Hillingdon Executive Summary

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

This plan has been developed jointly with health and care partners in Hillingdon

NHS Hillingdon Clinical Commissioning Group

Hillingdon London

H4All stronger together

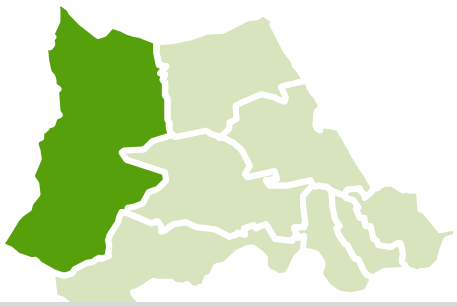
healthwatch Hillingdon

The Hillingdon Hospitals NHS NHS Foundation Trust

Hillingdon Health and Care Partners

NHS Central and North West London NHS Foundation Trust

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. The STP will act as a platform for development of new and innovative way of funding Health and Social Care in Hillingdon.

- **309,300** People (16/17 Estimate) increasing to approximately **321,000** in 2020/21
- **£347.8m** (16/17 CCG Allocation)
- **46** GP Practices and 4 GP Networks
- **302,198** registered Hillingdon CCG patients (01.07.2015)

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

Hillingdon is faced with potentially significant additional environmental and health burdens through the prospect of a third runway at Heathrow as well as opportunities through new developments such as Crossrail.

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
- Strategic Estates Plans
- 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 local STP builds on our approach of continuous dialogue with the public and partner engagement as a platform for the development of the above plans and strategies. In line with the NHSE guidance we will undertake an extended period of engagement on the local Hillingdon STP and ensure that public and stakeholder views are integral to how we progress our plans. Current content and thinking is subject to further reiterations and 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 –Hillingdon Whole System

The most likely growth assumptions over the next five years will see approx. 21% more activity being needed to be funded and to respond to this growth.

2020/21 estimates	Hillingdon £m	NWL £m
CCG	(39)	(248)
Primary Care	(2)	(15)
Social Care	(18)*	(145)
Acute and Community Care	(45)	(622)
Spec Commissioning	TBC	(188)
Total DO Nothing	***(104)***	***(1,219)***

* *Figure not inclusive of children element*

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.

Health in summary

The health of people in Hillingdon is varied compared with the England average. The projected 2020/21 resident population is 321,000. Deprivation is lower than average, however about 20.1% (11,800) children live in poverty. Healthy life expectancy at birth for both men (65.5) and women (63.2) is similar to the England average.

Child health

At 3%, Hillingdon's low birth weight is similar to London average (3.2%) and England average (2.9%). Levels of excess weight and obesity are a growing threat to population health.

Adult health

The excess weight prevalence in adults (63.4%) is similar to the national average (64.6%). Hillingdon's utilisation of outdoor space (14.7%) is similar to the national average (17.9%). The incidence of TB in Hillingdon is (41.9 per 100,000) higher than for both London average (35.4 per 100,000) and national average (13.5 per 100,000). Cancer screening rates for breast (70.9%), cervical (66.9%) and bowel (52.1%) in Hillingdon are lower than national averages.

Reduce Childhood Obesity

Currently, excess weight in 4-5 year olds is 21% and, in 10-11 year olds is 32.6%.

In 2021:
Sustained reductions in excess weight in 4-5 year olds and 10-11 year olds in line with the national ambition.

Reduce Smoking Prevalence

Currently , the smoking prevalence in those aged over 18 in Hillingdon is 17.1%. This is similar to the England average (18%) and the London average (17%).

Smoking in pregnancy is 7.4% which is better than England (11.4%) , but worse than the London average (4.8%).

In 2021:
Reduce smoking prevalence in pregnancy due to high levels of premature births in Hillingdon.

Increase Physical Activity

Currently, 55% of Hillingdon's residents are physically active.

Hillingdon Council is working on increasing activity levels through a number of initiatives.

In 2021:
Increase physical activity rates in all age groups.

Help Improve Peoples Mental Health

Currently, prevalence of self-reported depression and anxiety in the Hillingdon GP registered population is 9.9%.

Hospital admissions for self-harm (10-24 years) was 234.7 per 100,000 population.

In 2021:
Improve pathways and response for individuals with mental health needs across the life course, including CAMHS.

