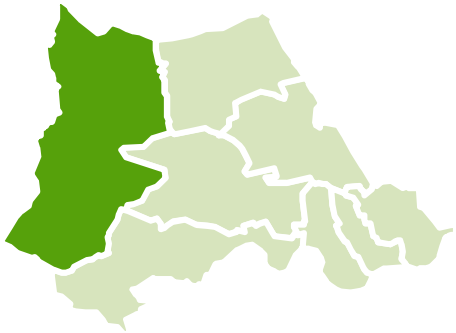
Hillingdon Executive Summary

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

This is a working document and content is not final

The Local Picture in Hillingdon



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

309,300 People (16/17 Estimate)

£347.8m (16/17 CCG Allocation)

46 GP Practices and 4 GP Networks

The majority of hospital based care occurs at The Hillingdon Hospital with smaller amounts of work done at Imperial and Northwick Park Hospitals.

Our local Community & Mental Health Services are delivered by Central & North West London NHS Foundation Trust.

We actively work together across health and local authority services to deal with our shared responsibilities including around commissioning services for people with Mental Health issues and Learning Disabilities as well as services for Children.

We are also working to establish an Accountable Care Partnership (ACP) that will see even closer integration between health providers as well as the Third and Voluntary Sectors..

Our STP is built on current local plans within Hillingdon and across NW London including (but are not limited to):

- Joint Strategic Needs Assessment
- Health and Wellbeing Strategy
- Better Care Fund Plan
- Our Digital Strategy
- Local Services Strategy
- Long Term Conditions Strategy
- End of Life Strategy
- Prevention Strategy
- Quality, Improvement, Productivity and Prevention (QIPP) Plans
- The Shaping a Healthier Future Programme
- NWL Local Services Programme
- NWL Whole Systems Integrated Care
- 2016/17 Operational Plan
- The Londonwide Strategic Commissioning Framework for Primary Care
- The NWL Primary Care Transformation Programme
- NHS Five Year Forward View
- GP Forward View

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

This executive summary is designed to feed in to the wider North West London plan and to provide an abbreviated account of the wider work underway and planned in Hillingdon and should be read with this context in mind.

The Financial Situation in Hillingdon

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

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

In £000s

Understanding Our Population: The Health & Wellbeing of Hillingdon

In Hillingdon our Health and Wellbeing Strategy and our Joint Strategic Needs Assessment, developed locally between the Local Authority and the CCG are the basis for our understanding of the changing needs and issues facing our population which include those shown below.

Reduce Childhood Obesity

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

Reduce Smoking Prevalence

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

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

Increase Physical Activity

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

Help Improve Peoples Mental Health

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

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

Reduce Social Isolation

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

Support to Manage LTCs

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

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

Reduce Alcohol Admissions

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

Make Every Contact Count

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

The 2021 Vision for Care & Support in Hillingdon

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

Health & Wellbeing

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

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

Care & Quality

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

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

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

Finance & Efficiency

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

The 9 North West London Priorities & Our Local Plans

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

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

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

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

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

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

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

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

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

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

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

6. Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice	**Key 16/17 Plans** • Develop integrated service model for Hillingdon. • Ensure that mental health support to people with LTCs and at End of Life is integral to the ACP programme • Publish and then implement new joint EoL Strategy (aligned to BCF). • Continue with EoL Forum and focus on expanding access to Coordinate My Care. • Increase access/use of Co-ordinate my Care within Primary Care • Primary Care incentivisation • Integration of Co-ordinate my Care and Primary Care clinical systems
7. Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed	**Key 16/17 Plans** • Focus on the 4 Acute Standards and seek selective delivery of services in other settings as per the strategy. • Mainstreamed 7 day therapy in HICU (intermediate care) • Develop dashboard to monitor outcomes and activity over 7 days to be reviewed via SRG. • Developing work with Buckinghamshire University in partnership with THH, CNWL and others to produce the necessary workforce • Increase in student numbers (nursing) via Bucks New University with more community based pathways • CNWL leadership programme for all new Band 7 and 8a posts • Implement National Cancer Vanguard Programme in partnership with Royal Marsde
8. Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease	**Key 16/17 Plans** • Deliver integrated services for Cardiology, Respiratory and Diabetic Services. • Development of Hillingdon ACP • Development of the strategy for adults and children with autism • Develop a programme to focus on management of co-morbidities and high users of services. • Capturing incidence and prevalence rates of co-morbidity which will support development of assertive treatment models, risk stratification, targeted service design and economic evaluation, which are not currently routinely collected • Enhancement of primary care systems through clinical decision support functionality to help GPs refer patients to the most appropriate pathway • Effective informatics and analytics systems to enable GP practices to work together to discuss and reduce variation
9. Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness	**Key 16/17 Plans** • Implementation of Cancer Improvement Strategy including an outcome based dashboard. • Cancer vanguard programme as a part of London Cancer Alliance • Develop outcome based dashboard for LTC Strategy and develop action plan. • Develop Pathways for Long Term Conditions • Implement Older People Integrated Care (including WSIC) • Implement Intermediate Care 'In Reach' from Community/Third Sector • Review of Homesafe Programme (Early Supported Discharge) and expand Integrated Discharge Planning • Development and implementation of the air quality management duties of the council.

