Entry of new medicines is managed carefully across the whole health economy. 28 Day Prescribing introduced. • **CNWL:** Improve district nurse prescribing of sip feeds and reduce the amount of wound care products used as well as facilitate the transfer of the wound care budget to CNWL. • **Community Pharmacy:** Greater understanding of medicines-related issues across prescribers. • **Public Health:** Improved medicines-use resulting from closer working between MM Team and PH workstreams e.g. smoking cessation, needle-exchange, health checks, flu vaccinations etc. • **NWL Workstreams** – Independent prescribing pharmacist (IPP) roll out. • **London Leads** – All DH & NHSE strategies shared and actions implemented as required.
5. Provide pharmacy advice to Transformation Groups.	• Medicines-related areas are addressed on a wide front in the Transformation Group Meetings for primary care, mental health, LTCs, elderly care, paediatrics and IT.
6. Provide pharmacy advice for all GP Networks.	• Practice pharmacists recruited have the appropriate skills and competencies necessary for the practice work. • Networks have the correct prescribing tools.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Continue to manage prescribing spend, reduce wastage and develop/manage the Medicines Management Local Incentive Scheme. • Facilitate transfer of Wound Care budget to CNWL for 16/17 and introduce Outpatient Prescribing (including 28 days) with THH. • Seek to review how organisations (including acute care) are incentivised to reduce unnecessary medication expenditure.	

Section 10i: End of Life Services

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	End of Life Services
CLINICAL LEAD	Dr Kuldhir Johal
COMMISSIONING LEAD	Debra Lake

OVERVIEW

Hillingdon CCG is committed to improving care for patients at the end of their life. This means ensuring that patients who are approaching the 'End of Life' phase are identified and provided with effective support that is integrated across primary, secondary and community care (including the third and voluntary sectors). This extends to supporting and assessing the needs of carers and families during the End of Life Phase.

As part of supporting the challenges at the End of Life, Hillingdon CCG with health and social care partners including London Borough of Hillingdon have an established 'End of Life Forum' that aims to manage the many complex issues and competing priorities for resources that exist in this area. A priority for the CCG for 2016/17 is to both understand, and where possible, streamline the provision of services so that patients, carers and families are correctly supported within the budget available.

2016/17 Will also see the expiration of the current 'End of Life Strategy' that the CCG, along with partners, has been working toward. This strategy will be reviewed and updated (including children at end of life) as part of the actions for the End of Life Services for 2016/17.

STRATEGIC OBJECTIVES FOR END OF LIFE SERVICES	
Objective	**Expected Outcomes**
1. Ensure that patients approaching their end of life phase are identified.	• Early identification will ensure that services are provided in a more-timely manner. • Increased number of patients able to choose where they would like to die and having their wishes met.
2. Provide all patients identified as approaching end of life with effective support.	• Improved support to patients, carers and families. • Improved system-wide awareness of what 'effective support' at end of life looks like.
3. Integrate Services across Primary, Secondary and Community Care plus Social Care, Voluntary and Third Sector.	• A seamless service provided to patients. • Faster access to support where needed.
4. Enhance Carer & Family Support and Assessment of Needs.	• Increase number of carers and family members feeling supported during their relative's end of life phase. • Improved bereavement support.
5. Adopt a whole system approach to communication, planning and monitoring.	• Improved monitoring of the system wide performance in supporting patients at end of life.

Key Actions For 2016/17

The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17:

- Review/improve service specifications and defragment the End of Life Service portfolio through a selective market testing/procurement exercise.
- Finalise the End of Life Strategy and review service gaps associated with Bereavement Support and Carers.
- Improve access to and use of Coordinate My Care (CMC) and introduce an End of Life Dashboard.

Section 10j: Community Services

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Community Services
CLINICAL LEAD	Dr Cherry Armstrong
COMMISSIONING LEAD	Debra Lake

OVERVIEW

Community Services are integral to supporting the CCG's Out of Hospital Agenda as well as the delivery of a wide range of our other strategies including those associated with Long Term Conditions, Planned Care, Unplanned Care and others.

