Hillingdon
Health and Wellbeing Strategy
2018-21

Contents

Foreword ... 2
Introduction ... 3
Our people and communities ... 4
Our health and wellbeing needs ... 5
Our strategy for health in Hillingdon ... 6
Our plans to deliver high quality health and care in Hillingdon ... 9
DA1 – Prevention and Wellbeing ... 10
DA2 – Supporting Long Term Conditions ... 14
DA3 – Improving Older People's Care ... 17
DA4 – Improving outcomes for children and adults with mental health and well-being needs ... 19
DA5 – Ensuring we have safe, high quality sustainable health and care services ... 21
Enablers ... 23

Foreword

Welcome to our Health and Wellbeing Strategy. This is a strategy for everyone in Hillingdon. It sets out how people, public services, businesses, voluntary and community groups will join together so that everyone can access the best opportunities to be healthy and well.

Hillingdon is a vibrant and healthy borough for people to live in. We have excellent leisure facilities, open green spaces and diverse resilient communities. Our local economy is strong and recent transport developments have already led to further growth with greater connections in the south of the Hillingdon. Health and wellbeing in Hillingdon is good overall, but we are determined to build on our record to date and make it even better for everyone

The NHS and Local Government are, however, facing unprecedented challenges. Our task is to make the best use of our resources to provide high quality health and social care that our growing population needs for more complex, seamless care. A strong partnership in health and care delivery in Hillingdon will help us to rise to meet these challenges.

Signed

Cllr Philip Corthorne

Chairman, Hillingdon Health and Wellbeing Board

Introduction

This Joint Health and Wellbeing Strategy outlines our local priorities and plans for ensuring the health and wellbeing of Hillingdon residents. It sets the agenda and focus for Hillingdon's Health and Wellbeing Board to oversee progress in achieving high quality health and care service outcomes in our borough over the next four years.

In order to enable our residents to live well, we commit to the shared North West London Sustainability and Transformation Partnership aims of improving health and wellbeing, the quality of treatment and care, and the sustainability of our health and care system. As a member of the North West London Sustainability and Transformation Partnership (NWL STP), we are aligned to the five Delivery Areas and associated priorities:

1. We will prioritise **prevention** of disease and ill-health through tackling risk factors, early detection, early intervention and proactive case management in primary care. We will work with parents and carers of babies, and children and young people, in order to give the next generation the best start in life with strong public health and social care engagement and support.

2. We will ensure healthcare services are delivered consistently by incentivising the integration of care services to improve the management of **long term conditions**. We will also address variation in health outcomes, particularly when it comes to caring for people with cancer, cardiovascular disease, respiratory disease, diabetes and dementia. We will reduce early deaths from circulatory diseases (heart disease and stroke) through early detection and prevention; and through improving quality and safety of treatment services.

3. We will achieve better experience and greater choice for **older people** in our communities. We will ensure care is coordinated between social, primary, community and acute care services to manage multiple conditions and frailty. We will reduce isolation and loneliness, especially for people suffering from multiple conditions and for their carers.

4. We will improve outcomes and opportunities to live well in Hillingdon for children and adults with **mental ill health needs and learning disability**.

5. We will ensure we have safe, high quality, **sustainable services**, seven days a week.

When anyone in our community experiences mental or physical ill health, or is living with a physical or mental health disability and requires support, health and care partners will come together to deliver high quality care in a setting that is appropriate and convenient for patients and service users. This strategy unifies and aligns local health partners to delivering the national, regional and local health agenda, including: the London Borough of Hillingdon, Hillingdon Clinical Commissioning Group (CCG), Hillingdon Healthwatch and our local health partners: The Hillingdon Hospital Foundation Trust, Central and North West London Foundation Trust, The Royal Brompton and Harefield Hospital, GP Confederation and primary care services, and third sector partners Hillingdon4All, voluntary organisations, and care homes. Through our shared goals, our strategy is our roadmap to achieving our health and wellbeing goals for Hillingdon, together.

Our people and communities

Hillingdon is a diverse, prosperous borough in West London bordered by Hertfordshire, Buckinghamshire, Hounslow, Ealing, and Harrow. Hillingdon is the second largest by area of London's 32 boroughs. The north of the borough is semi-rural with a large proportion protected by green belt regulation with Ruislip as the major centre of population. The south of Hillingdon is more densely populated, urban in character and contains the administrative centre of Uxbridge and towns of Hayes and West Drayton. There is a great deal on offer in Hillingdon to enable its people to live healthy lives. We have large amounts of green and open space. Hillingdon as a whole has around 800 acres of woodland, country parks, fields and farms, several rivers and the Grand Union Canal. We also have excellent leisure facilities, including the Hillingdon Sports and Leisure complex, Ruislip Lido, with a miniature railway and its own sandy beach. Hillingdon can also boast England's first playground designed specifically for disabled children, and several theatres and arts centres. We are proud to have rebuilt or completely refurbished all of our 17 libraries. Additionally, employment rates are high within the borough, and there are low levels of long-term unemployment.

Hillingdon's population is growing, and in 2018 is estimated to be 314,300 people. Hillingdon has one of the highest levels of projected population growth in England for the period 2014-2024, with a projected increase of 16.1%. Our population continues to grow every year and is expected to increase to around 340,000 by 2024. We are anticipating a 16% rise in those aged 65 or over living in Hillingdon, rising from 40,500 to 47,000. The proportion of people aged 85 or over will increase by an even higher proportion, 24.6%, from 5,700 to 7,100. Additionally, more than 78,000 children and young people aged 0-19 live in Hillingdon, representing 26.3% of the total population, slightly higher than the overall London proportion of 24.6%.

Our increasing population is in part due to the significant increase in the number of new births we have seen in recent years. In 2001, 70% of births in Hillingdon were to mothers born in the UK; by 2014 this had fallen to 44%. The largest increase has been births to mothers born in the Middle East, with Asia being the second most common group. The third most common has remained births to mothers born in Africa, and there has been a significant increase in births to mothers born in EU Accession states, now the fourth most common group. We are home to vibrant and diverse communities: one of most diverse boroughs in England with a high Black, Asian, and Minority Ethnic (BAME) population.

