NHS
Hillingdon
Clinical Commissioning Group

Commissioning Intentions 2018/19

DRAFT September 2017

Content

Section 1: About Hillingdon CCG (HCCG) & Aim of the Commissioning Intentions

Section 1a: About Hillingdon CCG

Hillingdon Clinical Commissioning Group (CCG) is the public agency responsible for purchasing most of the health services for the people of Hillingdon. We operate within a financial budget and aim to ensure that we use the money given to us to purchase health services that are appropriate, effective and safe and that offer value for money. Hillingdon CCG's role is to ensure that the health services in Hillingdon are designed in a manner that meets the highest possible standards of quality as well as the needs and reasonable expectations of our population now and prepares the way for changing health needs over the coming years. We are required to meet statutory financial obligations to remain in balance and maintain a 1% surplus. This document aims to set out how we will achieve these requirements in 2017-18.

**The population of Hillingdon includes all patients registered with a Hillingdon based GP and unregistered people resident in Hillingdon. Some elements of health care are commissioned by the London Borough of Hillingdon (LBH) and, particularly for Primary Care, other bodies such as NHS England (NHSE). In 2015/16 the CCG entered into an agreement around Co-Commissioning for Primary Care with NHS England (where the parties share responsibility for commissioning GP Based Services in Hillingdon) and this relationship continues to evolve.*

Section 1b: Aim of the Commissioning Intentions

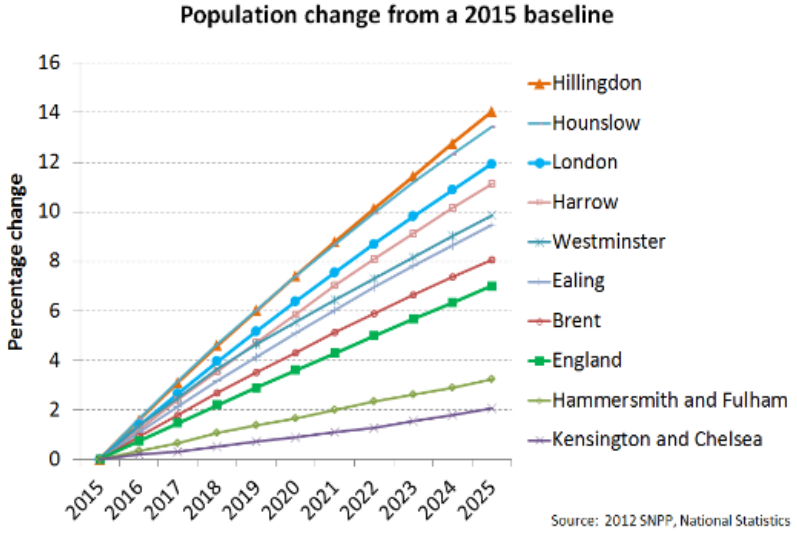
The aim of these Commissioning Intentions is to provide an overview of Hillingdon CCG's plans to purchase (commission) high quality health care to improve the health outcomes for Hillingdon patients for the Financial Year 2017-18 (FY18/19) and to set the scene for how we envisage services transforming over future years. To develop these Commissioning Intentions we have talked to a wide range of local people including patients, carers and the wider public along with our providers of healthcare services and our members in General Practice. We have also drawn on a wide range of sources of information and feedback. In Hillingdon we are continuing to work towards establishing a model of 'accountable care' where we commission providers of services to work together to look after the needs of a whole population, rather than commissioning distinct services that can sometimes be fragmented and duplicative. 2017-18 will provide us with an opportunity to test the effectiveness of this approach with our local providers.

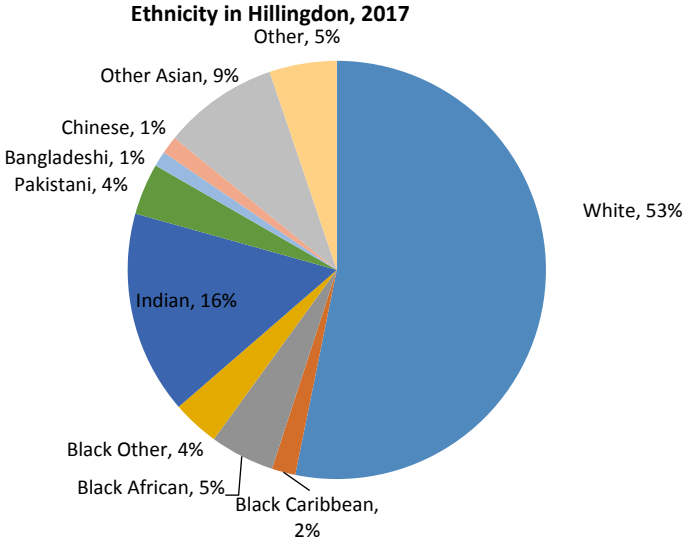
The Commissioning Intentions for 2017-18 is a living document that will evolve over time based on further engagement activities with the public, partners and providers. This document should also be read in conjunction with the Commissioning Intentions stated for NHS England (NHSE) and for the North West London Collaborative of CCGs.

Section 2: The Health Landscape in Hillingdon

Section 2a: Demographics

Hillingdon is the second largest London borough by area, located 14 miles from central London with the 12th largest population. Projections from the Office for National Statistics (ONS) indicate the Hillingdon population in 2018 will be 314,300 with 23,200 (7.4%) aged 0-4 years, 41,500 (13.2%) aged 5-14 years, 208,400 (66.3%) aged 15-64 years, 21,700 (6.9%) aged 65-74, 13,100 (4.3%) aged 75-84, and 5,800 (1.8%) aged over 85. The age structure of the population in Hillingdon is intermediate between London and England, with a distribution that is slightly older than London as a whole but younger than England. Among children and young adults however, there is a larger proportion resident in Hillingdon than for both London and England. Growth of just over 13,300 residents is projected between 2018 and 2021, with the largest growth being those aged 15-64 (9,300 [4.5%]) and 5-14 (3,700 [8.8%]). However by proportion older people aged 75-84 (11.3% [1,500]) and aged 85 and over (15.6% [900]) will grow faster than other age groups. Comparatively, the population growth in Hillingdon is projected to be higher than any other North West London CCG and will be above both the average for London and England. Hillingdon is also an ethnically diverse borough with 46.9% of residents in 2017 from Black and Minority Ethnic (BAME) groups. Population projections for Hillingdon suggest that BAME groups are increasing as a proportion of the population, with 50.4% of residents from BAME groups by 2021. Hillingdon is an ethnically diverse borough with 46.9% of residents in 2017 projected to be from Black and Minority Ethnic (BAME) groups. Population projections for Hillingdon suggest that BAME groups are increasing as a proportion of the population, with 50.4% of residents from BAME groups by 2021.





Section 2b: Health profile

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

- People living in Hillingdon live longer and healthier lives compared to the average for England.
- Adults in contact with secondary mental health services live in stable and adequate accommodation.
- Good levels of breastfeeding, which provides the best start in life for babies and leads to a healthier life, are higher in Hillingdon than the national average.
- A lower proportion of pregnant women in Hillingdon smoke, compared to the rest of England.
- Rates of teenage pregnancy in Hillingdon are similar to England average.
- Fewer people are admitted to hospitals in Hillingdon with an alcohol-related condition than the England average.
- Early death rates (under age 75) from respiratory diseases are lower than the England average.

However, this is just one part of the picture as some of our health outcomes are also significantly worse than the national averages.

- Rates of social isolation among social care users and their carers are still too high.
- Accommodation and employment needs of adults with learning disabilities are not being adequately met.
- A higher proportion of children aged 10-11 are overweight / obese as compared to the national average.
- Proportion of 5 year old children free from dental decay are significantly worse than the national average.
- Rates of childhood vaccination are lower than the national average.
- Proportion of adults who are physically active is lower than the national average.
- Deaths rates for men aged 75 or under from cardiovascular diseases is significantly higher than the England average.
- Cancer screening rates are low and the percentage of population being offered an NHS health check is low.

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

which increases dependency on care and support. Some of us are born with conditions which might require long term care and management, including physical and/or learning disability, and child and adult mental illness.

Hillingdon's Joint Strategic Needs Assessment (JSNA) identifies key health and wellbeing needs of people in Hillingdon toward informing strategic prioritisation of health and care transformation programs. It is regularly updated with the latest available information to ensure our programs and priorities are able to respond to the changing needs of our population. Our JSNA is available to read online at http://www.hillingdon.gov.uk/jsna. The JSNA is a key document informing the priorities and outcomes in this strategy. The JSNA underpins Hillingdon's Joint Health and Wellbeing Strategy (JHWBS), which is the overarching local strategy roadmap to addressing health and wellbeing needs and outcomes in Hillingdon.

Section 3: Strategic Context: The Sustainability & Transformation Plan (STP)

In developing our local Commissioning Intentions, Hillingdon CCG (HCCG) not only needs to consider our local challenges but the needs and challenges in the wider context of North West London and nationally. This chapter starts by exploring the national context and the North West London response to these challenges before outlining the local challenges.

Section 3a: The National Strategic Context

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

The Five Year Forward View further sets the Triple Aims of improving people's health and well-being, improving the quality of care that people receive and addressing the financial gap between the cost of expected services and planned budgets. This new approach across health and social care works to ensure that services are planned with a focus on the needs of people living in the area. As part of this new approach, the NHS recently organised itself into 44 Sustainability and Transformation Partnerships (STP) across England. Hillingdon is a member of the North West London STP (NWL STP). Through joined up STP working, the NHS will address population health and wellbeing needs through new ways of delivering care; better public health and prevention of ill health; joining up services across health and social care; empowering patients and communities; strengthening primary care; and achieving needed efficiencies in health and care services.

Section 3b: The North West London Sustainability & Transformation Plan (STP)

NHS organisations and local authorities of NWL STP have developed Sustainability and Transformation Plans, taking as its starting point the ambitions and knowledge in the national NHS Five Year Forward View strategy and applying them to the needs of the NWL STP. The NWL STP plan is characterised by broad and overarching themes common to each of the local areas to align local and regional goals. It aims to bring together local organisations to answer the challenge of delivering better health and care services according to the Triple Aims of the Five Year Forward View through nine priorities and five Delivery Areas. The NWL STP priorities and Delivery Areas are set out below.

North West London Priorities and Delivery Areas

Section 3c: The Local Digital Roadmap (LDR) for North West London (NWL)

The NWL LDR is key to supporting the identified STP priorities, harnessing technology to accelerate change as the NWL care community moves towards greater digital maturity in delivering clinical services – creating digitally connected citizens and care professionals. The main components of the LDR strategy are:

1. **Automate clinical workflows and records,** particularly in secondary care settings (primary care is already largely paper-light) to **remove the reliance on paper** within care settings and **support transfers of care through interoperability**, replacing paper correspondence between care settings

2. **Build a shared care record across all care settings**, again through interoperability, to deliver the **integration of health and care records** required to support emerging and new models of care, including the transition away from hospital care to new settings in the community and at home

3. **Extend patient records to patients and carers**, to help them to become more **digitally empowered** and take an active role in their own care, and supporting the shift to new channels of care

4. Provide people with **tools for self-management and self-care**, further supporting **digital empowerment** and the shift away from traditional care to new channels

5. Using **dynamic data analytics** to inform care decisions and support **integrated health and social care through whole systems intelligence**

To ensure the elements of the LDR deliver to best effect we need a continued focus on some of the underpinning principles of high quality IT including:

- Improved accuracy, timeliness and quality of data entered into clinical and non-clinical systems
- The mandated use of NHS number as patient identifier by all providers
- Ensuring data is safe and secure, further embedding role-based processes for access and as much as possible ensuring that access is systematised
- Identification and mitigation of issues of non-compatibility across software packages
- Maximisation of the opportunities presented by mobile working to reduce the need for double-entry and increase time for patient-facing activity

There is also a need to address how data is transmitted. In the last 5 years there has been a huge increase in the amount of data being transmitted to and from services. To allow for this growth to continue we will have to address the limits being imposed by the current service provider (N3). Working with partners across the system and ensuring that we align our commissioning and contracting intentions to these priorities will accelerate and strengthen the systematic use of data and information to deliver high quality, timely, secure and person-centred care.