The Commissioning Intentions for Community Services for 2016/17 are focused on the following four areas:

1. Ensuring that the services delivered are specified correctly.
2. Ensuring that the services offer true value for money.
3. Ensuring that the services are fully integrated with GP Networks.
4. Ensuring that the services work effectively as the third arm of the health care economy in supporting patients in an integrated manner.

The CCG intends to finalise discussions and decide on a way forward concerning whether selective or wholesale market engagement, testing and/or procurement may deliver the transformational pace of change that it is seeking for both community and mental health services or not. The decision on the way forward is expected to be finalised during Q4 15/16.

STRATEGIC OBJECTIVES FOR COMMUNITY SERVICES	
Objective	**Expected Outcomes**
1. Improve The Quality & Effectiveness Of Community Services.	• Improved measures and information to enable effective decisions to be made and taken. • Improved contract monitoring and reporting processes for all community services.
2. Redefine The Service Specifications For All Services.	• Ensure that the service definitions and specifications meet the needs of our community and are aligned with our Commissioning Intentions.
3. Improve Integration Between Primary, Community & Secondary Care.	• Community Services aligned to the delivery of our Out of Hospital/Planned Care & LTC Strategies. • Community Services integrated with our developing GP Networks.
4. Deliver QIPP Targets for 16/17 for Community Services.	• Ensure our services offer value for money. • Selectively engage and test the market to identify improved models of care and efficiencies.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Improve all service specifications and undertake either selective or wholesale market testing/procurement of services. • Align services with emerging GP Networks and support the integration of Community Service into the emerging strategies for LTCs and Older People. • Improve management of community equipment and reduce excess expenditure. • All service specifications will apply to all patients registered with a Hillingdon GP or those resident in Hillingdon but not registered with a GP.	

Section 10k: Primary Care

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Primary Care
CLINICAL LEAD	Dr Steven Shapiro
COMMISSIONING LEAD	Helen Delaitre

OVERVIEW

The role of primary care remains central to the ethos of the NHS but in order to survive current challenges and make primary care sustainable, primary care needs to:

- Adapt and embrace new models of care
- Review and invest in workforce and skill mix
- Improve and diversify access to services
- Work with partners to integrate services wherever possible
- Reduce variation in provision of services
- Develop premises options that are fit for the future needs of primary care

The CCG will assist primary care to achieve this by:

- Supporting GP networks
- Delivering more planned care services out of hospital
- Reviewing new models of primary care that suit local patient needs
- Developing networks of care using Accountable Care Partnership (ACP) arrangements

STRATEGIC OBJECTIVES FOR PRIMARY CARE	
Objective	**Expected Outcomes**
1. Adapt and embrace new models of care.	• A primary care system that can support the CCG's aspirations for Out of Hospital activity, Long Term Conditions, SaHF etc. • A financially sustainable primary care system that is able to meet the rising demand for services.
2. Review and invest in workforce and skill mix.	• Clinical and non-clinical staff will choose to come and work in Hillingdon because of the training opportunities available and the reputation Hillingdon has as a forward-thinking CCG.
3. Improve and diversify access to services.	• All patients will have access to the right service, at the right time, in the right place.
4. Work with partners to integrate services wherever possible.	• Delivery of integrated support to patients with LTCs and frail Older People. • Seamless services for patients in key areas.
5. Reduce variation in provision of services.	• Hillingdon patients receive the same services and the same level of care wherever they are registered in the borough.
6. Develop premises options that are fit for the future needs of primary care.	• Premises that allow the roll out of Out of Hospital Services and development of network hubs.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Continue to support development of GP Networks and the development of the ACP. • Review the extended hours DES (Directed Enhanced Service) with NHSE colleagues and the Rheumatoid Arthritis NES (following decommissioning by NHSE). • Agree model for Independent Pharmacy Prescribers and Tier 1 & 2 of the Diabetes Service at Network Level. • Ensure 16/17 Primary Care Contract specifications meet the CCG's Commissioning Agenda. • Improve patient awareness of the impact of DNAs on Primary Care access and capacity. • Seek to improve links between Primary Care and Public Health around the prevention agenda. • Review opportunities to use telemedicine to reduce demand for routine follow ups and improve patient monitoring. • Improve the intelligence gathered from primary care through better use of alerts on our extranet and via relevant fields on referral templates.	