Reduce Social Isolation

Currently, the proportion of people who use services and their carers who reported that they have as much social contact as they would like:
Users - 43.3%
Carers – 26.1%

In 2021:
Sustained increases in users and carers who report getting as much social contact as they would like.

Support to Manage LTCs

Currently, working on the common risk factors for premature morbidity and mortality
- Access to weight loss programmes for those with excess weight
- Lets Get Moving exercise referral scheme for those with chronic conditions
- NHS Healthcheck offer for 40-74 year olds for early identification and treatment of cardiovascular risk factors
- Smoking cessation service

Reduce Alcohol Admissions

The new recovery orientated substance misuse service (ARCH) went live 01/08/15.
It provides a liaison service within the hospital for patients whose admission is alcohol and/or drug related.

Public Health will work with the CCG to ascertain data regarding the number of alcohol admissions who have a dual diagnosis (e.g. mental health and alcohol misuse).

Make Every Contact Count

Making every contact count (MECC) is an integral part of the Hillingdon system moving forwards, with regular staff training across the borough.

In 2021:
Increase MECC training for all staff groups.

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 a 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.

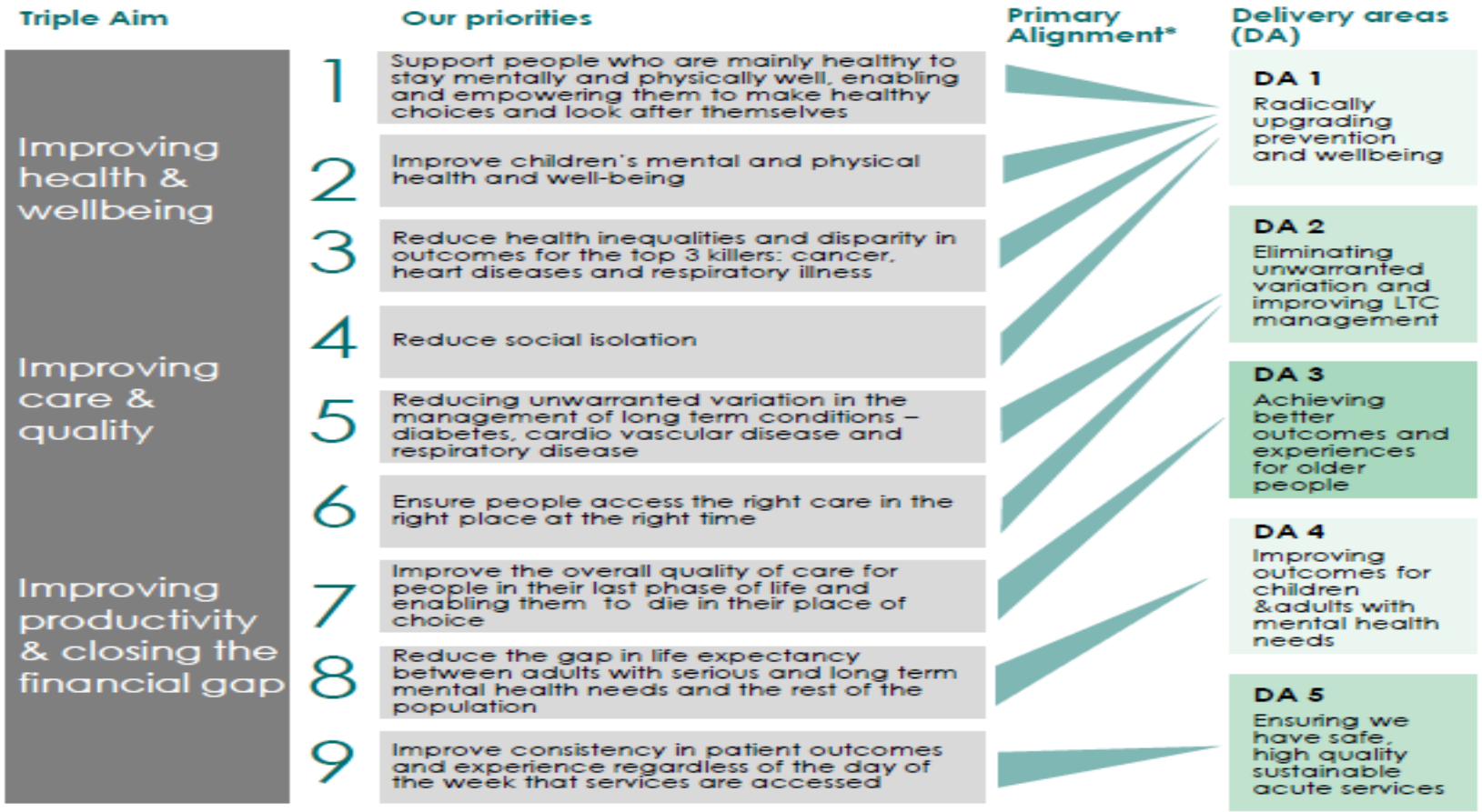
Finance & Efficiency

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.

Our Local Plans for Implementation Through the 5 Delivery Areas

How are we going to achieve our priorities through the 5 key delivery areas?

The NHS and local authorities across NW London have agreed to work together to deliver a better health and care system. The STP describes our shared ambition across health and local government to create an integrated health and care system that enables people to live well and be well. A draft plan of NW London's vision for improving the health and care system has been developed and was submitted to NHS England at the end of June and include 9 Priorities grouped in 5 Delivery Areas:



What will be different for Hillingdon residents in 2021?

DA 1 **Focus on prevention and wellbeing rather than treating illness**	*Our focus will be on developing services that place far greater emphasis on keeping people healthy and well in order to lead longer, more illness-free lives; preventing rather than treating illness.* *Our healthcare services will be focused on engaging people in keeping healthy.* *People in Hillingdon will have the support they need to manage of their own health and maintain their independence.*