We expect the population will continue to grow as new developments progress, bringing new residents to our borough. Within Hillingdon the areas around the town centres of Hayes, West Drayton and Uxbridge are more densely populated. The Great Western mainline also runs through the south of the borough. The construction of Crossrail, scheduled to start operation in 2019 as the Elizabeth Line, is generating major housing growth along its route, including a dedicated Housing Zone in progress in Hayes which includes the former Nestlé factory site. The development of the former RAF Uxbridge site at St Andrews Park, will all contribute to further population growth. Hillingdon also has Stockley Park, one of Europe's largest business parks and employment centres. Many major companies have their headquarters in Stockley Park, Uxbridge and Hayes. Both RAF Northolt and Brunel University are also located in Hillingdon, with Bucks New University at the edge of Uxbridge. Hillingdon is also home to the UK's largest transport hub – Heathrow Airport. Heathrow Airport lies to the south of the M4, the A40 and the Uxbridge Road, which run East-West through the borough.

Our health and wellbeing needs

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.
- Levels of breastfeeding, which provides the best start in life for babies are higher in Hillingdon than the England average.
- A lower proportion of pregnant women in Hillingdon smoke, compared to the rest of England.
- 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, some of our health outcomes are also worse than the national average:

- 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 compared to the national average.
- The proportion of children with dental decay is 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.
- Death rates for men aged 75 or under from cardiovascular diseases are 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 and differences in life expectancy depending on where people are living in the borough. As a result 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. . 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.

Our strategy for health in Hillingdon

Hillingdon has a history delivering health and care transformation to meet the needs of our residents. Our strategy is built on the findings in our JSNA and follows national guidance from the NHS Five Year Forward View and the NWL STP strategy.

We will continue to build upon the good work done in existing local plans, from which we have already seen the benefits:

- Hillingdon Joint Strategic Needs Assessment
- NHS Five Year Forward View
- The NWL Shaping a Healthier Future Programme
- Hillingdon 2013-17 Health and Wellbeing Strategy
- NWL Local Services Programme
- NWL Whole Systems Integrated Care
- NWL Local Services Strategy
- The NWL Primary Care Transformation Programme
- The GP Forward View
- The London-wide Strategic Commissioning Framework for Primary Care
- The HCCG 2017/18 Operational Plan
- Better Care Fund 2015/17 Plan
- The Council's Older Peoples Plan
- Digital Strategy
- Strategic Estates Plan
- Long Term Conditions Strategy
- End of Life Strategy
- Prevention Strategy Quality, Improvement, Productivity and Prevention (QIPP) Plans

The National Picture: The NHS Five Year Forward View, and the North West London Sustainability and Transformation Partnership

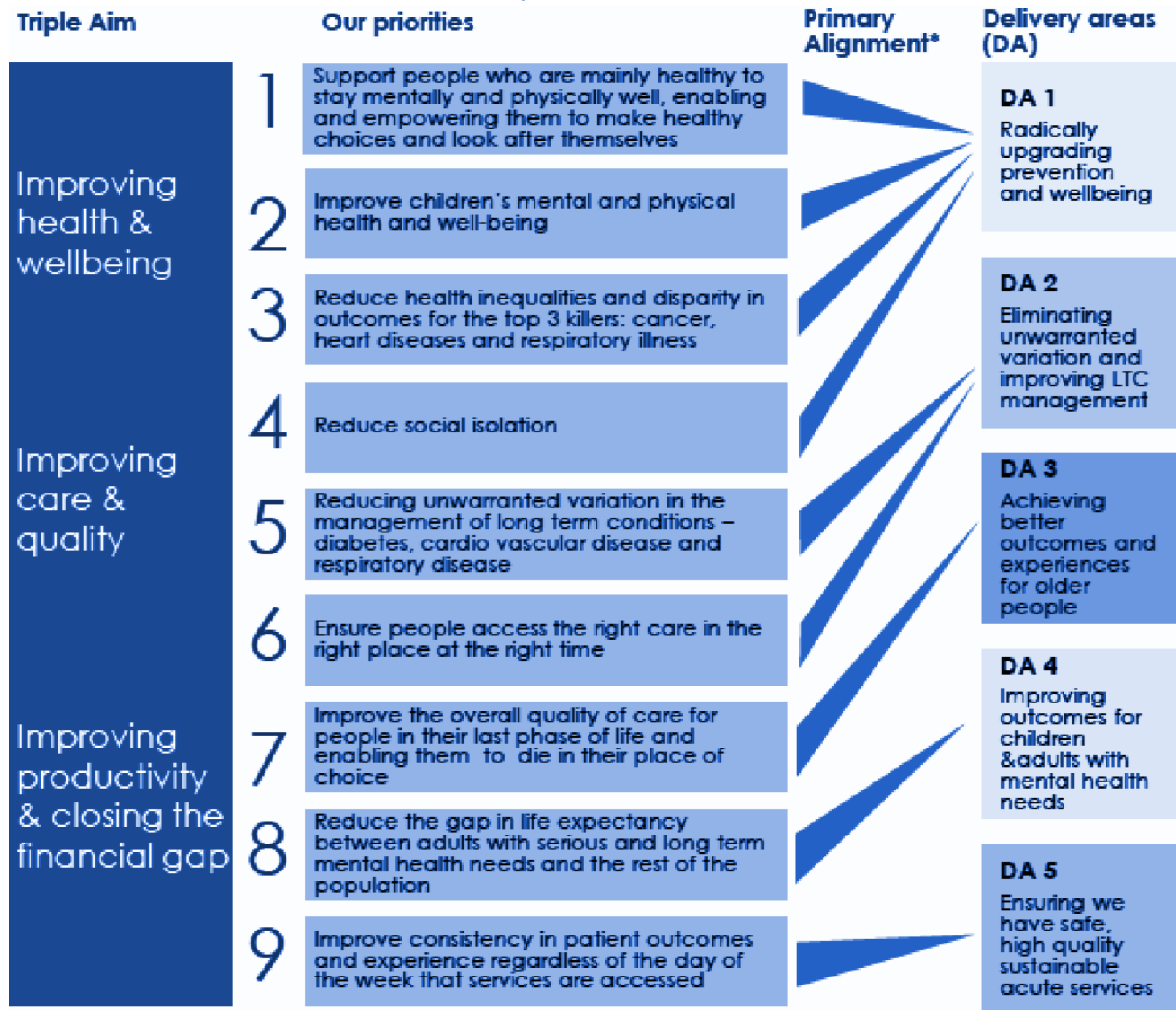
In 2015, the NHS Five Year Forward View articulated a major shift in policy towards place based systems of care through Sustainability and Transformation Partnerships. The approach envisions health and care organisations taking joint responsibility for the health of an entire population, within a particular geographic area. The shift in policy follows a period during which public providers of care services operated with a greater degree of autonomy and competition. The new approach requires organisations to be more strategic and to work to local 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). Joined up STP working 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.