Section 10l: Continuing Health Care (CHC) & Complex Care

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Continuing Health Care and Complex Care
CLINICAL LEAD	Nicky Yiasoumi/ Carole Mattock
COMMISSIONING LEAD	Nicky Yiasoumi/ Carole Mattock

OVERVIEW

Adult Continuing HealthCare is provided when an individual has been assessed by a multi-disciplinary team and been deemed to have a 'primary health need' After this has been defined health will develop a package of care which is arranged and funded solely by the health for individuals outside of hospital who have on-going healthcare needs. You can receive continuing healthcare in any setting, including the patient's own home or a care home.

There is also Continuing HealthCare which is provided when an individual child has been assessed by a multi-disciplinary team and been deemed to have a need arising from disability, accident or illness that cannot be met by existing universal or specialist services alone. As childhood is a period of rapidly changing physical, intellectual and emotional maturation alongside social and educational development there is a need for a wider range of agencies to be involved in the care of a child or young person with continuing care needs than in the case of an adult. These agencies will predominantly be health, social care and education. However additional to this is parental responsibilities as most care for children and young people is provided by families at home, and maintaining relationships between the child or young person, their family and other carers, and professionals is important to the wellbeing of the child.

Since October 2014 the CCG has offered and provide for those patients that wish to take up the offer and are in receipt of Continuing Health Care (CHC) a Personal Health Budget. This budget is provided to deliver care as defined in the patient's personal plan which has to meet their health and wellbeing objectives.

STRATEGIC OBJECTIVES FOR CONTINUING HEALTH CARE (CHC) AND COMPLEX CARE	
Objective	**Expected Outcomes**
1. New referrals will progress through the Continuing Health Care process as described by the National Framework within the spirit of the guidance (28 days).	• All new referrals processed within 28 days. • All Fast-Track referrals processed within 48 hours. • Referral processes audited regularly by CHC team leader with regular external audits undertaken.
2. 3 and 12 monthly Continuing Health Care eligibility reviews will be undertaken at specified agreed intervals.	• Eligibility reviews undertaken and assurance received that patients are receiving the correct package of care at the specified intervals.
3. Regular reviews undertaken to assess the quality and evaluation of an individual's care package.	• At least annual assurance that patients with a CHC care package are receiving the correct package of care.
4. Undertake a strategic workforce and capacity review to meet current and predictable future demand.	• A workforce that meets the needs of our population both now and into the future. • Improved productivity within existing team and resources.
5. Expansion of Personal Health Budgets outside of Continuing Health Care for those with a long term condition or a child with specialist educational needs.	• All relevant patients eligible for a PHB offered one.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Review of workforce requirements to be undertaken. • Develop a local offer for Personal Health Budgets (PHBs) for individuals with LTCs and Children with Specialist Educational Needs. • Develop a 3 Year Plan for PHBs.	

Section 10m: Patient & Public Engagement & Empowerment

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Patient & Public Engagement & Empowerment
CLINICAL LEAD	None
COMMISSIONING LEAD	Diana Garanito