DA 2 **Ensuring healthcare is delivered consistently well and improving the management of long term conditions**	*Healthcare services in Hillingdon are still not sufficiently joined up and do not deliver the best outcomes for patients. Services will work better together and there will be a reduction in variation in both quality of care and access to care throughout our Borough.* *Patients will receive more responsive, personalised care delivered out of hospital in a safe and effective way; such as our existing dermatology and pain management services.* *People with long term conditions will be supported to help lead a healthier life.*
DA 3 **Achieving better experiences and greater choice for older people in our communities**	*Our health and social care services will work better together to ensure local people receive better coordinated care – especially those with multiple long term conditions.* *The expansion of our community outreach programme will provide support for nurses and carers working to help their patients stay in the home for longer, rather than being taken into hospital.* *Mental health professionals and GPs will work better together with care home staff so they can help patients more effectively.* *We will have community based teams of local specialist clinicians including practice and community nurses, social care workers, allied health professionals, community mental health workers, GPs, and geriatricians.*

What will be different for Hillingdon residents in 2021?

DA 4 **Improving outcomes for children and adults with mental health and wellbeing needs**	*People in Hillingdon with mental health needs will have a single point of access and their requirements identified early to ensure prevention and improved wellbeing.* *Those with long term conditions will have psychological support in a community setting through local well-being and prevention services that are provided by primary, community and social care services working together in a coordinated way.* *Community based services will provide urgent, enhanced crisis and out of hours support giving people the care they need, in the best place and in a timely manner providing better opportunities for healthy active lives.*
DA 5 **Ensuring we have safe, high quality sustainable hospital services**	*Our hospitals will operate to a higher quality without the need for extra unplanned financial support with the ability to respond more effectively to increases in demand and provide more efficient diagnosis, timely triage and consultant services and effective transfer and discharge processes.* *Patients will see care beyond general practice services including specialist primary care outpatient clinics, treatment diagnostics and urgent care. Services will be coordinated and people in Hillingdon will receive complete 'joined up' care.*

What are we doing in 2016/17 against the 5 Delivery Areas?

Our local STP builds on a number of plans and strategies currently underway. There is therefore a great deal of work already in progress across the 5 Delivery Areas, some of which is detailed below and overleaf. Our plans for 2017/18 and 2018/19 are set out over the subsequent pages.