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

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

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

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

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

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

Main Challenges Facing Delivery

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

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

Overview of the Local Services Programme for NWL

Overview of the 6 Local Services Programme Initiatives

In parallel with the development of the Sustainability & Transformation Plan (STP) work has been underway at a North West London (NWL) level to review and prioritise initiatives under the heading of the Local Services Programme (LSP) (previously the Out of Hospital Programme) that will underpin the move of care away from hospital to support the NWL STP. The Local Services Programme has identified six initiatives which are summarized below.

Initiatives	Description
Initiative 1. New Models of Local Services Care	Developing new models of care utilising technology, patient activation and empowerment, different clinical models etc. For Hillingdon this is mostly covered by the Primary Care Model of Care and Older People Model of Care (which is also aligned to the Accountable Care Partnership)
Initiative 2. Self-care	Empowering and information patients with Long Term Conditions to enable them to take control of elements of their care, manage their condition more effectively and ultimately improve their long term outcomes. This also links to Personal Health Budgets.
Initiative 3. Wider determinants of health	Working across health and social care to jointly address wider issues that affect the health of individuals and populations including deprivation, homelessness, alcohol and substance misuse and social isolation.
Initiative 4. Rapid Response and Intermediate Care	Effectively and safely reducing the number of people who need to be admitted to hospital and are supported either to remain in their normal place of care or are supported home. This also encompasses supporting the effective and safe discharge of people following an admission to reduce their overall length of stay.
Initiative 5. Expanding Common Discharge	Improving the coordination of discharges across borough boundaries including supporting access to local services including reablement, rehabilitation, bridging care and other services.
Initiative 6. Last Phase of Life	Coordinating support for people at the end of their lives and supporting them and their carers to enable them to die in their preferred place of death with the right support provided to manage their care.

Our Local Approach To The Five Year STP Challenge

Our Local Approach To The Five Year STP Challenge

Our approach to delivering the challenges set out in this STP involves numerous activities many of which are closely related and all are inter-related. Therefore we have grouped our work into 9 Transformation Programmes and 6 Enabling Programmes that align to both the 9 North West London Priorities and the 6 Local Services Initiatives as detailed below. The Enabling Programmes by definition align with most, if not all, of the priorities and initiatives.

Hillingdon Transformation Programmes	Alignment To The 9 North West London Priorities									Alignment To The 6 Local Services Programme Initiatives					
	Prevention Priorities			Integration Priorities				Technology & Innovation Priorities		New Models of Local Services	Self-Care	Wider Determinants of Health	Rapid Response & Intermediate Care	Expanding Common Discharge	Last Phase of Life
	1	2	3	4	5	6	7	8	9	1	2	3	4	5	6
1. Transforming Care for Older People	X	X		X		X	X	X		X	X	X	X	X	X
2. New Primary Care Model of Care	X		X	X		X	X	X		X	X	X	X		X
3. Integrating Services for People at the End of their Life		X		X		X				X			X	X	X
4. Integrated Support for People with Long Term Condition (LTCs)	X		X				X	X	X	X	X	X		X	
5. Effective Support for People with a Mental Health need and those with Learning Disabilities	X	X	X		X		X			X	X	X			
6. Integrated Care for Children & Young People	X		X				X			X	X	X	X	X	X
7. Integration across Urgent & Emergency Care Services	X		X	X	X		X	X	X	X	X	X	X	X	X
8. Prevention of Disease & Ill-Health	X	X			X			X	X	X	X	X			
9. Transformation in Local Services	X			X			X			X	X	X	X	X	X

Our Transformation Programmes in Detail

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

Our Transformation Programmes in Detail

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

Our Transformation Programmes in Detail

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

Our Enabling Programmes in Detail

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

Our Enabling Programmes in Detail

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