OVERVIEW

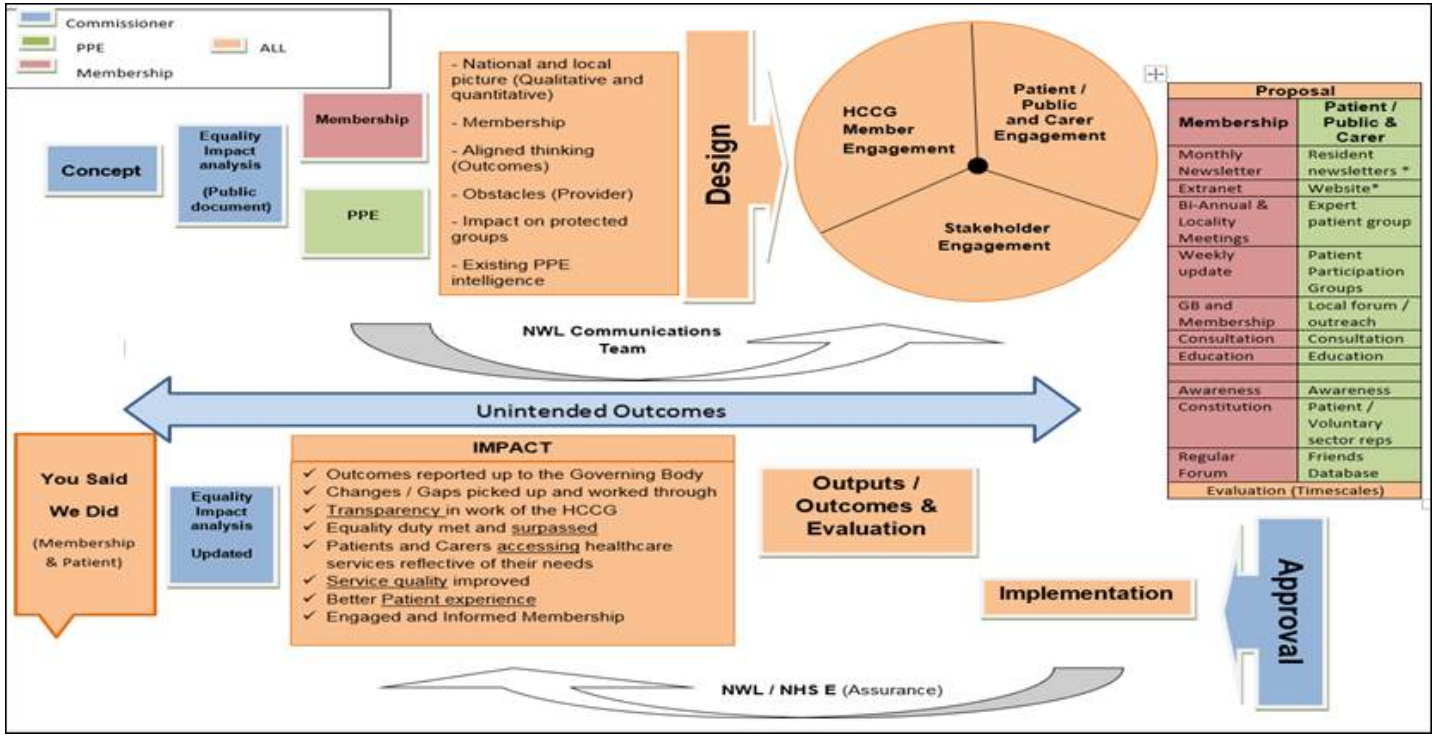
The vision for engagement is that every patient, carer and resident living in Hillingdon is given the opportunity to engage and be involved in the work of the CCG, and where they use a service commissioned by the CCG they experience a positive outcome. Central to this is empowering patients and carers to self-care and be knowledgeable about Hillingdon's health system. Over the years the CCG have tried and tested many methods of engagement, both with its public and its membership. The learning from these experiences has produced two key lessons that the CCG are and have been working on in 2014/15, and will continue to work on in order to sustain its approach to engagement and maximise the benefits of a fully informed health system:

Engagement needs to be delivered as a whole system contribution. For Hillingdon to thrive and for the work of its commissioners and clinical leads to be fully recognised by its outcomes, engagement must encompass the views of those who have experience of the system and those who work for, or with the system. Paramount to this are the views of those with the potential to either enhance the system (voluntary sector, pharmacist) and those who should be / could be users of the system.

Engagement needs to be joined up across the health and social care spectrum. Whilst there are clear benefits to the patient / carer in this process (survey fatigue) there are also longer term advantages to be gained:

- Resource and skill mix – organisations with limited resources would work together towards a project that would otherwise be carried out in isolation.
- Pathway experience mapping – organisations would be better able to detect root causes of a poor patient / carer experience and work together to address problems.
- Reaching the views of a representative population – the CCG's engagement as demonstrated below, is determined in most instances by an Equality Impact Analysis. This is important to ensure that those public engaged are those who are identified to be impacted by our work. Working in partnership not only means that we can reach a wider audience, but that conversations are fed back simultaneously to providers and the CCG.
- We expect providers to seek patient and community feedback and allow this feedback to influence service provision. To support this the CCG will draft what it believes to be good practice in PPE. Providers are also required to support the self-management aims of the CCG.

Figure 1: Hillingdon CCG Vision for Patient, Carer, Public and Membership Engagement



To learn more about the CCGs engagement across 2014/15 and its plans for 2016/17 you can read the CCG Annual Patient and Public Engagement Report. A link is available from Hillingdon CCG's website here.