Section 3d: The North West London 'Transforming Care Partnership Plan' (TCP)

The North West London (NWL) 'Transforming Care Partnership Plan' (TCP) focuses on improving the quality of life, life chances and expectancy and range of local services for children, young people and adults with learning disabilities, autism and challenging behaviour. This covers such things as:

- **Community Support:** including the utilisation of more skilled staff to manage more people with complex/challenging behaviour. This will specifically focus on accommodation and behavioural support for this cohort, informed by the market development work that we will undertake within NWL.
- **Crisis Care Pathways:** available 24 hours a day, 7 days a week, that ensure people with a learning disability and their families and carers receive care that meets their needs in times of crisis including when the crisis occurs outside of the standard working hours.
- **Community Forensic Pathway:** Development of a North West London service for people who have a forensic history and present a high risk of offending to provide the specialised psychological support required. This also includes people with Asperger's syndrome.

The overarching outcomes of the TCP are to:

- Reduce the reliance on inpatient services and strengthen support in the community.
- Improve quality of life for people in inpatient and community settings.
- Build up the community capacity to support the most complex individuals in a community setting and avoid inappropriate hospital admissions.

This is with view to:

- Supporting a universal level for positive access to, and effective response from, mainstream services.
- Targeted work with individuals and services enabling others to provide person centred support to people with learning disabilities and their families/ carers.
- Responding positively and effectively to crisis presentation and urgent demands.
- The quality assurance and development of strategic services in support of commissioners.
- Specialist direct clinical therapeutic support for people with both behavioural and health support needs.

Hillingdon's TCP Local Annexe can be found at:
https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/tcp_local_annex_hillingdon.pdf

Section 3e: The Local Financial Challenge

Between 2016/17 and 2020/21 it is expected that demand for services will increase by ~21%. This is made up of the expected growth in the population (called demographic growth) of ~7.4% and the growth in the prevalence of disease and ill-health through such things as increasing rates of diabetes (called non-demographic growth) of ~13.2%.

If we compare the expected growth in demand with the financial allocations we expect from NHS England over the next five years (this being the amount of money available to Hillingdon CCG to spend on healthcare services) we predict that Hillingdon CCG will develop a gap of ~£40m between now and 2020/21. It is therefore essential that our plans include a range of approaches to address this gap including preventing people becoming ill in the first place (through encouraging healthier lifestyles) as well as ensuring that the services we commission are truly delivering the outcomes we expect, in a way that provides best use of resource – integrating where appropriate, reducing duplication and improving coordination. In addition to the budgets we hold as a CCG substantial commissioning budgets are held by NHS England for specialist commissioning and primary care. The numbers in this document do not include the impact of those budgets if responsibility for them were to transfer to the CCG.

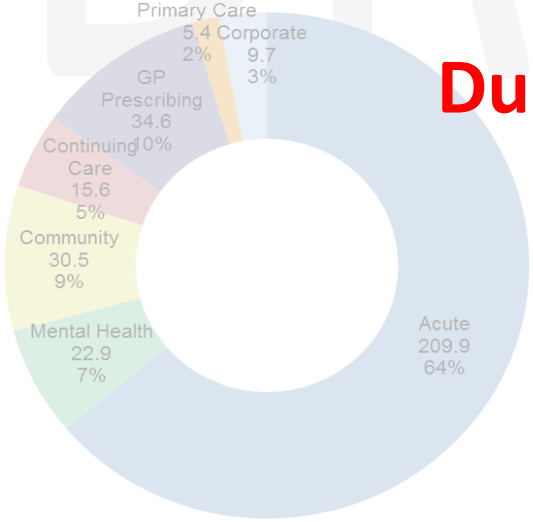
The following diagrams show how expenditure is likely to change based on projected allocations to CCGs over the period to 2020/21:

LOCAL FINANCIAL CHALLENGE

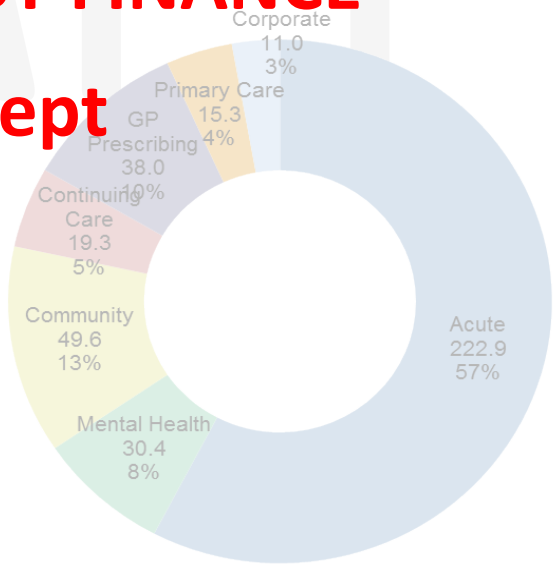
TO BE UPDATED BY FINANCE

Due end Sept

2015/16 (Total Spend £328.4m)



2020/21 (Total Spend £386.5m)



As mentioned, the growth in allocated funding for the CCG is expected to be less than the costs associated with the growth in demand. The savings (QIPP efficiencies) that are therefore required to ensure the CCG is sustainable are aligned to 10 Transformation Themes described in Section 7. Indicative efficiencies are stated for each year from 2016/17 to 2020/21. The reason for these figures being indicative is that it is difficult to fully disaggregate the expenditure for (say) Urgent & Emergency Care from the expenditure on Children & Young People as there is a significant overlap between the two. Both the QIPP targets stated in Section 7 and the estimated expenditure against each Theme stated below are therefore meant as an estimate and are both subject to change.

An indication of the settings where savings might be realised is given in the table below:

NET QIPP SAVINGS

	16/17	17/18	18/19	19/20	20/21	Total
	£'000	£'000	£'000	£'000	£'000	£'000
QIPP						
Acute	(8,977)	(9,118)	(8,602)	(8,520)	(8,765)	(43,982)
MH	(483)	(506)	(567)	(583)	(596)	(2,528)
Community	(1,354)	(714)	(293)	(618)	(574)	(3,552)
CHC	(294)	(305)	(174)	(304)	(182)	(1,459)
Primary Care	(1,500)	(1,650)	(1,574)	(1,512)	(1,444)	(7,680)
Reprovision Costs	4,163	2,950	3,700	3,100	2,750	16,663
Total	**(8,646)**	**(9,137)**	**(7,509)**	**(8,436)**	**(8,811)**	**(42,539)**

LOCAL FINANCIAL CHALLENGE

TO BE UPDATED BY FINANCE

Due end Sept

This is further broken down by the POD (Point of Delivery) as shown below:

	16/17	17/18	18/19	19/20	20/21	Total	Total
	£'000	£'000	£'000	£'000	£'000	£'000	Activity
Acute QIPP PODs							
A&E	(173)	(544)	(454)	(453)	(453)	(2,076)	(18,135)
Non-Elective Spells	(4,329)	(4,647)	(5,083)	(4,503)	(5,056)	(23,617)	(11,787)
Elective Spells	(75)	(1,001)	(1,001)	(1,001)	(1,001)	(4,079)	(3,299)
1st Outpatient attendances	(787)	(581)	(533)	(432)	(605)	(2,938)	(17,995)
All Subsequent Outpatient attendances	(1,298)	(1,276)	(1,203)	(1,102)	(1,124)	(6,004)	(58,586)
Other	(2,315)	(1,009)	(329)	(1,029)	(526)	(5,267)	(8,995)
Total	(8,977)	(9,218)	(8,602)	(8,520)	(8,765)	(43,982)	

LOCAL FINANCIAL CHALLENGE

TO BE UPDATED BY FINANCE

Due end Sept

Section 3f: Responding to Local Challenges

The previous section outlined the financial challenge faced by the CCG in the forthcoming years. To enable the CCG and our partners to continue to be able to deliver high quality, accessible services then we will need to change the way that patients are identified, supported, informed and involved including through the ways described below:

1. Proactively identifying people at risk of developing disease and ill-health and supporting them to avoid developing Long Term Conditions.
2. Managing people with Long Term Conditions to keep them stable and healthy for longer and therefore reducing the need for hospital based services.
3. Ensuring that people with an urgent or unplanned need are treated in the most appropriate setting which may not be at hospital.
4. Working across health and social care boundaries to provide truly integrated services for children, people with a mental health need and older people.
5. Moving services out of hospital into lower cost settings where appropriate.

To support the changes in our services outlined above we intend to test a new way of commissioning our providers that enables staff from different services and organisations to work together, delivering care that is centred on the patient without different funding streams, organisational targets and incentives getting in the way. **[UPDATE ON ACP TBC AFTER SEPTEMBER WORKSHOP]**

Transformation Plan (STP) and what we wish to do locally Hillingdon CCG has built the 18/19 Commissioning Intentions around 10 Transformation Themes and 6 Enabling Themes. The full list of the Transformation and Enabling Themes are detailed below and are expanded upon in Section 7:

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

These Themes (Transformation & Enabling) are aligned to the 22 Improvement Areas stated within the NWL STP as shown in the table below:

NWL STP Improvement Area	Main Alignment To The Hillingdon CCG Transformation & Enabling Themes
1. Enabling & Supporting Healthier Living	All 10 Transformation Themes
2. Wider Determinants of Health Interventions	(T4) (T9)
3. Helping Children To Get The Best Start In Life	(T7)
4. Address Social Isolation	(T1) (T4) (T5) (T9)
5. Improve Cancer Screening To Increase Early Diagnosis & Faster Treatment	(T5)
6. Better Outcomes & Support For People With Common Mental Health Needs, With A Focus On People With Long Term Physical Health Conditions	(T4)
7. Reducing Variation By Focusing On RightCare Priority Areas	(T2)(T4)(T5)(T9)(T10)
8. Improve Self-Management & "Patient Activation"	(T4)
9. Improve Market Management & Take A Whole Systems Approach To Commissioning	(T10)(E6)
10. Implement Accountable Care Partnerships	(E6)
11. Implement New Models of Local Services Integrated Care To Achieve Consistent Outcomes & Standards	(T1)(T2)(T3)(T8)(E4)(E5)
12. Upgrade Rapid Response & Intermediate Care Services	(T1)(T8)
13. Create A Single Discharge Approach & Process Across North West London	(T1)(T8)(T10)
14. Improve Care In The Last Phase Of Life	(T3)
15. Implement The New Model Of Care For People With Serious & Long Term Mental Health Needs To Improve Physical & Mental Health & Increase Life Expectancy	(T6)(E5)
16. Address The Wider Determinants Of Health	(T1)(T4)(T9)
17. Deliver Crisis Support Services Including Delivering The 'Crisis Care Concordat'	(T6)(T8)
18. Implementing "Future In Mind" To Improve Children's Mental Health & Wellbeing	(T4)(T7)
19. Specialised Commissioning To Improve Pathways From Primary Care & Support Consolidation Of Specialised Services	(T2)(T10)(E5)
20. Deliver The 7 Day Services Standards	(T10)(E4)
21. Reconfigure Acute Services	(T8)(T10)(E4)
22. Deliver The North West London Productivity Programme	All Transformation & Enabling Themes

Section 4: Listening to the Voice of Local People

Engagement has been a journey for Hillingdon. It started in 2012 with the formation of CCGs. The focus on membership engagement was necessary to first agree the principles that would be set out in the CCGs constitution. The process taken to agree the constitution paved the way and the CCGs approach to public engagement and involvement. Now in its fifth year of operation the CCGs approach to engagement has matured enabling the organisation to offer a tailored approach to the gathering and feeding back of patient, public and member intelligence.