In Hillingdon the Health and Wellbeing partners have developed a Sustainability and Transformation Plan that takes as its starting point the priorities locally and aligns them to the approach of the NWL STP. The NWL STP plan is characterised by broad and overarching themes and 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



The Local Hillingdon Joint Health and Wellbeing STP Strategy Chapter

Hillingdon partners support and promote the high quality, sustainable health and care goals of the Triple Aims, through the NWL STP priorities and alignment of our local transformation programs with the five Delivery Areas. We commit to addressing the unique and specific health and wellbeing needs of Hillingdon, taking advantage of the opportunities that present given the coterminous service provision across the borough. By 2021, we want people living in Hillingdon to be able to say:

- "I am helped to take control of my own health and social care provision"
- "I only have to tell my story once and they pass my details on to others with an appropriate role in my care"
- "If I do need to go to hospital, they start to plan for my social and health care in the community from day one of my stay"
- "Social care and Health Services help me to be proactive. They anticipate my needs before I do and help me to prevent things getting so bad that I need to stay in hospital"
- "I am treated with respect and dignity, according to my individual needs"
- "It doesn't matter what day of the week it is - as I get the support appropriate to my health and social care needs"
- "Systems are sustainable and what once might have been spent on hospital care for me is now spent to support me at home in my community"

Our local approach to achieving these vision statements and implementing the Triple Aims are set out below.

Five Year Forward View Triple Aims – Local Approach

Health and Wellbeing	We will work collaboratively across health, social care and public health to improve outcomes and reduce inequalities for our population with a focus on those with both traditional Long-term Conditions (physical and mental health) and emerging categories of Long-term Conditions such as pain, frailty and social isolation. Our coordinated programme of work will bring together our existing plans for the Better Care Fund (BCF) and seek to engage the whole community to create a resilient population and assist people to remain independent with a better quality of life.
Care & Quality	We will provide care that is safe, effective and provided by experienced practitioners through collaborative working across health and social care services. We will be able to share information that improves the quality of health and social care services and that enables our population to make informed choices. We will deliver the best and highest quality care possible within the constraints of our local economy and the growth in demand that we are predicting.
Sustainable Services	We are committed to achieving better outcomes for individuals and their families through the integration of services and an increased focus on prevention and supported patient empowerment to manage their condition(s).

Our plans to deliver high quality health and care in Hillingdon

Hillingdon has identified 10 transformation themes and 6 Enabling themes as part of our efforts to focus on local priority areas and address health needs within the borough. These themes align with the 5 Delivery Areas outlined in the NWL STP Strategy.

Transformation Themes	
T1. Transforming Care for Older People (DA3)	**T6. Supporting People with Serious Mental Illness and those with Learning Disabilities (DA4)**
T2. New Primary Care Model of Care (DA1)	**T7. Integrated Care for Children & Young People (DA1)**
T3. Integrating Services for People at the End of their Life (DA3)	**T8. Integration across the Urgent & Emergency Care System (DA5)**
T4. Integrated Support for People with Long Term Condition (LTCs) (DA2)	**T9. Public Health and Prevention of Disease & Ill-Health (DA1)**
T5. Transforming Care for People with Cancer (DA2)	**T10. Transformation in Local Services (DA5)**
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**

Our plans to deliver high quality health and care in Hillingdon are linked to a number of key actions and associated outcomes. We have linked key actions and outcomes in order to track progress against goals as actions are taken and milestones achieved. We intend to evaluate service delivery and success from the perspective of enabling our residents to live healthier lives. We therefore draw heavily from the Public Health Outcomes Framework (PHOF) indicators to measure success.

In addition to outcomes indicators, our plans rely on a number of strategies to inform transformation themes and specific service and population programme developments. As such, some actions outlined in this document will be addressed in significantly more detail within the relevant associated strategy. The aim of this strategy is to highlight these key actions and link these programmes to outcomes indicators. In doing so, we will be able to prioritise and focus our efforts to the areas of most need, and to directly link outcome improvements to action plans.

Our plans for the 10 local Transformation Themes detailed in the following pages, aligned to the 5 Delivery Areas, following by plans for the 6 Enabling Themes:

- DA1. Prevention and Wellbeing
- DA2. Supporting Long Term Conditions
- DA3. Improving Older People's Care
- DA4. Improving outcomes for children and adults with mental health and well-being needs
- DA5. Ensuring we have safe, high quality sustainable health and care services
- Enabling themes

DA1 – Prevention and Wellbeing

Key transformation themes:

- Public health and prevention of disease and ill health
- Integrated care for children and young people
- New primary model of care at scale

"I am helped to take control of my own health and social care provision"

In delivering prevention and wellbeing in Hillingdon, we will focus on developing services that place far greater emphasis on keeping people healthy and well in order to lead longer, more illness-free lives. Our healthcare services will be focused on engaging people in keeping healthy. People in Hillingdon will have the support they need to manage their own health and maintain their independence.

We recognise the importance of public health in preventing disease and ill-health and will work to improve our public health outcomes to address variation in health outcomes and prevent disease. We will proactively engage with residents in developing programmes designed to enhance quality and quantity of life, with particularly focus on enabling people to actively take control of their own health and well-being. We further intend to provide integrated services for children and young people to enhance and ensure service coverage so that every child, parent and carer has access to the right care and information to ensure they have a healthy start in life.

A **healthy start in life** for children and young people begins with their mother's health. Avoiding smoking in pregnancy, breastfeeding, and preventing childhood obesity, and good dental health will give our children the best start in life to become healthy young people and adults. By 2021 we aim to reduce the number of women who smoke during pregnancy, promote and increase the rate of breastfeeding, and reduce dental ill-health and childhood obesity in line with the national ambition to give children a better start in life.

Reducing smoking in pregnancy is important to improve health and pregnancy outcomes for both mother and baby. Smoking during pregnancy is detrimental to the growth and development of the babies and the health of mothers. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy. The proportion of pregnant women who were smokers at the time of delivery in Hillingdon has remained around 8% over the previous 4 years but fell slightly to 7.1% in 2015/16. This is below the national average but above the London average.

Breastfeeding is known to promote the health and attachment of mother and baby and reduce the risk of illness in infancy. Current guidance now advises that ideally babies should be exclusively breastfed for about 6 months. Services in Hillingdon have worked hard to ensure that the proportion of mothers who start to breastfeed their babies is high, at 83%. Around 1 in 5 mothers stop breastfeeding after a few weeks. The proportion of mothers still breastfeeding at 6-8 weeks is 65% (2014/15). These figures are higher than the England average but lower than London as a whole.