STRATEGIC OBJECTIVES FOR PATIENT & PUBLIC ENGAGEMENT & EMPOWERMENT	
Objective	**Expected Outcomes**
1. Increase our understanding of the needs of people with LTCs.	• Improved health outcomes for people with LTCs. • Improved correlation between the needs of patients and how services are delivered.
2. Empower young adults and their families/carers to better manage their condition.	• Reduced unplanned care attendances for parents with children. • Improved outcomes for children.
3. Develop resources/tools to help patients better manage their condition.	• A financially sustainable system for Hillingdon. • More patients better able to manage their conditions. • Fewer unplanned care needs for patients, particularly those with an LTC.
4. Work with primary care, social care and the voluntary sector to enhance and improve their support to patients with LTCs.	• Improved health outcomes for people with LTCs. • Improved correlation between the needs of patients and how services are delivered.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Deliver the existing Empowered Patient Programme and expand to include more conditions. • Implement and evaluate the Patient Activation Model (PAM) • Build the capacity of health connectors and voluntary organisations. • Providers to be required to seek out the views of patients and the community and show how this has positively influenced service provision and design. • The CCG will issue guidance about what it believes good practice is in public and patient engagement. • Providers will be required to support the CCG's aims around self-management.	

Section 10o: IT & Technology

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Information Technology
CLINICAL LEAD	Dr Kuldhir Johal
COMMISSIONING LEAD	Eddie Clark

OVERVIEW

Information Technology (IT) plays an ever increasing importance part in patient care and management. From the ability of clinicians to share patient records and diagnostic results, through the ability to seek clarification and on to providing remote support, monitoring and care of patients.

The work of Hillingdon CCG in the area of IT for 2016/17 is focused on three areas:

1. Continuing to support both the CCG and Primary Care to maintain hardware and software that comply with NHS required security, confidentiality and patient access standards whilst maintaining operability of networks at all times.

2. Improving the ability of providers to access, review and update (where appropriate) patient records so that care is optimised, outcomes are improved and duplication is reduced. This also includes expanding the breadth of agencies able to appropriately and confidentially access data.

3. Exploring how to extend the use of IT to improve patient care including exploring decision support tools and other issues such as telehealth solutions that will, in the medium to long term, transform the way that care is provided to a cohort of our patients.

STRATEGIC OBJECTIVES FOR INFORMATION TECHNOLOGY	
Objective	**Expected Outcomes**
1. Maintain Hardware/software to required standards that allows services to be delivered.	• Equipment remains operable. • Security and confidentiality remain protected. • Costs are managed and controlled.
2. Review and renew the Multiagency Information Gateway (MIG).	• Current MIG agreements reviewed. • Integration with other software packages (ie Patient Knows Best) as appropriate.
3. Update and renew other supporting software as appropriate.	• Software meets emerging and planned needs for Hillingdon CCG and our providers and patients as closely as possible.
4. Improve usage of data to support Patient care.	• GP Practices utilising existing software effectively (for example Shared Care Record, EPS2 etc) • Improved appropriate utilisation of the Shared Care Record (SCR) by clinicians with better outcomes for patients.
5. Continue to provide support to Networks.	• GP Networks provided with appropriate levels of support and service to enable to continue to improve and extend the care provided to patients.
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Improve use of the Shared Care Record (SCR) and expand to new (appropriate) providers. • Renew the MIG Agreement and allow other services to see and add to the GP Clinical Record as appropriate. • Update GP Hub Servers.	

Section 10p: Safeguarding (Adults & Children)

COMMISSIONING INTENTIONS 2016/17	
STRATEGIC AREA	Safeguarding (Adults & Children)
CLINICAL LEAD	Dr Reva Gudi
COMMISSIONING LEAD	Jenny Reid (Children's Safeguarding Lead) and Sacha Ikeme (Adult Safeguarding Lead)

OVERVIEW

NHS Hillingdon CCG is fully committed to safeguarding and as part of its statutory responsibility, the CCG will:

- Ensure that, as commissioners of NHS Health Services, health contribution to safeguarding and promoting the welfare of adults and children is effectively discharged across the local health economy through its commissioning arrangements; this includes specific responsibilities for Looked after Children and supporting the Child Death Overview Process specifically for Children.