For example patients, members of the public and CCG members told us:

- They needed a more in-depth Hillingdon-specific data set to understand the needs of the different communities across Hillingdon
- The CCG needs to engage with voluntary sector organisations who also manage patients and policies across Hillingdon
- The CCG needs to inform every one of the changes to their GP services and get their views on what is needed
- You wanted to further engage with residents of both Heathrow Villages and the traveller populations so that service specification recommendations could be reflective of this disempowered cohort

So we:

- Designed and delivered a successful targeted engagement strategy to specifically involve and include the diverse population across the borough
- Identified and nurtured relationships with key stakeholders from local and national patient facing organisations, engaging via various platforms including face to face and digitally, to both learn from their experiences with Hillingdon residents and engage outwards with our parallel patient engagement opportunities.
- Designed and implemented a communication and engagement strategy to inform and empower patients of both relevant practices, to invite and listen to their views, and to feedback regularly on the various stages of the consultation and decision making process.
- Reached out to these communities and had conversations with key stakeholders from the community action groups and public representation organisations, as well as the council and desk based research into current provision and demographics. We collated this information and data into a key recommendation which has been adopted in the final service specifications.

In summary NHS Hillingdon CCG want every resident and member to have a voice, to know, by evidence of the CCGs actions and not just from writing on a PowerPoint presentation that their involvement is respected and that their views can and will support the transformation and longevity of local health services. To do this the CCG have been and will continue to work in a way that will meet and exceed the outcomes of this vision. We will be flexible with our approach by tailoring its methods and reviewing its equality and diversity approach regularly to constantly align with changing plans and demographics of Hillingdon.

Section 5: Our Local Quality Priorities

Section 5a: Our Vision for Quality: 'Improving quality creating consistency'

We believe that the people of Hillingdon are entitled to a high quality and safe experience in any of the healthcare services commissioned by Hillingdon CCG. We will continue to listen to our patients and carers and work with all our service providers to achieve continuous improvement and reduce variation in the quality of their services.

Our quality duty is a statutory obligation and we consider we are well placed to assure people about the quality of the health services they commission. This is because we:

- Are a clinically led commissioning organisation
- Have in-depth knowledge about local health services and communities
- Involve local people in the design of healthcare services and receive and analyse their feedback
- Are dedicated to placing quality at the heart of commissioning activities
- Work in close partnership with other commissioners

We will ensure learning from our quality and safety assurance processes is triangulated from a variety of sources to inform what high quality, safe and effective care looks like across the Borough of Hillingdon.

From our engagement sessions we have learnt that the following are key priorities for our patients and carers:

Key priority for our patients and carers	What We Will Do
Provide Seamless Services Across Providers	We will continue to foster partnership working across organisations both through our on-going Clinical Quality Review Group structure and through the development of our Accountable Care Partnership. The development of the Sustainability & Transformation Plan for North West London has also given us the opportunity to work with partners to understand how we can improve services. Lastly, we will continue to progress the existing integrated care services we have already introduced and those we are planning including for people at End of Life and those for people with various Long Term Conditions.
Improve partnership working across health and social care services	We will continue to share ideas and discuss opportunities with our social care partners and have various forums for this to occur within. We are exploring additional opportunities for joint working and joint commissioning with a focus on Children and Young People as well as services provided for older people.
Rapidly reduce the variation in care received across and within providers	This is a major reason for the work we have done to date to integrate services for people with Long Term Conditions (which include Diabetes, Respiratory Diseases and Cardiology). We will extend this work and will also be working with Primary Care Colleagues to develop a new Model of Care for Primary Care and a joint Prevention Strategy that will focus on both primary prevention (preventing disease and ill-health) and improving outcomes for people with Long Term Conditions once diagnosed.
Be open and transparent and be honest when things do not go as planned	We continue to undertake audits and to manage complaints we receive robustly. We monitor provider quality through our Clinical Quality Groups and constantly review whether we are seeking sufficient and appropriate assurance of the quality they are receiving, something we obtain through direct and indirect patient feedback as well as a range of quality indicators.
Ensure care is delivered with compassion and that it is personalised to the needs of each person	We will monitor and review the trends and themes from our provider patient experience teams which includes; complaints, friends and family test results and patient surveys. Any concerns in relation to these will be explored via the Clinical Quality Review Group.
Ensure providers continue to have a safe and skilled workforce that feel valued in their work	We will continue to monitor the providers' safer staffing reports and their staff surveys via the Clinical Quality Review Groups and seek assurances and actions when there are concerns raised in relation to the workforce.

Section 5b: Our Quality Principles

The CCG Quality and Safety team apply the following principles to all of the work done within the CCG:

- Apply systematic approaches to monitoring and improving quality with the patient at the centre and with them in the line of sight.
- Proactively address any organisational barriers which hinder quality of care.
- Foster an open and transparent culture across the local health system.
- Maintain a systematic approach to proactive and early identification of service quality failures.
- Ensure there are robust links between commissioning priorities, the strategy and transformation plans and quality.
- Prioritise our quality assurance and improvement efforts developing an integrated approach with social care to reflect the Better Care Fund changes.
- Drive effective engagement with key stakeholders across BHH to achieve the delivery of robust measurable outcomes that reflect *"what matters most to patients".*
- Build work streams to define robust integrated quality & safety indicators that will deliver agreed Place Based outcomes.
- Ensure evidence based guidance & learning from assurance processes across Health and Social Care underpin & inform the design of outcomes to support place based care.
- Ensure "I statements" from patients, families and carers engagement events are reflected in indicators and outcomes when redesigning services and measures.
- Ensure that governance and assurance mechanisms are appropriate to support "Place based" commissioning between the local authority and the CCG including: integrated pathways, integrated contractual monitoring (CQRG), integrated assurance visits, shared quality improvement plans.
- Embed the application of Quality Impact Assessment methodologies across Local Authority and CCG **QIPP (Quality, Innovation, Productivity and Prevention**) & financial plans including commissioned providers.

As an integral part of the commissioning process we will monitor the impact of our intentions and the quality improvements to services on a regular basis. We will do this via a series of quality and health impact and outcome assessments including carers impact assessments.

Everything we do is focused on delivering high quality care for the population we serve and these Commissioning Intentions have been written to align with our vision, priorities and principles.

Section 5c: Safeguarding

Hillingdon CCG has the required professionals, roles, systems and processes in place to protect and safeguard vulnerable children and adults. There are safeguarding strategy and policies available on the CCG website for further information. The CCG's quality governance roles and committees oversee reporting and monitoring of compliance with safeguarding requirements.

We will:

- Continue to be active members of Hillingdon Safeguarding Adults Boards and Safeguarding Children's Boards and ensuing task and finish groups.
- Continue to work together with Quality and Safety colleagues to ensure valuable learning and triangulation of data is effectively utilised alongside Safeguarding alerts and concerns.
- Work in close affiliation to the Continuing Healthcare team who manage and support some of the most vulnerable people in the community.
- Have joint meetings, alignment of complaints, serious incident and Never Event data, and feedback from quality assurance processes such as Clinical Quality Assurance Visits, CQG meetings etc. This will involve the coproduction of systems and processes to enable the timely sharing of such information.
- Participate in any Reviews relating to Adults or Children e.g. Domestic Homicide Reviews, Serious Adult Reviews or Serious Case Reviews and ensure that the CCG and Provider organisations complete all actions.

Our Safeguarding Priorities	What We Will Do
Listening to children & young people and adults at risk	• Work with children's services to review the needs of all Hillingdon's children and young people especially those with additional needs; children looked after and those involved with the youth offending services. • Make Safeguarding Personal (MSP) by involving adults at risk in safeguarding decision making • Ensure compliance with The Mental Capacity Act 2005; The Deprivation of Liberty Safeguards (DOLS, 2009/2014), and The Care Act 2014 • Ensure that this vulnerable group is consulted when new or changes in existing services are being considered/planned.
Safeguarding Education and Training (Adults & Children)	• Continue to monitor and challenge Providers of contracted services to comply with safeguarding responsibilities and achieve expected targets e.g. Training. • Safeguarding Children and Adults training should also include Child Sexual Exploitation (CSE), Female Genital Mutilation (FGM), Domestic Violence and Abuse, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS • CCG staff will also be compliant with the required safeguarding training • Gain assurance that lessons learnt from DHRs, SARs, SCRs, Incidents and complaints are disseminated throughout organisations. • Support the Safeguarding Adult Board in the provision of a multi-agency training programme
Safeguarding Medicals	• Continue to work with the commissioner and providers (community and acute) to ensure that robust arrangements are in place.

PREVENT	• Ensure training is delivered to staff that is commensurable to their level of responsibility as per the NHS England competency Framework. • Ensure that both Commissioner and Provider organisations are compliant with the Counter Terrorism and Security Act (2015) and the related Prevent Duty Guidance. • Ensure compliance with DHR actions and NICE Guidance for anti social personality disorder prevention and management
Domestic Violence and abuse	• Monitor compliance with Nice Guidance (2014/ph50; 2017) to ensure that staff are trained and that victims and families at risk are identified, assessed and referred for appropriate care. • Monitor number of victims identified by all providers, ensure that a system is in place to flag high risk victims and that their Policy reflects locally agreed pathways e.g. IRIS and IDVA service in a Health setting
Work with the sector to provide an evidence and needs base for CSE	• Working across North West London to develop a comprehensive and easily accessible service provision for children at risk of, or suffering as a result of, Child Sexual Exploitation (CSE), Child Sexual Abuse (CSA) or Female Genital Mutilation (FGM).
Information Sharing	• Continue to highlight responsibilities and importance of information sharing and support the CCG and providers to share information appropriately. Adhere to the Multi agency Safeguarding information sharing guidance and the relevant GMC Guidance.
Young Offenders, Looked After Children and Children with Disabilities and Additional Needs	• Work with children's services to ensure their health needs are identified and met. • Work with the providers to ensure they understand their roles and responsibilities.
Reduce the incidence of Pressure Ulcers	• Monitor compliance of Nice Guidance (2014) to ensure that staff are taking preventable measures to reduce pressure ulcer risks and are considering a safeguarding referral on review
Ensure adults at risk are protected from avoidable harm.	• Monitor providers adherence to the Care Act 2014 in relation to prevention of harm, promoting an outcomes approach to safeguarding and compliance with NHS England Safeguarding Vulnerable People in the NHS Accountability & Assurance Framework 2015
Medication	• Monitoring providers through Quality Review meetings in relation to adult safeguarding concerns being considered for medication incidents.
Learning Disability Mortality Reviews	• Ensure providers have the correct processes in place to be compliant in carrying out a Learning Disability Mortality Review • Monitor providers regarding NHS England Learning Disability Mortality Review Programme and embedding any lessons learnt.