DA 1 *Radically upgrading prevention and wellbeing*	• Mental Health and Wellbeing Programme – producing a case for change including a range of support and wellbeing options focusing on the mental health of Hillingdon residents • By the end of 2016/17 supporting 3,500 patients to have a better understanding of their long terms conditions through the Empowered Patient Programme • Developing a new service model for people at risk of falls • Developing a model for strengthening medical support to care homes • Currently evaluating the effectiveness of the joint Better Care Fund schemes developed by Hillingdon Local Authority and CGG • Development of a three-year BCF plan joint with LBH by March 2017 • Sign-off and implementation of our local Prevention Strategy • Expanding our programme of medication reviews in GP Practices to ensure effective and cost-efficient use of medicines • Consult on and agree an air quality and public health action plan • Ongoing implementation of the new Hillingdon Carers Strategy • Understanding the impact of social isolation on the health of the Hillingdon population, identifying tools enabling early identification in a range of primary and social care settings and developing a case for change • Implementing Patient Champions in the Urgent Care Centre • Improve access to online advice
DA 2 *Eliminating unwarranted variation and improving LTC management*	• Delivering services for patients with LTCs (Cardiology, Respiratory and Diabetes) through community based multi disciplinary integrated teams • A redesigned service for children suffering from asthma conditions • Development of an accountable care partnership for the Hillingdon population • Develop a programme to focus on management of long term conditions co-morbidities • Enhancing the effectiveness of primary care IT systems through use of clinical decision support tools to help ensure patients access the right pathways • Implementation of Hillingdon Cancer Improvement Strategy • Implement National Cancer Vanguard Programme in partnership with Royal Marsden • Developing plans to create direct access cancer diagnostic capacity for Hillingdon GPs to support early diagnosis of cancer • Effectiveness of Long Term Condition Strategy to be captured and measured by patient outcomes data • Implement Remaining Cancer Stratified Pathways • Redesigning pathways for stroke and early supported discharge in community services, in partnership with local providers

What are we doing in 2016/17 against the 5 Delivery Areas (2)?

DA 3 *Achieving better outcomes and experiences for older people*	• Implementing a new Older People's Integrated Care service model • Implementing Intermediate Care 'In Reach' from Community /Third Sector from October • Reviewing Homesafe Programme (Early Supported Discharge) and expanding integrated discharge planning • Developing the accountable care partnership to support integration between acute, community, primary care health and social care / other local providers initially focusing around older people • Publish and begin to implement the new joint End of Life Strategy from December to improve planning of, access to and integration of end of life services, including a single point of access • Early identification and support for frail patients through implementation of frailty tool linked to risk stratification and care planning. Clear methodology to collect and use patient outcomes as a service improvement mechanism • Better engagement with voluntary and community sector via Hillingdon4All • Embedding health and wellbeing gateway and Patient Activation Measures (PAM) to support self-management • Embedding of memory clinics and ensuring robust links to primary care • Developing an integrated health and social care service model for Hillingdon • Developing a range of focused programmes targeting the Care Homes population • More patients able to access consultants in community setting including a new care of the elderly consultant post in Hillingdon A&E • Integrated service model available 7 days a week • Delivery of anticipatory care planning and coordinated care through deployment of Care Connection Teams across Hillingdon (following pilot)
DA 4 *Improving outcomes for children & adults with mental health needs*	• Developing a business case for services to support those in care homes with serious mental health needs by January 2017 • Implement and deliver national and NWL strategies - Future in Mind / Like Minded from March 2017 • Implementation of all age Early Intervention Services from October 2016 • As a part of further development of Hillingdon Urgent Care pathways we will develop clear mechanism for the Crisis Resolution Home Treatment rapid response pathways • Development of a strategy for adults and children with autism • Evaluating the effectiveness of 24/7 Mental Health Single Point of Access service model • Implementing new Community Learning Disabilities Service from July 2016, including ASD, ADHD packages of care to provide enhance health planning and community based services • Developing a Suicide Prevention Strategy following publication of audit in October 2016 • Roll out of a service for young people with eating disorders from August 2016 and embed enhanced crisis and urgent out of hours service for CAMHS • Developing CYP IAPT service in partnership with children & young people and their parents/carers • Improving perinatal mental health service provision along with the development and implementation of perinatal strategy • Ensure that mental health support to people with LTCs and at End of Life is integral to the ACP programme
DA 5 *Ensuring we have safe, high quality sustainable acute services*	• Focus on the 4 Acute Standards and seek selective delivery of services in other settings as per the strategy • Mainstreaming of 7 day therapy in HICU (intermediate care unit) by January 2017 • Develop dashboard to monitor outcomes and activity over 7 days • Developmental work with Bucks New University in partnership with THH, CNWL and others to ensure development of the future workforce. • CNWL leadership programme for all new Band 7 and 8a posts. • Review quality of Delayed Transfers of Care monitoring data to ensure patients receive seamless services • THH audit of neo-natal births & babies screening programmes. • THH working with GPs and community providers to pilot new models of acute care using a networked approach. • Master-planning process for redesign of the hospital site • Develop new consultant led escalation model for enhanced care linked to optimised community intermediate care services • Pilot a nurse-led acute medical clinic, before offering the service 7 days per week • Adopt e-prescribing at Hillingdon hospital and Mount Vernon hospital. • improve access to diagnostics - to ensure cancer RTT targets continue to be met