- Ensure that all Providers of NHS Health Services have clear and effective arrangements in place to safeguard and promote the welfare of all adults and children, especially vulnerable adults, children and young people that assure themselves, regulators and commissioners that these arrangements are effective.

- Ensure that the Organisation and their Providers will, through the CCG's commissioning arrangements and service specifications, be fully engaged to work with partner agencies in order to improve outcomes for adults, children, young people and their families.

- Monitor compliance through its governance arrangements for service contracts.

STRATEGIC OBJECTIVES FOR SAFEGUARDING (ADULTS & CHILDREN)	
Objective	**Expected Outcomes**
1. Ensure that the voice of children and young people are heard.	• Children feel listened to and are able to actively participate in their care in a child and young people friendly NHS. • Improved and increased access to NHS services by children and young leading to improved health outcomes (e.g. teenage pregnancy, STIs, LAC health assessments).
2. Develop a comprehensive and easily accessible service provision for children at risk of, or suffering as a result of, Child Sexual Exploitation (CSE) or Female Genital Mutilation (FGM).	• Improved detection and prevention leading to more appropriately funded services for any subsequent long term conditions e.g. depression, back pain, pelvic inflammatory disease, genito urinary infections, infertility, complex child birth and possible child deaths. • Improved recording and reporting which will inform decision making as regards the viability of locally, across BHH or NWL funded service provision. • Improved access to services leading to early detection of cervical cancers due to increased uptake of screening opportunities.
3. Improve support to vulnerable children and adults including those at risk of radicalisation and/or domestic abuse.	• Assurance through contract monitoring that front line service staff in commissioned services are trained to the appropriate level to: o Identify and report interventions so that service demands match service needs. o Identify and refer those suspected of, affected by or living in households where these issues exist to ensure that necessary safeguards are in place. • Training levels (Prevent & Domestic Abuse), number of staff trained monitored through contractual arrangements to assure compliance.
4. Reduce the incidence of Pressure Ulcers (Grade 3 and 4).	• Reduce harm to patients. • Incremental reduction in pressure ulcers.
5. Ensure adults at risk are protected from avoidable harm.	• Ensure a positive experience of care in a safe environment. • Training levels on Mental Capacity Act (MCA) and Deprivation of Liberty safeguards (DoLs), number of staff trained monitored through contractual arrangements to assure compliance. • Prioritise Best interests of adults at risk
Key Actions For 2016/17	
The following is a summary of the key actions that will be undertaken to deliver these objectives during 2016/17: • Work with providers to ensure they listen to the voice of children and young people and implement CSE and FGM Champions. • Implement Child Protection Information Sharing protocols and systems. • Work with providers to improve their systems around recording/reporting domestic abuse and reduce the rate of incidence of pressure ulcers. • Ensure providers have processes in place to ensure that staff receive appropriate Mental Capacity Act and Deprivation of Liberty.	

Section 11: QIPP Requirements for 2016-17

The Quality, Innovation, Productivity and Prevention (QIPP) programme is a large-scale programme developed by the Department of Health to drive forward quality improvements in NHS care, at the same time as making efficiency savings.

The QIPP efficiency target for 2016/17 will be finalised toward the end of 2015 which is after the date that the Commissioning Intentions are published. At the time of writing we expect the minimum QIPP efficiencies to be in the region of 3% of the CCG's total budget.

The delivery of QIPP efficiency targets allows Hillingdon CCG to ensure that essential services remain funded and operational and can therefore cope with the demands placed upon it. Failure to achieve the QIPP efficiency targets means that Hillingdon CCG will not be in a position to fund specific services and will need to scale back activity.

A summary of the current QIPP efficiency schemes for 2016/17 and other aspects of our QIPP plans are stated below. For the 2016/17 QIPP efficiency programme we have considered three areas:

1. Existing and planned schemes that are already underway or are in development along the planned activity changes associated with them where known.
2. Areas where data analysis shows Hillingdon CCG to be a significant outlier when compared to other North West London CCGs at either a Treatment Function Code (TFC), Healthcare Resource Group (HRG) or Procedure Code (PPC) level.
3. Other areas where it can either be shown via analysis or value for money exercises that efficiencies exist or where it is felt through a variety of means (including soft market testing) that efficiencies can be realised.