Section 6: The Provider Market in Hillingdon

Hillingdon CCG is responsible for the commissioning of the majority of healthcare related services in Hillingdon. These services are delivered by a variety of different organisations (providers) in different settings (such as hospitals, community clinics and GP practices) but also includes services delivered by Carers, Voluntary and Third Sector partners in a variety of domestic and other settings and collectively these organisations and partners along with services commissioned by NHS England and our Local Authority (The London Borough of Hillingdon) form 'The Provider Market'. This section provides an overview of the Provider Market in Hillingdon as it stands today and gives a look forward as to our intentions for 2018/19.

Section 6a: The Current Provider Market

This section provides an overview of the current situation of the main aspects of the provider market in Hillingdon.

Primary Care

Primary Care services are predominantly those delivered by GPs in practices and until recently were mostly commissioned by NHS England. This approach is changing with *delegated commissioning* where the responsibilities for commissioning, monitoring and assuring primary care services will be shared between CCGs and NHS England. Hillingdon CCG having taken on delegated commissioning of primary care in 2018/19. There are currently 46 GP Practices within Hillingdon and these (with the exception of two practices) are organised into four GP Networks which provide opportunities for shared learning, capacity building on a scale greater than an individual practice and also for developing and delivering new services. The vast majority of GP Practices provide their own Out of Hours support to patients with only a minority 'opted out' which places the responsibility for provision with the CCG. More recently Hillingdon GPs have inaugurated a GP Confederation to represent their interests in the borough and through which Hillingdon CCG can engage with regarding at-scale primary care transformation and delivering the priorities of the GP Forward View. Primary care services also include our recently opened Hubs, pharmacy, dental, and optical, among other services.

Community Services

This is a broad title covering a wide range of services from District Nursing to Wheelchair Services. The vast majority of Community Services are delivered by Central and North West London NHS Foundation Trust (CNWL) and Hillingdon CCG is the lead commissioner for CNWL's Community Services, acting on behalf of other Clinical Commissioning Groups who are party to the same contract with CNWL. Other aspects of community services, such as the provision of community equipment, is jointly commissioned by the CCG with the London Borough of Hillingdon through a shared funding arrangement called a Section 75 Agreement, whilst items such as Pressure Relieving Mattresses, Wheelchairs and Non-Emergency Patient Transport (amongst others) is commissioned directly by the CCG with a range of other providers.

Mental Health Services

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

Hospital Based Acute Care

Our hospital based care is provided predominantly by The Hillingdon Hospitals NHS Foundation Trust (THH) where Hillingdon CCG is the lead commissioner. THH provide the Emergency Department and associated services with an Urgent Treatment Centre. THH also provide the bulk of all elective or planned care, from such things as knee operations through to maternity services. THH is set to continue as a 'fixed point' within the transformation of acute care services that is occurring across NWL via the Shaping a Healthier Future (SaHF) programme and has already absorbed increased activity following the closure of the maternity unit at Ealing Hospital in July 2015 and the transition of Paediatric Services at Ealing Hospital that occurred in July 2016.

Hillingdon CCG is also the lead commissioner for Royal Brompton & Harefield NHS Foundation Trust (RBH) on behalf of all CCGs who commission services with RBH although the main commissioner of services from RBH remains NHS England due to the specialist nature of services provided by RBH.

In addition to being the leads on the contracts for THH and RBH, Hillingdon CCG is also an associate commissioner on the contracts for other acute trusts where our residents receive care. We work closely with the lead commissioners of those trusts to ensure that the commissioning intentions laid out here are applied across all providers from which our residents access care.

Voluntary & Third Sector

Hillingdon has a vibrant voluntary and third sector who deliver a wide range of services that are commissioned by Hillingdon CCG as well as a broad range of services that are commissioned through other routes including through charitable donations. These organisations make a valuable contribution to the health and social care system in Hillingdon.

Local Authority Commissioned Services

Our Local Authority (London Borough of Hillingdon (LBH)) is responsible for commissioning many important aspects of the health and social care system in Hillingdon including Public Health services, Health Visiting, School Nursing, Alcohol & Drug Addiction Services and of course Social Care to name just a few. In the increasingly interconnected world of health and social care LBH and the CCG are working together to develop, commission and manage a wide range of services.

Carers

We must not forget the valuable contribution made by carers of all types who support individuals of all ages and greatly add to their quality of life and the outcomes they experience.

Section 6b: Our Intentions for 2018-19

This section provides a high level overview of our Commissioning Intentions for 2018-19 in respect to the Provider Market. This lists on the left what we intend to do and on the right the expected benefits to the population we serve.

General Intentions (Applicable to all Providers)	
• We expect all providers to make full use of eReferrals and aim to eliminate any referrals issued via other means. No referrals should be made by fax. • We expect all NHS providers to utilise EMIS compatible systems to access, update and use a full Shared Care Record that is integrated across Health and Social Care to improve patient care. This goes beyond the limited expectations set out for the Summary Care Record (SCR). • We will implement a schedule of clinical and quality audits guided by anomalous activity, CQC reports, patient feedback or other sources. • We will explore opportunities across NWL with partner commissioners to undertake joined up procurement of services that may benefit from at-scale provision • We will seek to procure pathways of care to focus operational resource, accountability, and strategic development of services through service consolidation	**What does this mean for the population we serve?** • Referrals sent immediately and with less chance of being 'lost' • Improved data sharing between clinicians enabling care to be better coordinated. • Improve quality of care provided from different healthcare organisations and more assurance that the CCG is commissioning high quality services.
Integration	
• The CCG is committed to the concept of an Accountable Care Partnership (ACP) or similar structure as outlined in the NHS Five Year Forward View. We tested the clinical model of care in 2017-18 in anticipatory care and escalated care for the older population aged 65 years and over. We also commenced design work further development of care models including the discharge to assess and frailty pathways. We have agreed a baseline for services in scope and intend to move to a capitated payment model based on the outcomes of the assurance process for 2017-18 progress. Through this process we will expect providers involved in the ACP to contribute to the delivery of the three main NHS challenges (Health & Wellbeing, Care & Quality & Finance & Efficiency) and also address how membership of the ACP can flex and change if needed over time. **UPDATE DUE AFTER SEPT W/SHOP**	**What does this mean for the population we serve?** • A joined up, integrated and coordinated health care system across all health care providers in Hillingdon including voluntary and third sector providers. • Improved coordination of services across health and social care. • A coordinated and capable urgent care system that will improve access to information to enable clinicians to

• In line with the Commissioning Standards for Urgent & Emergency Care (UEC) we will be seeking to design and commission Integrated Urgent Care services to improve the coordination of care between the various elements including the NHS 111, Urgent Treatment Centre, GP Out of Hours and A&E based services.	make timely and appropriate decisions.
• Greater integration across care settings will need to be supported by the evolution of shared care records (including the NWL Diagnostic Cloud) across health and social care and work on this will continue into 18/19 and on-going delivery of our Better Care Fund (BCF) plan.	
• The CCG is also committed to seeking additional opportunities to jointly commission services with our local authority and to the delivery of the joint objectives outlined in our Better Care Fund programme.	
Primary Care	
• We will continue to support the development of our GP networks and GP Confederation and will work with them to design, shape and deliver a new Model of Care for Primary Care that sees them playing an essential role in supporting our Out of Hospital Strategy and an increasingly important role in supporting patients with Long Term Conditions to self-manage elements of their care.	**What does this mean for the population we serve?** • Improved access to Primary Care particularly for those with complex needs and a reduction in the variation of care received by people with Long Term Conditions. • Better coordination between Social, Primary, Community and Secondary (hospital) care and improved sharing of appropriate information to enable clinicians to make appropriate and timely decisions.
• The new Model of Care will include current commissioned services including the Integrated Care Programme (ICP) and a new approach to the Primary Care Contracts (PCCs) and various other contracts we hold with practices as well as new services focused on supporting Older People and those with Long Term Conditions.	
• We will continue with our local delivery plan for the strategic commissioning framework for primary care (as set out by NHS England) that focusses on accessible, proactive and coordinated care	
• We remain committed to supporting Primary Care in areas such as access, premises and workforce development to enable practices to support the CCG's Out of Hospital and QIPP Agendas.	
• We will work with acute and urgent care services to support the delivery of local services strategy actions and outcomes, as well as the integrated urgent care agenda.	

Community Care	
• We recognise that service specifications that were written in the past may not now reflect the way forward and as such need to be revised in line with the direction of travel for the CCG.	**What does this mean for the population we serve?** • Services redesigned to meet the future needs of our population and which are integrated fully with other provider organisations. • More services delivered closer to home.
• We will work with our main Community Provider (CNWL) on how they can support our need to move more activity out of hospital and to align Community Services to the emerging Primary Care Model of Care and Older People Model of Care and to embed and expand the existing work around supporting people with Long Term Conditions.	
• We will continue to work closely with CNWL on the delivery of the efficiencies within the contract and also additional, opportunistic, efficiencies.	
Mental Health	
• We will continue to work collaboratively with the main provider of Mental Health Services CNWL to develop cost effective high quality services in the borough, evaluating the impact on the whole Mental Health system of the Business Cases approved in 2015/16.	**What does this mean for the population we serve?** • Improved access to Mental Health Services for people of all ages whether they have a need that is unplanned or planned. • Improved outcomes for the investment we make in Mental Health services.
• We expect to see a positive impact of additional investment in perinatal services in line with the 5 year Implementation Plan.	
• We expect Talking Therapy Services to achieve the Access and Recovery Targets within existing resources, Early Intervention in Psychosis Services to meet national targets and agreed outcome measures and the full implementation of the Hillingdon Dementia Action Plan.	
• We will continue to roll out the 5 year CAMHS Transformation Programme and will expect to see a reduction in local waiting times and the number of admissions to Out Of Area (OOA) Tier 4 services.	
• We will work in partnership with key stakeholders to develop a fully integrated Children and Young Peoples Mental health Service from wellbeing and prevention to specialist interventions	
• We will expect to see evidence of a reduction in psychiatric admissions via A&E and to see a positive impact of additional investment in Learning Disability Services.	
• We anticipate the local development of Employment support services embedded in both Talking Therapies and Primary Care plus Services in line with the Trailblazer Employment initiative.	
• In conjunction with the Local Authority we expect to see the development of a comprehensive Rehabilitation Pathway.	