What will we be doing in 2017/18 against the 5 Delivery Areas?

DA 1 *Radically upgrading prevention and wellbeing*	• By the end of 2017 we will have rolled out a Joint Physical Activity strategy with LBH • BCF - evaluation of the effectiveness of interventions / schemes, and assessment of impact of benefit realisation on the NHS and LA • By September 2017 we will have expanded the Empowered Patients Programme to cover a wider range of conditions • From April 2017 we will begin to implement our Prevention Strategy • Rollout of Proactive Case Finding in Primary Care to be ready by September 2017 • We will expand Personal Health Budgets in Hillingdon, putting patients in charge of their treatment options • Expand the usage of Patient Activation Measures (PAM) • Expand access to and use of online information and advice • Ongoing implementation of the Hillingdon Carers Strategy • Delivery of wellbeing training programme for schools • Implementation of the recommendations from the audit of neo-natal births & babies screening programmes
DA 2 *Eliminating unwarranted variation and improving LTC management*	• By June 2017 we will rollout our approach to tackling co-morbidities and complex needs • Rationalisation of Primary Care Contracts and investment in enhanced, at scale primary care • By June 2017 we will complete analyses to help us close the gap between those who have diagnosed and un-diagnosed LTCs • Ongoing rollout of actions from our Cancer Improvement Plan • By September 2017 we will have mobilised new AF and stroke pathways and services • Continued delivery of National Cancer Vanguard Programme • Development of psychological support for people with long-term conditions including access to Talking Therapies • Enhanced progression of BHH RightCare Programme in line with strategic plans developed in October 2016 • Implementation of Primary Care Model of Care
DA 3 *Achieving better outcomes and experiences for older people*	• By April 2017 we will have embedded Care Connection Teams across Hillingdon • By June 2017 we will have rolled out the accountable care partnership model of care for older people • From April 2017 we will rollout new models of care for care homes integrating Primary, Community and Secondary Care support including embedding the use of frailty tools • Implementation of post discharge follow ups in the community • Rollout of the EoL Strategy and new integrated service model • Increase access to Coordinate My Care (CMC) • By April 2017 we will achieve full integration of Co-ordinate my Care and Primary Care clinical systems
DA 4 *Improving outcomes for children &adults with mental health needs*	• Delivery of the Like Minded Programme • Improve support for patients with MH related LTCs • Implement MH support for people with a physical LTC • Expand integrated care planning to include people with MH needs • Rollout new model of Community MH Support • Rollout SPA for CYP • Implement crisis and out of hours support for CAMHS • Implementation of the strategy for adults and children with autism
DA 5 *Ensuring we have safe, high quality sustainable acute services*	• Provide medical retina services at Mount Vernon hospital to treat macular degeneration • Focus on additional 7 Day Standards • Develop ambulatory acute care for frail elderly by adopting a networked approach • Finalise Local Services Strategy for Hillingdon • Rollout new 111 Service and Primary Care Triage Model • Improved access to consultant led paediatric services

What will we be doing in 2018/19 against the 5 Delivery Areas?