Good dental health is a significant factor in supporting children to have a healthy start in life. A survey of dental data for 5 year olds in Hillingdon have been found to have one decayed, missing or filled tooth each, significantly worse than the national average. Access to NHS dentistry for children

is also slightly worse than the London and England average. Dental caries (tooth decay) was the commonest single cause of hospital admission in 1-18 year olds, particularly in those aged 5-9. For children the key elements of improving dental health are healthy eating, breastfeeding, good dental care through regular brushing and the application of fluoride varnish at least twice a year for children aged 3 and over, alongside access to dental care.

Childhood obesity can lead to excess weight in adulthood. Evidence from sample surveys carried out by the Sport England 'Active People' Survey for 2014/15 indicates that 62% of Hillingdon adults are overweight or obese. Children are weighed at school at ages 4-5 and 10-11. The results from 2015-16 show that 78% of children starting school aged 4-5 were a healthy weight. This means that 1 in 5 children aged 4-5 is either overweight or obese, according to their Body Mass index (BMI) measurement – or 800 young children in Hillingdon with excess weight. Around half of these children were obese. By the age of 10-11, (Year 6), only 61% were of healthy weight. More than 1 in 3 (37.2%, or around 1,200 children) were overweight or obese which was significantly worse than the England average (34.2%). Evidence from the Active People survey indicates that 51.5% of our residents said they were physically active which was significantly below the England average (57%). Hillingdon's utilisation of outdoor space (14.9%) was below the national average (17.9%), despite the significant amount of greenspace and opportunities for active lifestyles that exist in the borough. We want to ensure that everyone has the opportunity to live an active lifestyle. By 2021 we aim to see an increase physical activity rates in all age groups.

We want our young people to have the best start in life as children, and to have the opportunities available to them to give their children the best start in life. We want to help our young people succeed and to therefore continue to see teenage conceptions in Hillingdon fall. The rate of **teenage conceptions** has fallen considerably in Hillingdon in recent years; from 43.9 per 1000 females aged 15-17 in 2003, to 18.4 per 1000 in 2015. Most teenage pregnancies are unplanned and around half end in an abortion. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than adult mothers. The children of teenage mothers likewise have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems. Infant mortality rates for babies born to teenage mothers is also sadly around 60% higher than for babies born to adult mothers.

Social isolation and loneliness are growing problems, despite our digitally connected society. Surveys of social care users and carers indicate the problem is significant where Hillingdon is achieving poorly against the national rates for users of social services and their carers Age UK evidence suggests that older people are particularly likely to be socially isolated and suffer from loneliness. By 2021, we will have embedded opportunities to enhance social networks that will see a sustained increase in older people, social care service users and carers who report getting as much social contact as they would like.

Smoking is the greatest risk factor for developing respiratory disease, and a leading cause of preventable death and disability. It is estimated to contribute to more than 300 deaths in Hillingdon annually. 15.2% of Hillingdon residents smoke, which is similar to the England average. A higher proportion of younger adults in Hillingdon smoke in comparison to the London average.

Preventing a large proportion of respiratory diseases is possible by addressing lifestyle factors such as smoking as well as environmental factors such as air pollution and damp housing. Furthermore

earlier detection of respiratory disease provides significant benefit to patients and the health service which should be a priority for Hillingdon.

Alcohol and drug addiction and related admissions to hospital indicate a significant need for strong social care and support for those living with addiction. Hillingdon already has liaison and support services in place, and we aim to continue to improve upon our track record, including a locally commissioned Integrated Community Drug & Alcohol Treatment & Recovery Service. There is also a targeted, confidential support service for children and young adults aged 11-25 who are struggling with a drug or alcohol related problem.

Domestic Abuse remains an area of concern in Hillingdon. Multi-agency partners are committed to acting on the recommendations of the Domestic Homicide Reviews for 'Charlotte' and 'Lottie', including reviewing agencies' procedures as well as training and guidance for all front line staff to give them the skills to support and engage with those at risk, and making every contact count.

Prevention and wellbeing will be further supported by a New Primary Care Model. Hillingdon CCG has recently in 2017 taken on delegated commissioning from NHSE England, with the new approach aiming to deliver locally-led transformation in primary care. Locally led approaches to care will provide opportunities to ensure the sustainability of primary care through at-scale joined up delivery via collaboration and networked working. We will work closely with primary care services to improve service capacity, provide extended hours of operation, and improved pharmacy services. Our plans for primary care will be detailed in our Primary Care Strategy, due for publication for Winter 2017.

Transformation program	Key actions to 2021	Key outcomes by 2021
DA1 Radically upgrading prevention and wellbeing ***I am helped to take control of my own health and social care provision***		
T9. Public Health and Prevention of Disease and ill-health	○ Joint Early Intervention and Prevention Services Plan (currently 2015-2018), with implementation from January 2019 ○ Physical Activity Strategy (due April 2018) ○ Develop Suicide Prevention Strategy ○ Address smoking prevalence in young people and adults ○ Embed Patient Education Programme ○ Review of Air Quality action plan.	○ Integrated approach to addressing the wider determinants of health in the borough ○ Improved rate of adults engaging in physical activity to England average ○ Reduced suicide rate ○ Proportion of adult social carers and care users who have as much social contact as they would like ○ Reduced admissions related to alcohol ○ Improved successful completion of drug and alcohol rehabilitation courses ○ Reduced deaths from drug misuse ○ Reduced domestic abuse related incidents and crimes ○ Reduced smoking prevalence in young people and adults ○ Reduced air pollution levels in Hillingdon
T7. Integrated care for C&YP	○ Implement children's health commissioning strategy 2016-2020 ○ Refreshed Children with Disabilities Strategy ○ Improve vaccination coverage to C&YP against vaccine preventable communicable diseases. ○ Implementation of the recommendations from the audit of neo-natal births & babies screening programmes ○ Implement action plan from EQA visit Sept 2016	○ 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 unplanned care needs for CYP ○ Reduction in the risk of harm to children and young people ○ Increased rates of vaccination in the borough ○ Reduced attendance to hospital due to cold/flu related illness ○ Reduced smoking status at time of delivery ○ Improvement in breastfeeding initiation and prevalence at 6-8 weeks after birth