• We will work in partnership to expand the Primary Care Plus service to full coverage across the Borough.	
• We will expect to see a positive impact on reducing Bed numbers following investment in the Urgent Care Business Case.	
• We will work in partnership to develop a Personality Disorder Pathway.	
• We will work in partnership to implement the Like Minded 5 Year Vision for services for people with Serious and Long Term Mental Health problems, Common Mental Health problems, Primary Care, Wellbeing and Health Promotion.	
• We will work in partnership to lay the foundations to ensure we are best placed to achieve the vision for the delivery of services over the coming years to 2020/21 as set out in the Five Year Forward View for Mental Health.	
Hospital Based Acute Care	
• We will work with our main acute provider (THH) to consistently achieve our Operating Plan priorities around A&E Performance, Referral to Treatment (RTT) Targets and those associated with Cancer and Diagnostics.	**What does this mean for the population we serve?** • Continued delivery of our access and quality targets. • Improved access to services delivered both 7 days per week and, where appropriate, "Out of Hospital" and nearer to patients' homes. • Improved access to clinical information across organisations to improve clinical decision making and ultimately improve outcomes for patients.
• We will seek to move more activity out of hospital where possible and to transform our local pathways so that patients who do not need to be treated in hospital are treated in a more appropriate setting in line with the NWL Local Services Strategy.	
• We will work to embed our existing Integrated Services for people with Long Term Conditions and seek new opportunities to improve outcomes for people living with LTCs, for example extending access to Talking Therapy IAPT services for people with LTCs such as Diabetes, COPD and Cancer as set out in the Hillingdon CCG Cancer Improvement Plan.	
• We will focus attention on the Community Assessment & Treatment Services (CATS) delivered by THH to ensure they continue to deliver our Out of Hospital aspirations and will focus on developing new CATS for Gastroenterology and Neurology Services.	
• We will work to achieve relevant 7 Day Standards in partnership with THH.	

• We will use and build upon the RightCare analysis undertaken to commission care that brings the quality, effectiveness and efficiency of our services in line with best practice in our peer group. In the first instance this involves a focus on MSK, Diabetes, Cardiology, Circulatory, Respiratory Disease, Cancer, and Neurology pathways.	
• We will be seeking to improve the coding of appropriate co-morbidities with THH so as to improve the ability of the CCG to plan services and access data, particularly in relation to Long Term Conditions such as Diabetes, Cardiology and Respiratory.	
Carers, Voluntary & Third Sector	
• We will seek to strengthen the voluntary and third sector involvement in delivery of services and to integrate where them into the ACO where appropriate.	**What does this mean for the population we serve?** • Improved support to carers. • Improved coordination of support across health care and the third sector which will lead to improvements in wellbeing as well as health.
• We will assess the impact of the Health & Wellbeing Service delivered by Hillingdon for All (H4All) and determine whether this will continue to be funded.	
• We will seek to achieve all of our obligations to carers as defined in the Care Act 2014 and to support young carers (those under 18) in collaboration with our Local Authority colleagues.	
Service for Children and Young People:	
• We will continue to work with the Local Authority to deliver our obligations as defined in the Children & Family Act 2014 integrating services and co-producing redesign with children young people their families and carers as part of our five year plan. This will involve proactively working with children and young people and ensuring that their voice is clearly heard in the design of services to support them.	**What does this mean for the population we serve?** • Improved integration in the support of Children and Young People across health providers and across health and social care which will ultimately lead to improved outcomes.

Section 7: 2018-19 Commissioning Intentions

As stated in Section 3 our Commissioning Intentions for 2017-18 are focused on the delivery of 10 Transformation Themes supported by 6 Enabling Themes and this section provides a breakdown of our intentions for each of these and how they will contribute to our priorities and objectives including an **indicative** QIPP efficiency (saving) associated with each Transformation Theme and one of the Enabling Themes.

<table>
<tr><th colspan="3">1. New Model of Care for Older People</th></tr>
<tr><th>2020/21 Outcomes</th><th>Commissioning Intentions 18/19</th><th>Indicative Commissioning Intentions Beyond 18/19</th></tr>
<tr>
<td>By 2020/21 we will be delivering the following outcomes:
Coordinated Care for Older Peoples' Planned & Unplanned Care Needs across Care Settings
Improved Health Outcomes and reducing Unplanned Care needs through focusing on LTCs and age related complicating factors such as frailty
Integrated Health & Social Care support for those patients who need it
Empowering people to plan for their own care
A diverse market of quality care providers maximising choice for local people who have complex needs covering both older people and other vulnerable groups</td>
<td>We will:
Enhance and embed the capacity and capability of the Care Connection Teams in Hillingdon
Develop new 'Core Offer' for Care Homes and extra care sheltered housing, including support for the EMI and people with SMI and Dementia with Challenging Behaviours as part of BCF
Improve coordination between health and social care around support from Continuing Health Care (CHC)
Continue to develop and embed the integrated model of care for older people including self-care (PAM)
Implement an integrated, shared care record across health and social care
Develop and implement frailty pathway aligning with new discharge pathways including Home2Assess as well as support for carers
Undertake integrated commissioning and brokerage with partners, including joint specifications
Integrating End of Life projects with Older Peoples agenda</td>
<td>We will:
Progress the next phase of an integrated system for older people including transition to capitated payment and outcome based commissioning.
Commission a single integrated system of care via a full capitated budget.</td>
</tr>
<tr><th>Measuring Success</th><th>Supporting the Integration Agenda</th><th>Supporting Strategies & Assurance</th></tr>
<tr>
<td>Delivery of this Transformation Theme will realise:
Reduction in Non-Elective Admissions for people aged >65 years old
Reduction in Zero-Length of Stay Admissions for people aged >65 years old
Reduction in overall costs associated with supporting Older People</td>
<td>The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:
Joint projects with regard to Care Homes, extra care Sheltered Housing and Home Care between LBH and HCCG
Specifying and commissioning of a framework of services for older people as part of the development of the ACO</td>
<td>The work for this Transformation Theme is underpinned by the following strategies:
Whole System Integrated Care Strategy
Better Care Fund
Local Digital Roadmap
The delivery of this Transformation Theme will be managed and monitored via the Older People's Delivery Group which in turn reports to the Transformation Group.</td>
</tr>
</table>

2. New Primary Care Model of Care

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19

By 2020/21 we will be delivering the following outcomes:
 	
• Strengthened primary care provider landscape able to deliver new primary care models of care primary care services at scale
• Increasing number of people cared for and supported outside of the hospital setting with integration across Primary, Community & Secondary Care Services and Social Care
• Improved access to routine and unplanned services in primary care during the week, evenings and weekends
• Reduced variation in service and patient outcomes in primary care via outcomes based commissioning
• Sustainable primary care workforce and access
	We will:
	
	• Commission the first phase of the Primary Care Model of Care focused around Enhanced Access in core and extended hours, Unplanned Care, Care Homes, LTCs and enhanced access
	• Exploit existing investment in EMIS Web Clinical Services and ability of practices to access each other patient records and share data across Hillingdon, to support new services and delivery models within Networks & Hubs
	• GP Practices will pro-actively review their referral data at practice and sub-group (locality) level. They will develop sub-group based plans to reduce avoidable referrals in identified areas of concern. As part of their plans sub-groups will provide peer support to top referring practices in their areas and help improve decision support for all practices
	• Work with top referring practices to address variation and improve decision support
	• Roll out NWL Referral Criteria to top 20 priority specialities
		We will:
		
		• Continue to develop primary care providers via the integrated outcome based primary contracts with an emphasis in addressing variation
		• Link the Primary Care Models of Care to the CCG Hub Strategy
		• Deliver Phase 2 of the Primary Care Model of Care including:
		  ○ Embedding Mental Health Support in Primary Care and parity of esteem (with a special focus on physical health)
		  ○ Improving Acute Flows (and reducing demand for acute services)
		  ○ Further develop multimorbidity strategy (see LTCs section)

Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Increase in activity managed outside of a hospital setting. • Reduction in hospital referrals and outpatient follow up appointments • Reduction in A&E/UCC activity • Co-ordinated care for people with long-term conditions including primary prevention for sections of the population developing risk profiles; and secondary prevention for people with multi-morbidities to reduce hospital admissions • Reduction in variation of outcomes across general practice for key clinical indicators	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • The Primary Care Model of Care is a key element in the delivery of integrated services across Community and Acute Services and is key to the delivery of Out of Hospital Targets.	**The work for this Transformation Theme is underpinned by the following strategies:** • Five Year GP Forward View • NWL Local services delivery plan • Local Digital Roadmap • Hillingdon primary care strategy The delivery of this Transformation Theme will be managed and monitored via the **Primary Care Transformation Group** which in turn reports to the **Primary Care Transformation Board and Primary Care** Commissioning Board

3. Integrating Services for People at the End of their Life

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Increasing number of people able to die in their preferred place • Reducing number of admissions for people in the last 30 days of their life • Improve information access for clinicians and professionals supporting people at End of Life to anticipatory care plans • Coordination of support to people at End of Life and their families/carers on a 24/7 basis and across all care settings	We will: • Rollout the End of Life Strategy and manage via the Older Peoples Strategy Group • Implement an integrated service model including 24/7 SPA and Palliative Overnight Nursing Service (PONS) in collaboration with Social Finance • Consolidate End of Life services commissioning to enable an integrated and consistent service delivery • Increase usage of Coordinate My Care (CMC) and use of the Shared Care Record • Improve support from the CHC Fast Track programme for eligible patients • Seek to integrate health care and social care services for people at the end of their lives to improve the quality of care received and the support to families and carers • Enhance the bereavement support to carers and family • Implement the ReSPECT DNAR form	We will: • Embed the Single Point of Access (SPA) and Palliative Overnight Nursing Service (PONS) and continue to increase the number of people who die in their preferred place of death • Increase the percentage of people in the last phase of life with an Anticipatory Care Plan to greater than 60% of those in their last 12 months of life (measured via CMC usage)
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Increase in people dying in their preferred place • Increase in people with anticipatory care plans • Reduction in the costs associated with managing people at End of Life	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • This supports the integration agenda through the integrated service model and commissioning of services that will add a 24/7 SPA and PONS to the existing support spanning primary, community and secondary care plus consolidation of the services commissioned by the CCG from the third and voluntary sector • In addition, increasing access to Coordinate My Care (CMC) and the use of the Shared Care Record will support a more coordinated and integrated approach to supporting people at the end of their life	**The work for this Transformation Theme is underpinned by the following strategies:** • Hillingdon Joint End of Life Strategy • Better Care Fund • Local Digital Roadmap The delivery of this Transformation Theme will be managed and monitored via the **Older Peoples Strategy Group** which in turn reports to the **Transformation Group**.

4. Integrated Support for people with Long Term Conditions

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Improved outcomes and support for people with multiple LTCs and complex needs • Reducing unplanned care needs arising associated with LTCs • Reduced variation in care received by people with LTCs with a particular focus on variation in Primary Care • Increasing focus on improved outcomes through preventative measures (primary, secondary and tertiary prevention) • Pro-active and co-ordinated care for people with Multi-morbidities	We will: • Refresh the Long Term Conditions Strategy • Rollout Integrated Services for Respiratory and Diabetes • Ensure medication for AF and HF patients is optimised to prevent MI and stroke, improve patient outcomes and reduce admissions to hospital. • Develop a community based anticoagulation service which may involve decommissioning hospital provided anticoagulation to re-procure an integrated model. • Rollout an expanded Empowered Patient Programme (EPP) and increase usage of Patient Activation (PAM) • Improve support for GPs managing people with multiple co-morbidities through the introduction of virtual clinics with consultant and community MDT members. • Seek to reduce the number of Outpatient Follow Ups and Procedures associated with key LTCs • Develop plans around management of MH related LTCs • Pursue the opportunities identified in the RightCare methodology focusing on supporting people with Diabetes, Cancer, Cardiovascular and Respiratory diseases • Improve advice and support to carers of people with an LTC • Review rehabilitation services to develop a local pricing structure for hospital based cardiac rehabilitation or a combined cardiac/ pulmonary rehabilitation pathway. Rationalise hospital based Health Psychology at THH • Introduce an integrated, shared care record across health and social care and explore the use of apps and technology	We will: • Progress the next phase of the Integrated Services for Respiratory, Cardiology and Diabetes • Rollout the Complex Patient Programme to a wider cohort of people • Focus on improving the support to those who currently need to call 111 or 999 on a regular basis • Embed the concept of Mental Health Support for people with Physical LTCs to ensure their MH needs are met on a consistent and on-going basis • Ensure that Care Planning and PAM become the norm for people with LTCs • Further develop the multi-morbidities strategy
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Reduction in unplanned events for people with LTCs • Reduction in the costs associated with supporting people with LTCs • Increase in people with an LTC who self-manage elements of their care • Increase in people with an LTC who have an anticipatory care plan • Improved Quality of Life measures e.g. PAM • Improved support for Carers • Reduction in number of home visits, general practice appointments • Medicines Optimisation	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • The Integrated Services for Diabetes, Respiratory & Cardiology already combine the expertise of Acute/Secondary Care and Community Services and will be expanded to have much better integration with Primary Care.	**The work for this Transformation Theme is underpinned by the following strategies:** • Long Term Conditions Strategy • Hillingdon primary care strategy • Dementia Action Plan • Better Care Fund • Local Digital Roadmap The delivery of this Transformation Theme will be managed and monitored via the **Long Term Conditions Transformation Group** which in turn reports to the **Transformation Group**.