DA 1 *Radically upgrading prevention and wellbeing*	• By April 2018 we will complete evaluation and further development of Empowered Patient Programme • Bu January 2018 the Hillingdon Prevention Strategy will be fully implemented • Further implementation of Personal Health Budgets focusing on patients outside of Continuing Care • Evaluation of screening outreach programmes • Additional promotion of assistive technologies e.g. telecare and telehealth • Opening of two extra care sheltered units for older people • Expanded access to and use of online advice
DA 2 *Eliminating unwarranted variation and improving LTC management*	• By March 2019 we will complete a review and evaluation of our Cancer Improvement Plan • We will continue delivery of the National Cancer Vanguard Programme • Psychological support to people with long-term conditions will be fully embedded within Hillingdon health systems • Delivery of Primary Care Model of Care
DA 3 *Achieving better outcomes and experiences for older people*	• Enhanced progression of BHH RightCare Programme • Proactive identification and engagement at primary care level with groups at high risk of developing LTCs • Further development of the ACP Model • By March 2019 we will have evidence of closing the prevelance gaps between those with diagnosed and un-diagnosed LTCs • Evaluation and further development of programmes focussed on the care homes population • Delivery of EoL Strategy and new integrated service model • Further expanded access to Coordinate My Care (CMC) for proactive care planning • Delivery of a paperless system through the full integration of Co-ordinate my Care and primary care clinical systems
DA 4 *Improving outcomes for children &adults with mental health needs*	• Ongoing delivery of the Like Minded Programme • By January 2019 full operational delivery of the strategy for adults and children with autism • By March 2019 we will complete evaluation of support programmes for patients with MH related LTCs • Delivery of new model of Community MH Support • Delivery of Community LD Services • CYP SPA – evaluation process • Further delivery of wellbeing programme training programme for schools
DA 5 *Ensuring we have safe, high quality sustainable acute services*	• Full implementation of 7 Day Standards

Main Challenges Facing Delivery

The following is a summary of the challenges to the implementation of Hillingdon's plans for the 5 Delivery Areas

Hillingdon Health & Wellbeing Gaps

- Wider population health – development of range of interventions to prevent deterioration – management of demand by preventing or delaying the onset of ill-health
- Resilience in primary care
- Development of localised programmes enabling people managing their own conditions through easily available education, tools and support enabling them to remain as healthy as possible
- Greater presence and capacity of voluntary sector in supporting communities with their health and wellbeing resulting in less demand for primary and acute care as a result of community interventions
- Management of organisational change - health system wide consideration of Social Isolation as a Long Term Condition and its impact on both the physical and mental wellbeing of local population
- Development of new service models utilising integration of care home support with health and social care services
- Development of robust methodologies enabling effective access to information - whole system understanding of services available allowing for referral to the most appropriate service regardless of commissioner
- Development of localised service models based on needs of local pupation at locality level - meeting the needs of individuals with mental health problems from marginalised groups including Black and Minority Ethnic (BME) communities, homeless people, older adults, those in contact with the criminal justice system and people with learning disabilities have a further elevated risk of poor health outcomes

Hillingdon Care & Quality Gaps

- Current capacity of the health system - the most likely growth assumptions over the next five years will see approx. 21% more activity
- Access rates to first intervention – development of new referral / care pathways
- National shortage of suitably qualified staff
- Improved pathways for vulnerable groups including looked after children and people with learning disability
- Development of an understanding about future workforce gap for new service model
- THH estates gap – chronic condition of physical infrastructure and inefficient space constrains service provision. Significant capex required
- Gap to ensure appropriate set up/step down facilities, hospital front end primary care, increased diagnostic and ambulatory care provision
- Equitable access to care and support regardless of time of day or place of residence

Hillingdon Finance & Efficiency Gaps

- High cost acute activity can only be reduced by re-orientating the entire health and care economy towards prevention and integration
- Capital investment – estates to meet new capacity demands
- Pooled budgets and joint commissioning - Shared KPIs and performance management framework to ensure priorities are aligned / Best Value for the available funding
- Delivery of efficiencies through our existing and emerging QIPP Efficiency Schemes.
- Estate rationalisation to reduce the operational footprint and also to build on our hub strategy.
- Identification of efficiency savings through improved management of patients with LTCs and focusing on Prevention.
- Reduction in Length of Stay and Admission Rates (when clinically appropriate) as system wide contribution to reduction of overall bed usage.