Transformation program	Key actions to 2021	Key outcomes by 2021
	o Delivery of wellbeing training programme for schools o Improved access to consultant led paediatric services o Introduce Single point of Access for CYP	o Increase 0-4 year olds dental health to England average o Reduced childhood excess weight rates o Reduced teenage (under 18) conceptions
T2. New Primary Care Model of Care	o Rollout of Proactive Case Finding in Primary Care to be ready by September 2017 o Rationalisation of Primary Care Contracts and investment in enhanced, at scale primary care o Implementation of Primary Care Model of Care o Develop GP hubs in the North and South of Hillingdon. o Extended out of hours working implemented o Work with urgent care services to provide integrated urgent and primary care services o Expand access to and use of online information and advice o Proactive identification and engagement at primary care level with groups at high risk of developing LTCs o Explore opportunities for diagnostics in the community	o Increasing number of patients managed outside of hospital setting with integration across Primary, Community & Secondary Care Services and Social Care o Reduction in the mortality gap o Reduction in the unplanned care costs associated with supporting vulnerable people and those with an LD o Reduction in unplanned care needs arising for people with a known mental health condition o Greater access to primary care and GP services, with more appointments available

DA2 – Supporting Long Term Conditions

Key transformation themes:

- Integrated support for people with long term conditions
- Transformation care for people with cancer

"I only have to tell my story one and they pass my details on to others with an appropriate role in my care. If I do need to go to hospital, they start to plan for my social and health care in the community from day one of my stay"

Health and wellbeing needs are growing increasingly complex, with more and more people reporting living with chronic conditions. Long term conditions such as diabetes, respiratory (COPD/asthma), neurological (e.g. epilepsy), and heart disease, with some people managing multiple conditions, are a unique challenge to health and wellbeing today. It is estimated that some 20% of residents in Hillingdon are living with a long term condition. Cardiovascular disease, cancer, diabetes and respiratory ill-health are among the top concerns impacting long and healthy lives lived in Hillingdon.

The biggest cause of death in Hillingdon continues to be **cardio-vascular disease** (heart disease, stroke, diabetes, kidney (renal) disease and peripheral arterial disease). In Hillingdon, deaths as a consequence of circulatory diseases accounted for an annual average of 550 deaths (30% of all deaths) in the five year period 2010-2014.

Diabetes is a lifelong cardiovascular-related condition that causes a person's blood sugar to become too high. Type 2 diabetes (approximately 90% of diagnosed cases) is partially preventable – it can be prevented or delayed by lifestyle changes (exercise, weight loss, healthy eating). Earlier detection of type 2 diabetes followed by effective treatment reduces the risk of developing diabetic complications. Around 16,000 people over 17 years of age are diagnosed with diabetes in Hillingdon, 6.7% of the GP register adult population.

Respiratory disease is the third highest cause of death in Hillingdon. It contributes to at least 15% of hospital admissions and cost approximately £10m to the health service in Hillingdon annually, and costs an estimated £5.7m in working days lost. Poor air quality is thought to contribute to a sizable proportion of acute exacerbations of asthma and Chronic Obstructive Pulmonary Disease as well as up to 90 deaths in Hillingdon annually.

Respiratory disease disproportionately affects people of lower socio-economic status due to lifestyle and environmental factors. In Hillingdon there is a clear link between the rate of hospital attendance for acute respiratory disease and how deprived an area is. 3.5% of adults in Hillingdon are thought to have COPD but only 1.2% of them have been identified. The number of residents with COPD is expected to increase to 10,799 by 2030.

Hillingdon has an additional unique respiratory related health concern due to being home to one of its largest transport and employment hubs in England. Poor air quality around Heathrow Airport and high volumes of traffic presents a real threat to health. Other unique local concerns are asthma, with approximately 5% (or c.16, 000 of Hillingdon residents) having been diagnosed with the condition. This is expected to increase to c.33,000 by 2030. Hillingdon also has the sixth highest incidence of tuberculosis (TB) in London, at 36.5 per 100000 population.

Cancer is also a major cause of early deaths in Hillingdon. Nearly 5000 patients were diagnosed with cancer in Hillingdon in 2014/15, 1.57% of the GP registered population. Deaths from all cancers accounted for an annual average of 540 deaths (30% of the total) in the 5 year period 2010-2014. Increasing early diagnosis of cancer is a priority for Hillingdon.

In order to address these needs, there is significant opportunity for more joined up health and care services in Hillingdon in order to deliver the best possible outcomes for patients. By working better together, we will see a reduction in variation in both quality of and access to care throughout our Borough. Patients will receive more responsive, personalised care delivered out of hospital in a safe and effective way; such as through our existing dermatology and pain management services. People with long term conditions will be supported to help lead a healthier life.

Health and care partners are working to develop a common understanding of long-term conditions to provide better support for people in Hillingdon living with long-term conditions. Hillingdon has recently invested in enhanced cancer screening and survivorship services, and we aim to improve cancer screening and diagnosis to national targets by 2021.

In particular, we will work together to tackle early mortality from cardiovascular diseases. We will promote prevention of hypertension and hypercholesterolemia to reduce heart disease, stroke and impact on dementia. We will also promote prevention of Type 2 diabetes through signposting to weight loss services to adults with excess weight. Our goal is to prevent ill-health, and where ill-health conditions develop, or episodes of ill-health flare up, to have in place care pathways and care plans to better proactively support each individual's needs.

Transformation program	Key actions to 2021	Key outcomes by 2020/21
DA2 Eliminating unwarranted variation and improving LTC management ***I only have to tell my story once and they pass my details on to others with an appropriate role in my care. If I do need to go to hospital, they start to plan for my social and health care in the community from day one of my stay***		
T4. Integrated Support for People with Long Term Conditions	o Embed approach to tackling co-morbidities and complex needs o Determine approach to close the gap between those who have diagnosed and un-diagnosed LTCs and by March 2019 show evidence of the gap closing o New AF and stroke pathways and services targeting populations in areas of high need o Expand the Empowered Patients Programme, with initial focus around aiding self-management across a wider range of conditions. Evaluate by April 2018 o We will expand Personal Health Budgets in Hillingdon, putting patients in charge of their treatment options o Expand the usage of Patient Activation Measures to gauge impact of support o Mental health and well-being support to people with long-term conditions will be fully embedded within Hillingdon health systems o Improve support for patients with MH related LTCs o Rollout programme for complex users o Expand ICP to wider cohort	o Reducing prevalence growth for core LTCs and significant progress made in closing key prevalence gaps o Improved outcomes and support for people with multiple LTCs and complex needs o Reduced mortality from cardiovascular and respiratory diseases o Reducing unplanned care needs arising associated with LTCs o Significant progress in patient activation and the numbers of patients self-managing elements of their care o Increase access to and usage of Personal Health Budgets (PHBs) o Reduction in unplanned events for people with LTCs o increase in people with an LTC who self-manage elements of their care o Increase in people with an LTC who have an anticipatory care plan