5. Transforming Care for People with Cancer

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Increasing rates of cancer prevented and increasing survival rates • Reduction in the rates of reoccurrence • Reduction in variation rates in the quality of care • Patients and their families better informed, empowered and involved in decisions around their care • Improved health, wellbeing and quality of life for patients after treatment and at the end of life • Increase in early diagnosis of cancer evidenced by reducing number of patients identified as having Cancer following a non-elective presentation	We will: • Develop access to psychological support for people with Cancer • Develop a digital care support menu jointly with our partners at the London Borough of Hillingdon • Fully implement stratified care pathways for priority cancers • Embed localised programmes for delivery of lung and prostate screening • Work with partners to improve access to and support to our BAME community suffering with Cancer • Achieve the 28 day standard for cancer diagnosis in three site-specific areas: Breast, Urology and Lung • Promote awareness of the Cancer Decision Support Tools within EMIS • Review Dexa scan pathway and outcomes • Explore potential for colorectal direct access pathway • Enhance early diagnosis in primary care with training and out of hospital testing, aligning with best practice and proof of concepts to enhance cancer outcomes • Promote and embed NHSE HLP common standards for digital transfer protocols and message formates.	We will: • Finalise rollout of Cancer Stratified Pathways across all Cancers • Embed Cancer Support (including proactive case finding and screening) into the Primary Care Model of Care • Implement a clear policy on DNA follow ups • Significantly improve the coding of Cancer within Primary Care • Continue the rolling education programme in partnership with Cancer Research UK • Enhance diagnostic capacity to meet expected prevalence growth rates • Develop enhanced support to people living with Cancer • Explore the use of a Shared Care Record across the London Cancer Network
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Reduction in the prevalence gap around Patients identified with Cancer in Primary Care • Increase in early diagnosis of cancer evidenced by a reduction in the number of patients identified with Cancer following a non-elective presentation • Increase in life expectancy at 5 years following successful treatment of patients	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • Cancer by its very nature is a cross-cutting issue affecting all aspects of health care provision including Mental Health, Hospital Based Care and Primary Care. The Cancer Improvement Plan being developed by the CCG will ensure that support is coordinated across the entire Cancer pathway from screening/prevention through to survivability and end of life. This will ensure that support from third sector and voluntary organisations as well as the support from social care are fully integrated with services provided via NHS providers.	**The work for this Transformation Theme is underpinned by the following strategies:** • National Cancer Strategy • London Cancer Strategy • NWL Sustainability and Tr Plan • NWL TCTS Transformation Plan • Hillingdon Cancer Improvement Plan The delivery of this Transformation Theme will be managed and monitored via the **Cancer Clinical Working Group** which in turn reports to the **Transformation Group**. Elements of delivery will be managed by the **Cancer Board** which is led by clinicians at THH.

6. Transforming Support for people with Serious Mental Health Needs and those with Learning Disabilities

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Reduction in inequalities associated with the care of people with one or more LD • Reduction in risk of harm to vulnerable people • Improved support for people with an urgent mental health need • Significant progress in closing the mortality gap between people with an LD and the wider population • Full Implementation of Five Year Forward plan for Mental Health	We will: • Support people in crisis by fully embedding Urgent Care, OOH, SPA and rapid response functions • Develop all age early intervention service and packages of care for first episode psychosis • Expand ICP to include people with dementia and MH Conditions • Develop new models of care for people with severe mental illness and learning disabilities in the community • Implement NWL Like-Minded Strategies covering severe mental illness, common mental health, primary care and wellbeing and promotion to ensure sustainability • Further develop an integrated 5 year plan for CAMHS including Tier 4, moving towards THRIVE Model • Improve support to carers where needed and appropriate • Signal intention to market test and potentially procure LD Services • Signal intention to market test and potentially procure CAMHs Services. • Development of a Personality Disorder Pathway • Ensure the local Dementia Plan is fully implemented including EOL care and Challenging behaviour services • Assess a Business Case to continue the provision of Mental Health awareness training • Jointly assess the level of unmet need for longer term Counselling • Develop a coherent local pathway for people with ASD and ADHD	We will: • Implement Like-Minded Business Cases • Implement the recommendations from CAMHS OOH, Urgent Care and Like-Minded evaluations • Review 16/17 CAMHS investment and business cases • Consider the rolling out the collaborative care and care planning process for adult mental health with LTC • Comprehensive plans in place to meet the expectations set out in the Five Year Forward plan for Mental Health • Progress delivery of Transforming carte for people with LD • Progress delivery of 5 year CAMHS transformation plan • Progress delivery of Like Minded plans Specifically: • Implement Like-Minded Business Cases • Implement the recommendations from Adult and CAMHS OOH, Urgent Care and Like-Minded evaluations • Progress to an integrated CAMHS model • Consider the rolling out the collaborative care and care planning process for adult mental health with LTC • Comprehensive plans in place to meet the expectations set out in the Five Year Forward plan for Mental Health
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • People with SMI (Severe Mental Illness) to receive complete list of physical health check to achieve reduction in the mortality gap • Access to community mental health services and IAPT from BME groups, crude rates per 100,000 population • Unplanned readmissions of mental health patient within 30days of inpatient admission. • Percentage of service users in adult mental health services in employment. • Reduction in Psychiatric admissions via A+E	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • Expanding the Integrated Care Programme to include people with Mental Health Conditions will bring better coordination between physical and mental health services • Like Minded strategy to develop enhanced primary care mental service, services for severe and common mental health problems and wellbeing and prevention	**The work for this Transformation Theme is underpinned by the following strategies:** • Learning Disability Transforming Care Programme • Dementia Action Plan • Mental Health Transformation Plan • CAMHS Transformation Plan The delivery of this Transformation Theme will be managed and monitored via the **Mental Health Transformation Group** which in turn reports to the **Transformation Group**.

7. Integrated Care for Children & Young People (CYP)

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Coordination of support for children and young people across all health and social care services • Improved outcomes for children and young people with one or more LTCs • Reduction in the risk of harm to children and young people	We will: • Integrated Community Clinics: To embed and continue to develop a network of Community Clinics. Integrating relevant services as indicated by need; such as paediatric phlebotomy, aligning with the asthma allergy clinics. Improving admission avoidance, reducing people's reliance on unplanned care systems patient and professional confidence. • Work with partners to identify and target programmes of care to reduce: o A&E attendances in <4 year olds o Improved dental care and childhood immunisations • Continue to test Community Integrated Clinics for General Paediatrics and the viability of extending the model to complex care. • Continue to develop a Liaison & Diversion model building on the rapid health review of need, carried out in 2017. • Review the health needs of children & young people with an additional health need, working with partners to prioritise areas of high need. Including the potential to market test and procurement services such as child Development Services, Looked After and services for young people in the criminal justice system. Linking to the CAMHS work. • Maternity; continue to prioritise with partners ways to improve services, improving efficiencies where possible. • Technology: working with partners identify key areas to improve shared care records, and evidence based treatments on line. • Transition: to work with partners to develop systems for transition for Children & Young People aged 18-25 who remain in education and have a Health, Education and Care Plan	We will: • Implement integrated community models of care across the borough, based on population need and evidence of clinical service use. • Vulnerable children and young people: as a co-produced programme implement a revised and improved provision • Working with partners continue to: provide education programmes for professionals, families and children and young people, to self-manage their care: preventing hospital use • Using local and national data and working with partners, such as the local authority; target high areas of need; o Immunisation take improvement , including vulnerable children o Weight management 10-11 year olds o Hospital admission for Dental Caries
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Reduction in the need for secondary care activity associated with CYP: • Reduction in GP referrals to secondary care • Reduction in unplanned care needs for CYP • Reduction in the costs associated in managing CYP per capita	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • Support to CYP is jointly commissioned across Health & Social Care and we will work increasingly closely with our Social Care and Local Authority colleagues to develop joint plans. • Integrate Community Clinics; moving skills and expertise into community • We will continue to work closely with NHS England around support to CAMHS patients with CAMHS commissioners.	**The work for this Transformation Theme is underpinned by the following strategies:** • CAMHS Action Plan • Children's Transformation Plan • The children's JSNA May 2016 • The Children & Family Act 2014 • Local Digital Roadmap The delivery of this Transformation Theme will be managed and monitored via the **Children's Strategic Transformation Group** which in turn reports to the **Transformation Group**.

8. Integration Across the Urgent & Emergency Care System

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Coordinated support across all Urgent & Emergency Care services • Increased number of patients who have their unplanned care needs met outside of a hospital setting • Increased awareness in the community about how to access appropriate services • Increased number of people supported to avoid an admission and those supported home with a reduced Length of Stay	We will: • Develop our integrated urgent care approach to align urgent care services across social, primary, community and acute settings • Rollout new 111 Service and Primary Care Triage Model aligned to national guidelines • Develop and enhance ambulatory care pathway services in out of hospital settings and continue to increase the effectiveness of our UCC based Health Connectors to support patients along appropriate pathways • Expand Intermediate Care Services and integrate with Homesafe • Commission a new Directory of Service (DoS) • Change the focus of DTOCs to also include those who are Medically Fit For Discharge (MFFD) and rollout a joint approach to reducing LoS with the Local Authority and CHC • Reduce the number of alcohol related presentations a THH • Improve the support to those with alcohol addiction that has caused a long term medical condition • Introduce 'follow up' nurse support to reduce readmission rates following a non-elective presentation at THH • Deliver the Ambulance Handover Time targets consistently	We will: • Commission a fully Integrated Urgent and Emergency Care system • Improve the effectiveness of our NHS 111 Service • Improve integration of acute unplanned care services with GP-led urgent care • Reduce demand at the door of A&E and the UCC through improved access in Primary Care, Community, Education and through our support to people with LTCs • Integrate IT system across the UEC system to ensure professionals have access to essential medical records for people • Expand and update the DoS in line with national standards • Link the Urgent Care System with the Primary Care Model of Care and the CCG Hub Strategy
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Reduction in rate of growth for unplanned attendances at hospital • Increase in people accessing non-hospital based support for their unplanned care needs • Reduction in the costs per capita managing unplanned care needs • Reduction in Zero-Length of Stay and Unplanned Admissions and a Reduction in Length of Stay following an unplanned admission	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • The Multidisciplinary Integrated Discharge Team and A&E Delivery Board are examples of Integration across health and social care associated with Unplanned Care • The development of the Older Peoples' Model of Care and the Primary Care Model of Care will both enhance integration further across the UEC System as will the development of a truly Integrated Urgent Care (IUC) System	**The work for this Transformation Theme is underpinned by the following strategies:** • Unplanned Care Strategy • Commissioning Standards for Integrated Urgent Care • Local Digital Roadmap The delivery of this Transformation Theme will be managed and monitored via the **A&E Delivery Group** which in turn reports to the **Hillingdon CCG Governing Body**