This section focuses on the Planned & Existing QIPP Schemes and the associated activity changes. The other areas explored will form the basis of our challenges to providers (including capping activity above the North West London average and not paying for additional activity) and will also form the focus for market testing and possible procurement during 2016/17.

The following is a summary of the planned and existing schemes that will form part of the CCG's QIPP efficiency programme for 2016/17. It should be noted that the schemes described below do not account for the full year QIPP target for the CCG and therefore additional schemes will need to be added as they are defined. Any under-achievement against the 15/16 QIPP Target will roll-over into 16/17.

LONG TERM CONDITIONS			
SCHEME NAME	**SCHEME TYPE**	**NOTES**	**ACTIVITY CHANGES**
Integrated Cardiology Programme	Existing	Started in 2015/16	• 52 HF NEL Admissions Avoided • 45 Cardiology NEL Admissions Avoided • 45 Cardiology NEL Re-admissions Avoided
Integrated Diabetes Programme	Existing	Started in 2015/16	• 132 OPFA Reduction • 740 OPFUP Reduction • 180 OPProc Reduction • Note: We expect some NEL Admission Reduction but no. is TBD.
Integrated Respiratory Programme	Existing	Started in 2015/16	• 192 A&E Attendances Avoided • 393 COPD NEL Admissions Avoided • 11389 (Total) Respiratory OPFA and OPFUP Activity Reduction
Empowered Patient Programme (Phase 1 & 2)	Existing	Started in 2015/16	• 2960 Pts in 15/16 • 4000 Pts in 16/17 leading to: • 150 Attendances Avoided • 70 Admissions Avoided
Redesigning Cancer Pathways	Existing	Started in 2015/16	• Activity assumptions are still TBD.
Audiology Diagnostics	Existing	Started in 2015/16	• Reduction in block price. No activity changes.
Paediatric Asthma Programme	Existing	Expansion of pilot started 15/16	• 37 A&E Attendances Avoided • 13 NEL Admissions Avoided • Note: We expect some OP Activity Reduction by no. is TBD.

PLANNED CARE			
SCHEME NAME	**SCHEME TYPE**	**NOTES**	**ACTIVITY CHANGES**
Gastroenterology	New	Based on FCP but new for 2016/17	• 120 OP First Appointments
Community Ophthalmology Service	Existing	Rollover of scheme started 14/15	• 1223 OP First Appointments • 3871 OP Follow Ups
Community Dermatology Service	Existing	Started in 2015/16	• 486 OP First Appointments • 2993 OP Follow Ups • 2421 OP Procedures
Urology	New	Based on audit undertaken 15/16	• Activity based on Audit Results due Q3 15/16
ENT (Grommets)	Existing	Started in 2015/16	• 143 OP Follow Ups
Neurology (Headaches)	Existing	Started in 2015/16	• 180 OP First Appointments
MSK	Existing	Refreshed programme for 2016/17	Activity to reduce to North West London Average including: • Minimum of 750 OP First Appointments • Minimum of 300 OP Procedures • Minimum of 200 Spinal Procedure v48 • Minimum of 400 Spinal Procedure v54 • Implementation of Chronic Community Pain Service

UNPLANNED CARE			
SCHEME NAME	**SCHEME TYPE**	**NOTES**	**ACTIVITY CHANGES**
Intermediate Care	Existing	Started in 2014/15	• 7 Pts/Day Avoiding Admission via ED referrals • 1 Pt/Day Avoiding Admission via other routes
Ambulatory Emergency Care (AEC) Adults	Existing	Expansion of scheme started 14/15	• Minimum 1000 Additional Patients avoiding admissions over and above activity in 15/16 based on 390/Month from April to June 16 increasing to 420/Month.
AEC Emergency Gynae Assessment Unit (EGAU)	Existing	Expansion of scheme started 14/15	• Included in figures above.
AEC Paediatric Pathways	Existing	Continuation started 15/16	• Minimum of 420 Additional children avoiding admission over and above the 180 children supported to avoid an admission in 15/16.
AEC Surgical Pathways	Existing	Continuation started in 15/16	• Minimum of 640 Patients avoiding admission over and above the 320 Patients supported to avoid an admission in 15/16.
Falls & Falls Prevention Service	Existing	Started in 2014/15	• 60 Patients supported to avoid an admission (full year effect after 60 Patients are supported in 15/16).
Rapid Access Care of the Elderly (COTE) Clinics	Existing	Started in 2015/16	• 3 Patients/week avoiding an admission from September 15 onwards with 78 of these admissions being avoided during 16/17.
STARRS Programme	Existing	Benefits of Northwick Park STARRS	• No activity changes but financial savings will be realised.