Transformation program	Key actions to 2021	Key outcomes by 2020/21
T5. Transforming Care for People with Cancer	o Ongoing rollout of actions from our Hillingdon Cancer Improvement Plan leading to earlier diagnosis and improved treatment. o By March 2019 we will complete a review and evaluation of our Cancer Improvement Plan o Improve awareness in GPs to improve 2 week target for timely diagnosis of cancer o We will continue delivery of the National Cancer Vanguard Programme o Roll out clinical protocol for the follow ups in community o Develop Single Point of Access rehab model o Implementation of DA and STT o Rollout outstanding actions from Cancer Improvement Plan o Evaluation of cancer screening outreach programmes	o Reduced mortality from cancer o Improved screening coverage for breast, cervical and bowel cancer o Greater proportion of cancers diagnosed at Stage 1 or 2 o Holistic pathways covering both medical and nonmedical care pathways elements o Integrated cancer rehabilitation programme o SPA survivorship service model o Reduction in unplanned events o Early identification of Cancer patients in primary care/community settings o GP DA and STT community diagnostics

DA3 – Improving Older People’s Care

Key transformation themes:

- New model of integrated care for older people
- Integrated service and coordinate support for people at the end of life

“Social care and Health Services help me to be proactive. They anticipate my needs before I do and help me to prevent things getting so bad that I need to stay in hospital”

Our population is ageing, meaning that people are living longer. Many older people will lead healthy lives, but the demand for health and social care services will rise substantially. There are over 38,000 people living in Hillingdon aged over 65 years. This figure is projected to grow by 7.5% to 41,200 by 2020. This is twice the rate of overall population growth.

Not all extra years gained are spent in good health and disability free. Elderly people have complex care needs and it is estimated that over 30% of elderly patients in our hospitals could receive better care closer to home. Additionally, women who live longer spend a higher proportion of years in ill health than men. Tackling major causes of illnesses like diabetes, heart disease, cancers and stroke are essential for improving gains in disability free life years. Evidence based interventions to reduce high blood pressure, high cholesterol, controlling blood sugar, reducing ,smoking, reducing rates of overweight and obesity (estimated to be higher in older people) and increasing physical activity in older people are some of the strategies which can be used to target older people.

Loneliness and isolation is known to increase with age and is associated with higher use of health and care services independent of chronic illness. Levels of isolation for older people in Hillingdon are similar to national average, however social isolation among social care users and their carers is significantly higher.

Cancer and cardiovascular diseases cause majority of deaths in older people. Cardiovascular illnesses are a major cause of deaths from 'treatable' conditions and can be prevented through improving disease management and preventative action. Improving the uptake rates of flu immunisations and cancer screening programmes are other measures for improving quality and length of life.

There were 1,800 patients diagnosed with dementia on GP registers in Hillingdon in 2015/16, 0.6% of the GP register population. However it is believed that the actual numbers of people living with dementia may be higher with an estimated 2,750 people in Hillingdon in 2015 rising to 3,200 in 2020. This is a projected increase of around 16%. For those aged over 85 it is estimated that in 2015 there were 1,200 people in Hillingdon living with dementia a figure expected to rise by 20% to 1,500 by 2020.

In order to address these issues, our health and social care services will work better together to ensure local people receive better coordinated care –especially those with multiple long term conditions. Over the next five years, more intermediate-level care will be provided out of hospitals to meet the needs of elderly residents. This includes more specialist support to frail elderly people in nursing homes and care homes. It also means providing tailored health and care packages which

can be stepped-up in response to escalating needs; and stepped-down care as patients are rehabilitated. The expansion of our community outreach programmes will provide support for nurses and carers working to help their patients stay in the home for longer, rather than being taken into hospital. Mental health professionals and GPs will work better together with care home staff so they can help patients more effectively. We will have community based teams of local specialist clinicians including practice and community nurses, social care workers, allied health professionals, community mental health workers, GPs, and geriatricians.

Transformation program	Key actions to 2021	Key outcomes by 202021
DA3 Achieving better outcomes and experiences for older people ***Social care and Health Services help me to be proactive. They anticipate my needs before I do and help me to prevent things getting so bad that I need to stay in hospital***		
T3. Integrating Services for People at the End of their Life	○ Implementation of EoL Strategy and new integrated service model ○ Increase access and use of the Coordinate My Care record ○ Enhanced social support for those at end of life	○ Increasing number of people able to die in their preferred place of death ○ Coordination of support to people at End of Life and their families/carers on a 24/7 basis and across all care settings
T1. Transforming Care for Older People	○ Improved vaccination access and service coverage to older people in the borough, including care homes ○ Embed the Care Connection Teams across Hillingdon ○ Ongoing implementation of the Hillingdon Carers Strategy ○ Rollout new models of care for care homes integrating Primary, Community and Secondary Care support including embedding the use of frailty tools ○ Evaluation and further development of programmes focussed on the care homes population ○ Implementation of Home to Assess and integrated discharge pathways ○ Full integration of Co-ordinate my Care and Primary Care clinical records systems ○ Supporting those with dementia and their carers in the community	○ Increased rates of vaccination in the borough and reduced attendance to hospital due to cold/flu related illness ○ Estimated dementia diagnosis rate ○ Reduced emergency admissions due to falls ○ Enhanced reablement outcomes with reduced proportion of older persons still at home 91 days after discharge from hospital, and proportion of clients where no further request made for ingoing long term care ○ Reduction in permanent admissions of older persons to residential and nursing care homes, enabling them to live independently and in the family home for longer ○ Increase in use of Connect to Support service ○ Improved PAM scores in older people ○ Improved proportion of those aged 55+ participating in screening programmes ○ Improved number of carers assessments completed and carers receiving respite or other related service following assessment ○ Increased registered carers on Hillingdon Carers Register ○ Reduced delayed transfers of care ○ Coordinated Care for Older Peoples' Planned & Unplanned Care Needs across Care Settings ○ Improved Health Outcomes through focusing on LTCs and complicating factors ○ Integrated Health & Social Care support for those patients who need it ○ Reduced frequency of unplanned events ○ Reduction in Non-Elective Admissions ○ Reduction in Zero-Length of Stay Admissions ○ Single point of access implemented to simplify referral pathways

DA4 – Improving outcomes for children and adults with mental health and well-being needs

Key transformation theme:

- Effective support for people with mental health and learning disability needs

"I am treated with respect and dignity, according to my individual needs"

Good mental health and well-being is of great importance to ensuring the health and wellbeing of our people and communities. There is some evidence of an increase in numbers of mental health problems in children and young people nationally, although it is not clear if this is because mental health problems are now identified more easily or because the number of problems has risen.