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 informing 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.Transforimg Care for People with Cancer	X		X	X		X	X		X	X	X	X		X	X
6. Effective Support for People with a Mental Health need and those with Learning Disabilities	X		X				X	X	X	X	X	X			
7. Integrated Care for Children & Young People	X							X	X	X	X	X	X	X	X
8. Integration across Urgent & Emergency Care Services	X	X		X	X		X	X	X	X	X	X	X	X	X
9. Prevention of Disease & Ill-Health	X	X	X	X			X			X	X	X			
10. 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	• Reduction in Non-Elective Admissions • Reduction in Zero-Length of Stay Admissions • 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 of capitated budget as part of ACP	• Rollout new care model via ACP 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 patients managed outside of hospital setting with integration across Primary, Community & Secondary Care Services and Social Care	• Five Year Forward View	• Increase in activity managed outside of a hospital setting • 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	• Increase in people dying in their preferred place of death • Increase in people with anticipatory care plans • 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	• Reduction in prevalence growth • Reduction in prevalence gap • Reduction in unplanned events for people with LTCs • Reduction in the costs associated with supporting people with LTCs • increase in people with an LTC who self-manage elements of their care • Increase in people with an LTC who have an anticipatory care plan • 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	• 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 • 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. Transforming Care for People with Cancer	• Holistic pathways covering both medical and non medical care pathways elements • Integrated cancer rehab • Early identification • Improved uptake rates for screening programmes • SPA survivorship service model • DA and STT diagnostics model	• Hillingdon Cancer Improvement Plan – Cancer Strategy • London Cancer Strategy	• Reduction in unplanned events • Early identification of Cancer patients in primary care/community settings • GP DA and STT community diagnostics • Pathway stratification • Treatment options close to patients homes	• Finalise rollout of Cancer Stratified Pathways • Roll out Lymphedema service model • Develop Hillingdon Cancer Board for non clinical cancer support services • Develop diagnostic capacity to meet demands and targets for Cancer pathways • Review screening programmes • Review Q Cancer Tool utilisation	• Roll out clinical protocol for the follow ups in community • Develop SPA rehab model • Implementation of DA and STT • Rollout outstanding actions from Cancer Improvement Plan

Our Transformation Programmes in Detail

HILLINGDON TRANSFORMATION PROGRAMMES

	2020/21 OUTCOMES	UNDER-PINNING STRATEGIES	EXPECTED IMPACT	KEY 16/17 ACTIONS	ACTIONS 17/18+
6. 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	• Reduction in the mortality gap • Reduction in the unplanned care costs associated with supporting vulnerable people and those with an LD • Reduction in unplanned care needs arising for people with a known mental health condition	• 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
7. 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	• Reduction in the need for secondary care activity associated with CYP • Reduction in unplanned care needs for CYP • 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
8. 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	• Reduction in rate of growth for unplanned attendances at hospital • Increase in people accessing non-hospital based support for their unplanned care needs • Reduction in the costs per capita managing unplanned care needs • Reduction in Zero-Length of Stay and Unplanned Admissions • Reduction in Length of Stay following an unplanned admission	• 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

Our Transformation Programmes in Detail

HILLINGDON TRANSFORMATION PROGRAMMES					
	2020/21 OUTCOMES	**UNDER-PINNING STRATEGIES**	**EXPECTED IMPACT**	**KEY 16/17 ACTIONS**	**ACTIONS 17/18+**
9. 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	• Reduction in the prevalence gap for key conditions • Reduction in the rate of growth of prevalence • 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 gap
10. 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	• Reduction in growth rate for planned attendances and admissions • Increase in planned care provided in non-hospital based settings • 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 • Re-establish 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 PROGRAMMES					
	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 • Brunel University London (BUL) with THH NHSFT and CNWL NHSFT establishing an Academic Centre for Health Sciences • Develop plans with Buckinghamshire New University for workforce development	• Rollout recruitment and retention strategy and workforce plans
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 • Development of diagnostic capacity to meet demands and targets for Cancer pathways	• Rollout resilience plans

Our Enabling Programmes in Detail

HILLINGDON ENABLING PROGRAMMES					
	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	• Implement ePrescribing in acute care • 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 and care needs of the local population within the financial constraints • A diverse market of quality providers maximising choice for local people	• 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 • THHFT Estates Master planning for new hospital build • Joint market shaping activities with CCG and LBH for care services	• Rollout and trial ACP model and develop plans for future cohorts • Develop Network Development Strategy • Implement recommendation of THH master planning exercise • Implement the 2016/17 market shaping activities