9. Prevention of Disease & Ill-Health

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Hillingdon wide self-management / education programme for all patients regardless of their length of diagnosis for a number of conditions • Reduced prevalence gap for key conditions meaning that more people are identified as having conditions such as Diabetes and Hypertension (adults and children • Fully informed, engaged and activated patients taking control of the process of care for their own conditions • Reduced rate of growth in prevalence to improve long term outcomes and slow the growth in demand for health related services • Reduced variation in management of conditions to reduce the number of exacerbations that occur for people and ultimately improve their long term outcome	We will: • Develop and rollout a Prevention Strategy as well as a Suicide Prevention Strategy • Develop targeted screening programmes for AF, Hypertension and Diabetes to diagnose patients earlier and prevent adverse events. identify further prevalence gaps to address in later years • Rollout an Air Quality Review with Public Health to understand why Hillingdon is an outlier for Respiratory related activity • Rollout of Proactive Case Finding in Primary Care as part of the Primary Care Model of Care • Expand access to and use of online advice and contribute to raising the awareness of the public around prevention of long term conditions • Utilise data from the JSNA, NHS RightCare and other external parties to support the development of the Prevention Strategy • Explore the use of apps and technology to help people stay well and prevent exacerbations	We will: • Close the prevalence gaps for Hypertension and Diabetes by more than 30% • Expand the range of conditions for which proactive case finding can be utilised to identify those at risk of developing disease and ill-health • Expand the range of conditions where the NHS can use prevention techniques to reduce complications and co-morbidities for those people who already have a long-term condition **Note:** much of the longer term impact of this Transformation Theme will be delivered via (T4) and (T5) with respect to Secondary and Tertiary Prevention.
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Reduction in the prevalence gap for key conditions including Hypertension, Cholesterol, and Diabetes • Reduction in the rate of growth of prevalence • Reduction in the costs of managing people with LTCs	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • Prevention is a shared issue between the NHS and the Local Authority. Although the development and rollout of the Prevention Strategy for the CCG will be very much focused on the NHS elements of prevention we will be working closely with our Local Authority colleagues (particularly public health and the health and wellbeing teams) to develop this strategy and roll it out.	**The work for this Transformation Theme is underpinned by the following strategies:** The delivery of this Transformation Theme will be managed and monitored via the **Long Term Conditions Transformation Group** which in turn reports to the **Transformation Group**.

10. Transformation in Local Services

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Reduced rate of growth in hospital attendances and admissions for people with planned care needs • Increasing scope and amount of activity delivered Out of Hospital and closer to home for patients • Reduction in Length of Stay following a planned admission • Increased use of alternative services to deliver planned care support	We will: • Deliver the 4 Priority Acute Standards for 7 Day Services • Reduce activity to NWL averages within the THH and RBH contracts for key specialties focusing on OPD and OPPROC • Consolidate clinical efforts through Planned Care Clinical Transformation Group • Identify opportunities for rehabilitation in the community • Enhance early diagnosis and intervention in Gastro to prevent unnecessary invasive procedures, as well as support patients to manage long term conditions such as IBS with community based diet advice and counselling support • Develop Neuro community support service to address and prevent emergency epilepsy admissions, help manage Parkinson's, and embed community neuro rehab outreach service, as well as explore phased piloting/implementation of additional neuro-related community services • Review and rationalise bariatric and sleep apnoea pathways • Explore opportunities to assess and treat minor conditions and minor surgeries in the community • Procure a community MSK service, including a Single Point of Access for all MSK conditions. Potential sub-delivery of the procuring community MSK service, including development of care plans to manage issues and pain due to flare-ups or ongoing pain • Develop and implement Virtual Fracture Clinic (VFC) with NWL collaborative team, and enhance the Fracture Liaison Service (FLS) with NWL collaborative team • Implement shared care guidelines for the management of stable Disease-Modifying Anti-Rheumatic Drugs (DMARDs) • Procure a community Dermatology service, and explore opportunity for teledermatology • Implement post discharge follow up calls to reduce readmissions • Ongoing embedding of integrated, shared care record across health and social care • Adoption and integration of NHS RightCare programme recommendations for key specialties (MSK, Diabetes, Respiratory, Cancer, Neurology) • Proactively engage in the negotiations for the contracts where HCCG are significant associates to obtain improved efficiency • Implement a Placement Efficiency Programme for patients with a physical need • Review elective pathways	We will: • Restructure and improve the effectiveness of Clinical Working Groups (CWGs) to empower them to take more control of clinical decision making across providers • Focus on additional 7 Day Standards in line with NWL and HCCG priorities • Reduce Length of Stay to the NWL Average wherever this exceeds the average by more than 10% • Increase the scope of services delivered Out of Hospital and closer to patients' homes as well as the amount of activity delivered Out of Hospital • Rollout NWL Referral Criteria to the next 20 specialities whilst continuing to monitor impact on the Top 40 specialties and the rate of growth • Reduce Internally Generated Demand to NWL average rates where applicable whilst ensuring the policy is applied where clinically appropriate to reduce delay and burden on primary care • Improve patient access to community MSK services by introducing self-referral to community MSK service
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Transformation Theme will realise: • Reduction in costs and growth rate for planned attendances and admissions • Increase in planned care provided in non-hospital based settings	**The following areas of this Transformation Theme will contribute to the Integration Agenda in Hillingdon:** • The move to drive more activity out of hospital will contribute to the integration across secondary, community and primary care services and this will be combined with an increasing focus on self-care and patient activation	**The work for this Transformation Theme is underpinned by the following strategies:** • NWL Local Services Strategy The delivery of this Transformation Theme will be managed and monitored via the **Planned Care Transformation Group** which in turn reports to the **Transformation Group**.

Enabling Themes

The following pages provide the detail of each of the Enabling Themes.

1. Developing The Digital Environment		
2020/21 Outcomes	**Commissioning Intentions 18/19**	**Indicative Commissioning Intentions Beyond 18/19**
By 2020/21 we will be delivering the following outcomes: • Effective and efficient integrated care services enabled by shared health and care records • Relevant information, safely and appropriately available when needed to coordinate care for people • Clear analytical information available to aid planning of services	We will: • Improve access to and use of Shared Care Records to support integrated care, including the NW London Care Information Exchange • Improve use of digital analytics, where possible, to move towards population-level health management, using local and NHS NWL tools • Develop plans for digitally enabled self-care and the use of real time data in decision making for both clinicians and patients • Complete the implementation of electronic clinical correspondence (including e-Referrals and e-Discharges) and eradicate use of fax in care services	We will: • Encourage secondary care to move towards paperless operation at the point of care • Complete development of a shared care record across all care settings including social care, facilitating integrated out of hospital care, including the NWL and pan-London Care Information Exchanges • Extend patient records (from all settings) to patients and carers, and provide them with digital self-care and management tools such as apps, to help them become more involved in understanding and managing their own care; to include implementation of common digital identity and consent management functions across NWL and where possible, pan-London • Use dynamic analytics to inform care decisions and support integrated health and social care across the system through whole system intelligence
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • High utilisation of Shared Care Record across settings by appropriate health and care professionals • Services planned using accurate and timely data • Improved outcomes for patients through effective use of shared records and therefore better informed health and care decisions	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • The Shared Care Record will facilitate integrated working across settings and across providers.	**The work for this Enabling Theme is underpinned by the following strategies:** • Local Digital Roadmap • Hillingdon IT Strategy The delivery of this Enabling Theme will be managed and monitored via the **IT Transformation Group** and **Pan Hillingdon IT Group** which in turn report to the **Hillingdon CCG Transformation Group**. Providers are expected to participate in the **Pan Hillingdon IT Group**.

2. Creating the Primary Care Workforce for the Future

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • A primary care workforce that is sufficient to sustain general practice. • A workforce that grows new roles and skills to support patient care • New systems and processes to release clinical time • An expanded primary care workforce that is competent and confident to work in new models of care delivery and new provider structures. • A supported workforce environment that promotes Hillingdon as an attractive place to work. •	We will: • Increase the mentorship and student placement capacity in general practice for both clinical and non-clinical staff • Ensure supported, and sometimes targeted, recruitment of new staff into general practice including through apprenticeship programmes • Establish GP chambers • Continue to provide staff forums, training and education opportunities • Develop cross-organisational working within the GP Confederation and the ACP • Develop new workforce functions with a focus on sign-posting (care navigators) and medical correspondence Resource change management programme to embed new roles and processes in general practice • Resource local practice managers groups for peer support in IT, HR and general business sustainability	We will: • Establish multi-disciplinary, multi-organisational and multi-HEI packages of properly tariffed student placements • Create targeted, multi-organisational pipeline of new staff recruitment • Develop a CEPN (Community Education Provider Network) function sitting with the ACO provider for multi-disciplinary forums, training and education • Develop more generically skilled, multi-professional workforce managing patients across multi-morbidity packages of care • Continue to properly evaluate and develop new workforce functions and competency frameworks with HENWL and HEIs
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • The workforce required to sustain general practice and help deliver any new models of care or provider structures. • The skills and consistency required to care manage multi-morbidity and increasingly complex patients. • A supported environment in which staff want to stay and work. • Longer clinical appointments in primary care for patients with LTCs due to released clinical time	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • The practice of multi-organisational student placements, staff recruitment including apprenticeships, staff training and working patterns contribute to significant integration across health care settings, • The development of a more generically skilled, multi-professional workforce managing patients across multi-morbidity packages of care will further integrate how care is provided for people.	**The work for this Enabling Theme is underpinned by the following strategies:** NW London Workforce transformation Strategy -2016-2021 Hillingdon Primayr Care Strategy The delivery of this Enabling Theme will be managed and monitored via the **Primary Care Transformation Group** which in turn reports to the **Transformation Group**.

3. Delivering Our Strategic Estates Priorities

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • An estate portfolio that meets the needs of our Transformation Themes.	We will: • Deliver Local Estate Strategy for Hillingdon to support the delivery of the Five Year Forward View and 'One Public Estate' vision • Deliver local services hub business cases for the North and Centre of the Borough • Maximise utilisation of existing estate and reduce void costs • Deliver a temporary solution for Yiewsley Health Centre whilst continuing to find a long term solution for the site • Identify a permanent premises solution for Shakespeare Medical Centre and Yeading Court Surgery • Build primary care estate capacity in Hayes Town to respond to the growth derived from the Housing Zone • To develop a plan for the future of the Northwood and Pinner Community Hospital that respects the heritage of the site and realises the potential of its location	We will: • Deliver a local service Hub in North of Hillingdon by 2020/21 • Deliver a local service Hub in the Uxbridge and West Drayton area by 2020/21 • Deliver a solution for Yiewsley Health Centre by 2019/20
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • A service with the capacity and capability to meet the needs of our population	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • Local services hubs provide physical locations to support patients with a variety of needs through the provision of varying services across primary, community and secondary care with the opportunity to integrate certain elements of services delivered by the Local Authority. • The provision of high quality premises and estate will both contribute to the improvement in the quality of care as well as improved financial performance allowing more funds to be released to support further integrated working elsewhere.	**The work for this Enabling Theme is underpinned by the following strategies:** • Strategic Estates Plan • Strategic Outline Case Part 1 (SoC 1) • Primary Care Strategy The delivery of this Enabling Theme will be managed and monitored via the Strategic Estates Group and **Governing Body Board**.