The prevalence of self-reported depression and anxiety in the Hillingdon GP registered population is 9.9%, with hospital admissions for self-harm (10-24 years) 234.7 per 100,000 population. An estimated 4,000 children aged 5-16 in Hillingdon have a mental health disorder, about 60% of whom are boys. Conduct and hyperkinetic disorders are more common among boys and emotional disorders among girls. Some groups are at particular risk including looked after children, young offenders, those with learning difficulties or autism spectrum disorders, and those with long-term physical health problems. There are estimated to be around 2,000 young people aged 16-19 with neurotic disorders, over 350 aged 5-10 with autistic spectrum disorders, and around 480-620 with a learning disability who also have a mental health problem.

Long running concerns about Child and Adolescent Mental Health Services (CAMHS) nationally have been raised in many reports in recent years. Whilst investment has been made into provision of eating disorders and self harm services, more needs to be done to reduce waiting times and intervene early. It is increasingly recognised that the current 'Tier' model of CAMHS should be replaced by a model which places children and young people and their needs at the centre of care.

People in Hillingdon with mental health needs will have a single point of access and their requirements identified early to ensure prevention and improved wellbeing. Those with long term conditions will have psychological support in a community setting through local well-being and prevention services that are provided by primary, community and social care services working together in a coordinated way. Community based services will provide urgent, enhanced crisis and out of hours support giving people the care they need, in the best place and in a timely manner providing better opportunities for healthy active lives.

Community based services will provide urgent, enhanced crisis and out of hours support giving people the care they need, in the best place and in a timely manner providing better opportunities for healthy active lives. Partnership working is critical to improve the co-ordination of care and outcomes, and 'Future in Mind' identifies five priority areas: prevention/early intervention, access to effective support, care for the most vulnerable, accountability and transparency, and workforce development and training. By 2021 we will have improved pathways and response for individuals with mental health needs through our Children and Adults Mental Health Services (CAMHS). We want to ensure those with Serious Mental Illness, Learning Disabilities, and Anxiety have access to the right care, advice, and support.

Transformation program	Key actions to 2021	Key outcomes by 202021
DA4 Improving outcomes for children & adults with mental health needs ***I am treated with respect and dignity, according to my individual needs***		
T6. Effective Support for people with a Mental Health need and those with Learning Disabilities	○ Delivery of the Like Minded Programme ○ Improve support for patients with MH related LTCs ○ Implement MH support for people with a physical LTC ○ Expand integrated care planning to include people with MH needs ○ Rollout new model of Community MH Support ○ Development of psychological support for people with long-term conditions including access to Talking Therapies ○ By January 2019 full operational delivery the strategy for adults and children with autism ○ Implement crisis and out of hours support for CAMHS ○ Commission new CAMHS pathway without tiers by December 2017 ○ Delivery of new model of Community MH Support ○ By March 2019 we will complete evaluation of support programmes for patients with MH related LTCs ○ Delivery of Community LD Services ○ Expand ICP to include people with MH Conditions ○ Rollout new model of Community MH Support ○ Rollout Community LD Service	○ 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 ○ Reduction in the mortality gap ○ Reduction in the unplanned care costs associated with supporting vulnerable people and those with an LD ○ Reduction in unplanned care needs arising for people with a known mental health condition ○ Improved rates of adults with a learning disability living in stable and appropriate accommodation ○ Improved Access to Psychological Therapies (IAPT) recovery rate ○ Improved achievement of two week wait for people with a first episode of psychosis or at risk mental state ○ Reduced waiting time for children waiting for CAMHS treatment

DA5 – Ensuring we have safe, high quality sustainable health and care services

Key transformation themes:

- Transformation in local services
- Integration across urgent and emergency care services

“It doesn’t matter what day of the week it is – I get the support appropriate to my health and social care needs. Systems are sustainable and what once might have been spent on hospital care for me is now spent to support me at home in my community

Our NHS is under significant pressure to radically change the approach to care in order to provide personalise, localised, specialised and integrated care to all. The **NWL Local Services Strategy** outlines in detail how we can ensure we have safe, high quality, sustainable health and care services will see the needed transformation in local services and integration in urgent and emergency care.

There are a number of key challenges facing local services. People across demographies are living longer lives, which is a great achievement for healthy living. It has also meant we are living longer and growing frailer with complex and multiple long term conditions often characterising our last decades. Our local services are seeing growing patient demand with a growing population, and within the problematic context of recruiting, training and retaining our clinical workforce, we are seeing demand outstripping service capacity to provide enough appointments. Underlining these issues is the financial challenge the NHS, and all public services, are facing - even a decade after the global financial crisis. Within the NHS, and NWL, there remains inconsistent provision and access to services, opportunities to improve integration along care pathways, and a need to commission care and interventions much earlier to address the risks and indicators of ill-health. Above all, we must engage and empower residents to take control of their health and well-being.

Implementation of key local actions from the NWL Local Services Strategy will help our hospitals respond more effectively to increases in demand and provide more efficient diagnosis, timely triage and consultant services and effective transfer and discharge processes. Patients will have greater access to care in non-acute settings, including specialist primary care outpatient clinics, treatment diagnostics and urgent care for urgent need. Services will be coordinated and people in Hillingdon will receive complete ‘joined up’ care. We will see the right care provided in the right place, at the right time. Our strategy further acknowledges the role social care can play in putting in place the right reablement, rehabilitation and intermediate care services to support individuals to return home and/or regain their independence.

We aim to address the whole person, and as such our plans will embed mental health and well-being within care pathways to make every contact count. Mental health and well-being care will be integrated into pathways to ensure support is readily available for severe mental illness, learning disabilities, general well-being to address depression and anxiety, as well as support to give patients and their families the confidence to better manage their long term condition, flare-ups of an on-going concern, and general health after a spell in hospital.