COMMUNITY SERVICES			
SCHEME NAME	**SCHEME TYPE**	**NOTES**	**ACTIVITY CHANGES**
Community Services Contract	New	Efficiencies from contract	• Efficiencies from selected services through negotiation and/or service redesign and procurement.
Integrated Wheelchair Service	Existing	Started in 2015/16	• Block contract efficiencies following procurement exercise with no major resulting impact on activity changes assumed at this stage.
Pressure Relieving Equipment	Existing	Started in 2015/16	• Block contract efficiencies following procurement exercise with an approximate 10% increase in activity levels taken into account.
Community Rehabilitation Equipment	Existing	Started in 2015/16	• Reduction in spend through better controls and rationalisation of stock list.
Small Contract Productivity	Existing	Started in 2015/16	• Reduction in costs through procurement with potential areas of focus being Non-Emergency Patient Transport Services or End of Life Services (not including those from the Acute Sector).

MENTAL HEALTH			
SCHEME NAME	**SCHEME TYPE**	**NOTES**	**ACTIVITY CHANGES**
Urgent Care Impact on Bed Occupancy	New	Based on work done in 2015/16	• Reduction in 5 Beds from Q4 15/16 onwards.
Complex Placement Programme	Existing	Started in 2015/16	• Focusing on 10 Patients during 2016/17.
Primary Care Plus Reduction in Secondary Care	Existing	Expansion of 14/15 programme	• 380 Pts transferred back to Primary Care (or not referred to secondary care) as a minimum.
Efficiencies due to MH Business Cases	New	Based on Business Cases from 15/16	• 350 Admissions from Mental Health Assessment Lounge.
Contract Efficiencies	New	Efficiencies from existing contract	• Efficiencies from selected services through negotiation and/or service redesign and procurement.

PRESCRIBING			
SCHEME NAME	**SCHEME TYPE**	**NOTES**	**ACTIVITY CHANGES**
Prescribing & Medicines Optimisation	Existing	Started in 2012/13	• Reduction in spend through better optimisation of medicines and selected initiatives.
Care Homes Admissions Avoided	Existing	Started in 2014/15	• 22 NEL Admissions Avoided

CONTINUING HEALTHCARE (CHC)			
SCHEME NAME	**SCHEME TYPE**	**NOTES**	**ACTIVITY CHANGES**
Procurement of services for Complex Children	Existing	Started in 2015/16	• Reductions through purchase efficiencies.
CHC Patient Reviews of Service Needs	Existing	Started in 2015/16	• Reductions due to enhanced assessment processes.

PRIMARY CARE			
SCHEME NAME	**SCHEME TYPE**	**NOTES**	**ACTIVITY CHANGES**
Integrated Care Programme	Existing	Started in 2015/16	• 150 NEL Admissions Avoided
Practice Commissioning Initiative	Existing	Started in 2013/14	• Not continuing in existing form but reductions in activity will occur via the following areas: o Decision Support Tools o Reduction in Variation in Primary Care o Formulary of READ Codes

Section 12: 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
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				
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				
JSNA	Joint Strategic Needs Assessment				
LA	Local Authority	LIS	Local Incentive Scheme	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		
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				
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	STARRS	Short-Term Assessment, Rehabilitation & Reablement Service
TB	Tubercolosis	TFC	Treatment Function Code	THH	The Hillingdon Hospital NHS Foundation Trust
UCC	Urgent Care Centre	UEC	Urgent & Emergency Care		
VTE	Venus Thromboembolism				
WSIC	Whole System Integrated Care	WTE	Whole Time Equivalent		
ZLOS	Zero Length of Stay				