4. Delivering Our Statutory Targets Reliably		
2020/21 Outcomes	**Commissioning Intentions 18/19**	**Indicative Commissioning Intentions Beyond 18/19**
By 2020/21 we will be delivering the following outcomes: • Achievement of NHS Targets for Referral to Treatment (RTT), A&E and Cancer Waits and Diagnostics as well as our other statutory targets associated with Mental Health	We will: • Continue to achieve the 92% RTT target for Incomplete Pathways for Hillingdon CCG Registered population • Return performance of THH to the expected standard of 95% for 4 hr waits in A&E • Explore in detail the impact of Cancer Breach Sharing Standards and continue to achieve Cancer Wait Targets whilst undertaking an end to end review to ensure continued resilience based on projected prevalence growth in Cancer. • Continue to achieve the statutory targets for mental health	The plans beyond 18/19 will be dependent upon national statutory targets and any changes that are made centrally.
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • Achievement of our Statutory Targets	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • As delivery of our statutory targets normally requires integrated working across multiple providers such as Cancer which will involve Primary Care and a mix of secondary care providers.	**The work for this Enabling Theme is underpinned by the following strategies:** • Hillingdon CCG Operating Plan The delivery of this Enabling Theme will be managed and monitored via the **Planned Care Transformation Group, A&E Delivery Board, Cancer Clinical Working Group, and Mental Health Transformation Group** which in turn report to the **Transformation Group** and **Transformation Board**.

5. Medicines Management

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Reduction in overall medicines expenditure per capita including reduced wastage taking into account growth in costs • Improved outcomes for people utilising medicines and a reduction in avoidable harm • Supporting in reducing unplanned admissions related to medicines • Increased use of skilled workforce e.g. specialised clinical pharmacists in GP practice setting	We will: • Increase support to Care Homes to work towards reducing unplanned admissions in relation to medicines • Focus on medicines optimisation and rollout of practice level specialised pharmaceutical support for medicines reviews • Increase support for virtual clinics for CVD ,Respiratory and Diabetes • Undertake domiciliary medication reviews by specialist pharmacists for the frail and elderly • Undertake domiciliary medication review of newly discharged patients by specialised pharmacists • Review and streamline repeat prescription processes in practices to further support NWL initiatives • Focus on reducing wastage and reducing inappropriate usage of antibiotics • Focus on patient education related to medicines for LTCs via various portals e.g. Health videos • Increase joint working with health professionals across the interfaces and with NWL and London-wide Pharmacy Networks • Increase use of EPS2 and also implement EPS Release 4 and ePrescribing in THH	We will: • Carry on monitoring and supporting practices in ensuring high quality, cost effective prescribing is being carried out without compromising patient care • Support in improving quality and safety of medicines use • Support in the reduction of Medicines waste • Support in Improving patient experience • Increase joint working with health professionals across the interfaces and with NWL and London-wide Pharmacy Networks • Link medicines management within the primary care models of care • Support as an enabler in the transformation themes where appropriate. • Carry on integrated working across the CCG to support the wider strategic agenda
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • Reducing spend per capita on medication • Quality and safety of medicines use is improved • Reducing incidents of harm • Improving outcome for people arising from the effective use of medication • Patient experience is improved with their medicines • Medication waste is reduced • National and local guidance is implemented • Reduction in polypharmacy /Medicines Optimised • Partnership working with relevant stakeholder to improve patient care	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • Medication is an issue that spans the entire healthcare sector and also links into areas such as Care Homes, Social Care and the support provided by Carers. As such, medication and medicines management is by its very nature an issue of integration.	**The work for this Enabling Theme is underpinned by the following strategies:** • Medicines Management Plan The delivery of this Enabling Theme will be managed and monitored via the **Hillingdon Medicines Management Committee** which in turn reports to the **Hillingdon CCG Governing Body**.

6. Redefining the Provider Market

2020/21 Outcomes	Commissioning Intentions 18/19	Indicative Commissioning Intentions Beyond 18/19
By 2020/21 we will be delivering the following outcomes: • Improved capability across the system in meeting the health needs of the local population within the financial constraints • Payment and risk share arrangements that incentivises innovation, quality and sustainability, based on delivery of defined patient-centred outcomes in order to improve quality and demonstrate system transformation • Improved clinical, social, integrated care systems and financial sustainability • System incentivised to work together to enable the needs of the whole person to be met	We will: • Develop a shadow outcome based commissioning model for older people via an ACO (locally referred to as an Accountable Care Partnership or ACP) and seek to identify further cohorts to work with, including recent developments in End of Life, stroke ESD, mental health and MSK, among transformation themes and projects intended for implementation in this year and future years • Create a GP Network Development Strategy	We will: • Enhance and drive forward the 3 year BCF plan with LBH to deliver longer term alignment and integration across Health and social care • Deliver a transformation in Primary Care support through our Primary Care Model of Care • Commission outcomes based services for further population groups including CHC (care homes and home care), other EOL, LTCs, integrated prescribing and children's services • Work with LBH to shape the market and re commission services [illegible] Tier 4 arrangements for people with complex needs. • Further develop the concept, scope and impact of our ACP • Further develop the scope of our capitated payment model and impact of ACP providers.
Measuring Success	**Supporting the Integration Agenda**	**Supporting Strategies & Assurance**
Delivery of this Enabling Theme will realise: • Significant proportion of care delivered through integrated delivery vehicles • A high functioning, cost effective Accountable Care Partnership • Established GP networks and federation capable of delivering services in out of hospital settings • Performance improvement against a set of 29 quality outcome measures of the ACP, linked to improved patient experience, patient and carer quality of life and independence, achievement of care planning goals and support to keep people at home if their needs escalate	**The following areas of this Enabling Theme will contribute to the Integration Agenda in Hillingdon:** • The reshaping of our Provider Market and our work on our Better Care Fund (BCF) Programme is already driving improvements in integrated care across health and social care and will continue to do so. In particular the ACP brings together all health partners and third sector organisations and naturally therefore delivers on our integration agenda for health.	**The work for this Enabling Theme is underpinned by the following strategies:** • Hillingdon BCF • New Care Models for Primary Care & Older People • Local Service Plan • Hillingdon Strategic Estates Plan • NWL Digital Roadmap The delivery of this Enabling Theme will be managed and monitored via the **BCF Officers' Group**, the **ACP Commissioning Group** and **GP Co-Commissioning Board**. These groups are overseen by the **CCG's Governing Body, Transformation Board** and the **Health & Wellbeing Board** collectively.

Section 8: List of Abbreviations Used

Term	Meaning	Term	Meaning	Term	Meaning
A&E	Accident & Emergency	AEC	Ambulatory Emergency Care	ACP	Accountable Care Partnership or Alternative Care Pathway
ACO	Accountable Care Organisation	AF	Atrial Fibrillation	AIDS	Acquired Immune Deficiency Syndrome
BCF	Better Care Fund	BHH	Brent, Harrow, Hillingdon CCGs		
COTE	Care of the Elderly	CCG	Clinical Commissioning Group	CSE	Child Sexual Exploitation
CQC	Care Quality Commission	CQG	Clinical Quality Group	CYP	Children & Young People
COPD	Chronic Obstructive Pulmonary Disorder	CAMHS	Children & Adolescent Mental Health Services	CWHHE	Chelsea & Westminster, West London, Hounslow, Hammersmith & Fulham and Ealing CCGs
CHD	Chronic Heart Disease	CHF	Chronic Heart Failure	CNWL	Central & North West London NHS Foundation Trust
CKD	Chronic Kidney Disease	CMC	Coordinate My Care	CHC	Continuing Health Care
CIE	Care Information Exchange	CIP	Cost Improvement Programme	CVD	Cardio-Vascular Disease
CATS	Community Assessment & Treatment Service	CAATS	Clinical Advice & Triage Service	CQRG	Care Quality Reference Group
DES	Directed Enhanced Service	DTOC	Delayed Transfer of Care	DH/DoH	Department of Health
DNA/s	Did Not Attend/s				
ENT	Ear, Nose & Throat	EoL	End of Life	EGAU	Emergency Gynae Assessment Unit
ED	Emergency Department				
FGM	Female Genital Mutiliation	FY	Financial Year	FUP	Follow Up (Appointment)
FT	Foundation Trust				
GP	General Practitioner	GPwSI	GP with a Special Interest	GB	Governing Body
HCCG	Hillingdon CCG	HAI	Healthcare Acquired Infection	HF	Heart Failure
HRG	Healthcare Resource Group	HENWL	Higher Education North West London	HWB/HWBB	Health & Wellbeing Board
HIV	Human Immunodeficiency Virus	HICU	Hawthorne Intermediate Care Unit		
IT	Information Technology	IV	Intravenous	IPP	Independent Pharmacist Prescriber
ICP	Integrated Care Programme	IAPT	Improving Access to Psychological Therapies	IM&T	Information Management & Technology
ICO	Integrated Care Organisation	IUC	Integrated Urgent Care		
JSNA	Joint Strategic Needs Assessment				
LA	Local Authority	LIS/LES	Local Incentive Scheme Locally Enhanced Service	LoS	Length of Stay

LAS	London Ambulance Service	LAC	Looked After Children	LTC	Long Term Condition
LD	Learning Disability	LBH	London Borough of Hillingdon	LNWH	London North West Hospitals NHS Foundation Trust
MH	Mental Health	MMT	Medicines Management Team	MSK	Musculo-Skeletal
MIU	Minor Injuries Unit	MDT	Multi-Disciplinary Team	MFFD	Medically Fit For Discharge
NWL	North West London	NEL	Non-Elective	NES	Nationally Enhanced Service
NHSE	NHS England	NEPTS	Non-Emergency Patient Transport Service		
OBC	Outline Business Case	OOA	Out of Area	OOH	Out of Hours or Out of Hospital
PKB	Patient Knows Best	PH	Public Health	PCI	Practice Commissioning Initiative
PHB	Personal Health Budgets	PPC	Primary Procedure Code	PYLL	Potential Years Life Lost
PHE	Public Health England	Pt/Pts	Patient/s	PTS	Patient Transport Service
PPE	Public & Patient Engagement	PCC	Primary Care Contract		
QIPP	Quality, Innovation, Productivity & Prevention				
RTT	Referral To Treatment	RA	Rheumatoid Arthritis	RBH	Royal Brompton & Harefield Hospitals NHS Foundation Trust
SRG	System Resilience Group	STI	Sexually Transmitted Infection	SaHF	Shaping a Healthier Future
SSoC	Shifting Settings of Care	SCR	Shared Care Record or Summary Care Record	STARRS	Short-Term Assessment, Rehabilitation & Reablement Service
STP	Sustainability & Transformation Plan				
TB	Tuberculosis	TFC	Treatment Function Code	THH	The Hillingdon Hospital NHS Foundation Trust
UCC	Urgent Treatment Centre	UEC	Urgent & Emergency Care		
VTE	Venus Thromboembolism				
WSIC	Whole System Integrated Care	WTE	Whole Time Equivalent		
ZLOS	Zero Length of Stay				