Transformation program	Key actions to 2021	Key outcomes by 202021
DA5 Ensuring we have safe, high quality, sustainable acute services ***It doesn't matter what day of the week it is - as I get the support appropriate to my health and social care needs. Systems are sustainable and what once might have been spent on hospital care for me is now spent to support me at home in my community***		
T10. Transformation in Local Services	o Implement NWL Local Services Strategy o Provide medical retina services at Mount Vernon hospital to treat macular degeneration o Enhanced progression of BHH RightCare Programme in line with strategic plans developed in October 2016 o Full implementation of 7 Day Standards o Enhanced progression of BHH RightCare Programme o Rollout of Prevention Strategy o Rollout of Proactive Case Finding in Primary Care o Work to close prevalence gap o Explore opportunities for diagnostics in the community	o Reduction in prevalence gap for key conditions o Reduction in the rate of growth in prevalence o Reduction in the variation in management of conditions o Reduction in the prevalence gap for key conditions o Reduction in the rate of growth of prevalence o Reduction in the management of people with LTCs
T8. Integration across Urgent & Emergency Care Services	o Develop Integrated Urgent Care approach, aligning urgent care services across social, primary, community and acute settings o Rollout new 111 Service and Primary Care Triage Model aligned to national guidelines o Robust monitoring of individuals discharged from hospital to monitor success in avoiding emergency readmissions o Develop and enhance ambulatory care pathway services in out of hospital settings	o Coordination of support across all Urgent & Emergency Care services o Reduced emergency attendance, and non-elective admissions that could be treated in the community o Increase in the number of patients who have their unplanned care needs met outside of a hospital setting o Increased awareness in the community about how to access appropriate services o Increased number of people supported to avoid an admission and those supported home with a reduced Length of Stay o Reduction in rate of growth for unplanned attendances at hospital o Increase in people accessing non-hospital based support for their unplanned care needs o Reduction in the costs per capita managing unplanned care needs o Reduction in Zero-Length of Stay and Unplanned Admissions o Reduction in Length of Stay following an unplanned admission o Reduction in the number of emergency readmissions within 30 days of discharge from hospital

Enablers

Key transformation themes:

- Developing the Digital Environment for the Future
- Creating the Workforce for the Future
- Delivery of our Statutory Targets
- Medicines Optimisation
- Redefining the Provider Market

- Better Care Fund

Our six enabling themes will provide the underpinnings for success in ensuring the sustainability of the health and care system, structures and organisations in Hillingdon. The strategies associated with each of these enablers provide enhanced detail as to the key actions and milestones for implementation.

The Better Care Fund is included here as an enabler due to its role as a pooled budget for the NHS and Local Authorities to agree joint social and health programmes to support improved health outcomes.

Transformation program	Key actions to 2021	Key outcomes by 2020/21
Enablers		
E1. Developing the Digital Environment for the Future	○ Improve access to Shared Care Records ○ Develop plans for digitally enabled self-care ○ Develop plans for use of real time data in decision making ○ Additional promotion of assistive technologies eg telecare and telehealth ○ Delivery of a paperless system through the full integration of Co-ordinate my Care and primary care clinical systems ○ Become paper free at the point of care ○ Eradicate use of fax in care services ○ Deliver robust Shared Care Record that is highly utilised ○ Real time use of data used to inform patients	○ Relevant information safely and appropriately available when needed to coordinate care for people ○ Clear information available to aid planning of services ○ High utilisation of Shared Care Record across setting ○ Services planned using accurate and timely data ○ Improved outcomes for patients through shared record keeping ○ Reduce reliance on paper records
E2. Creating the Workforce for the Future.	○ Develop recruitment and retention strategy ○ Develop mutli-professional workforce plans ○ Brunel University London (BUL) with THH NHSFT and CNWL NHSFT establishing an Academic Centre for Health Sciences ○ Develop plans with Buckinghamshire New University for workforce development ○ Rollout recruitment and retention strategy and workforce plans	○ A workforce that meets the needs of the evolving health and social care market ○ A service with the capacity and capability to meet the needs of our population ○ Reducing sickness and absence rates ○ Improving skills and competences within the workforce
E3. Delivering our strategic estates priorities	○ Better utilise estates with a view to integration of health and care services	○ Deliver Local Estate Strategy for Hillingdon

Transformation program	Key actions to 2021	Key outcomes by 2020/21
E4. Delivery of our Statutory Targets	○ Robust demand and capacity study undertaken around RTT, Cancer and Diagnostic Targets ○ Continued focus on improvement in A&E Performance ○ Develop resilience plan around core measures ○ Development of diagnostic capacity to meet demands and targets for Cancer pathways ○ Rollout resilience plans	○ Continued, consistent and sustained achievement of our mandatory and statutory targets: ➢ A&E ➢ RTT ➢ Cancer ➢ LAS handovers
E5. Medicines optimisation	○ Focus on medicines optimisation and rollout of practice level pharmacy support with medicines reviews and repeat prescriptions ○ Focus on reducing wastage and reducing inappropriate usage of antibiotics ○ Implement Choosing Wisely	○ 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 ○ Reducing spend per capita on medication ○ Reducing incidents of harm ○ Improving outcome for people arising from the effective use of medication
E6. Redefining the Provider Market	○ Rollout and trial ACP model and develop plans for future cohorts ○ Develop Network Development Strategy ○ Implement recommendation of THH master planning exercise ○ Implement the 2016/17 market shaping activities ○	○ A market capable of meeting the health and care needs of the local population within the financial constraints ○ A diverse market of quality providers maximising choice for local people ○ Significant proportion of care delivered through integrated delivery vehicles ○ A high functioning, cost effective Accountable Care Partnership

Better Care Fund

The Better Care Fund was introduced by Government in 2015 to support closer working between health and care sectors, with the ambition of integration of health and social care by 2020. It established a joint pooled budget for services and encouraged joint working. In Hillingdon focus was directed at supporting services for people aged over 65 especially those with long term medical conditions.

The BCF plan is key to the delivery of the aspects of Hillingdon's Sustainability and Transformation Plan that are dependent on integration between health and social care or closer working between the NHS and the Council for delivery. The Better Care Fund proposals for 2017-19 identifies six detailed workstreams:

- Early intervention and prevention
- Integrated support for carers
- Better Care at end of Life
- Integrated Hospital Discharge
- Improving care Market management and development
- Living well with dementia

Key actions and outcomes include:

- Evaluate the impact of BCF schemes for over 65s. Assessment of impact of benefit realisation on the NHS and LA.

- Early intervention and prevention workstream (BCF1) including access to information and advice, use of patient activation measure to gauge impact of support and developing the preventative role of the third sector though the H4All Wellbeing service, Stroke prevention initiatives, promoting physical activity in older people and developing use of assistive technology and disabled facilities grants.