HILLINGDON'S JOINT HEALTH AND WELLBEING STRATEGY 2018-2021

Relevant Board Member(s)	Councillor Philip Corthorne Dr Ian Goodman
Organisation	London Borough of Hillingdon Hillingdon CCG
Report author	Kevin Byrne, LBH Health Integration Sarah Walker, HCCG Transformation and QIPP
Papers with report	Appendix 1 - Delivery area, transformation programme and progress update

1. HEADLINE INFORMATION

Summary	This paper reports against Hillingdon's Joint Health and Wellbeing Strategy 2018-2021. It also highlights key current issues that are considered important to bring to the Board's attention regarding progress in implementing the Strategy.
Contribution to plans and strategies	The Hillingdon Joint Health and Wellbeing Strategy (JHWBS) and the Hillingdon Sustainability and Transformation Plan (STP) local chapter have been developed as a partnership plan reflecting priorities across health and care services in the Borough. The JHWB strategy encompasses activity that is underway including through various commissioning plans, the Better Care Fund and in taking Hillingdon towards an Accountable Care System.
Financial Cost	There are no costs arising directly from this report.
Ward(s) affected	All

2. RECOMMENDATIONS

That the Health and Wellbeing Board:

1. **considers the issues raised at 3 below regarding live and urgent issues in the Hillingdon health and care economy.**
2. **notes the performance issues contained at Appendix 1.**

3. INFORMATION

Background Information

3.1. Performance and Programme management of the Joint Strategy

Hillingdon's Joint Health and Wellbeing Strategy was published following agreement by the

Board in December 2017. The system turnaround functions of the Transformation Group and Transformation Board have been redirected toward monitoring progress against the 10 priorities and 6 enabling priorities identified in the strategy.

The Transformation Group monitors performance against the priorities set and receives regular highlight reports on progress against transformation aims, enabling challenge from partners and explorations of further actions. The Transformation Board consists of the senior executive officers from partners and promotes the Joint Strategy and aligns organisational objectives to the shared priorities. Key performance issues emerging from this process are identified in Appendix 1.

3.2. Key Issues - Current

In addition, the Board has asked to be kept fully aware of any significant live and urgent issues that may emerge as part of the delivery of the Strategy. These are:

3.2.1. Financial position across the Health and Care System in Hillingdon

There is a cumulative underlying deficit within the Health and Care system in Hillingdon of some £40-50m in 2018-19, based on current forecasts of outturn against control totals and budgets, including internal organisational efficiencies needed to achieve these. HCCG and Hillingdon Health and Care Partnership (HHCP) are working towards a 3-5 year financial plan to underpin the joint strategy. Funding and demand pressures continue to dominate transformation plans.

3.2.2. Unplanned Care

Unplanned care continues to be a focus for the system so that we can ensure that where people require unplanned care this is provided in the setting most appropriate to that need. Partners are working together through an integrated A&E recovery plan which has support from regulators NHS England and NHS Improvement to address admission, in-hospital flows and discharge toward returning home. Transformation efforts are likely to be impacted by plans to rebuild part of the A&E unit with an additional 8 beds, for which current plans require relocation of the Urgent Care Centre facilities. The next step is to build on the successful approach to discharge to reduce admissions and support primary care and community based services.

3.2.3. Discharge from hospital and DTOCs

Collaboration around early discharge from hospital continues to produce good results for residents. The outturn at year end 2017/18 for Delayed Transfer of Care (DTOC) against target was some 2,800 days below the target set via the Better Care Fund (see separate BCF report). Provision has been procured within the community to enable safe discharge and processes within the hospital reviewed. Challenges remain regarding the longer funding of the community provision and creating space for a multi-partner discharge team at THH.

In addition, the new targets proposed via the BCF for 2018/19 appear to penalise this success by setting increasingly demanding targets. Further work is underway to establish what, from the Hillingdon system's perspective, would be a fair and reasonable target. These challenges are set out in the BCF report for consideration by the Board.

3.2.4. Developing Hillingdon Health and Care Partnership

Hillingdon Health and Care Partnership is moving its focus from older people (65+) to all adults' care in 2018/19. The Partnership is using the joint governance and joint delivery

approaches developed last year to further galvanise whole system transformation around self-care, urgent care, falls and frailty, end of life, care home, enhanced case management (physical and mental health), integrated MSK and prescribing. The aim is to deliver continued improvements in year and further develop integrated models for 2019/20 and beyond. Additional work has been focused on developing partnership and joint approaches to workforce development and business intelligence to support integrated care across all partners in Hillingdon.

3.2.5. Alignment of Children's therapies services

The Council and HCCG have been jointly working with parents and carers, schools, early year settings and service providers to identify key improvements that would better support children, parents and their carers. There has been a focus on integrated therapies as an area for joined up commissioning and development that will address best practice in prevention, simplified access and additional coaching and development for parents, schools and practitioners.

3.2.6. Public Health

There are no new infectious disease concerns to bring to the Board's attention on this occasion. The Scarlet Fever outbreak mentioned at the last meeting has receded and fallen to 386 cases nationally at week 22 (to 3 June 2018) down from 1,267 at week 17. There were no cases reported in Hillingdon but small numbers in Harrow, Hounslow, Ealing and Hertfordshire. There are no current issues with sexual health and substance misuse services.

3.3. Key Issues – Looking Ahead

3.3.1. Social Care Green Paper

The Government has indicated it will produce a social care green paper before the summer recess. Media reports reflect positioning from within NHS and local government regarding the overall shortfalls in funding and lobbying for resolution. Further details should be available for the Board's next meeting. The Green Paper is more likely to provide some sort of view as what health and care integration really means and how work started in Better Care fund plans should proceed over coming years.

3.3.2. London Devolution

The Mayor of London is also pressing ahead with proposals to seek devolution of functions. A London Estates Strategy is expected over the summer.

3.3.3. The Hillingdon Hospital CQC Inspection

The recent inspection is expected to report soon.

4. Financial Implications

There are no direct financial costs arising from the recommendations in this report.

5. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

The framework proposed will enable the Board to drive forwards its leadership of health and wellbeing in Hillingdon.

Consultation Carried Out or Required

Public consultation on the Joint Health and Wellbeing Strategy 2018-2021 was undertaken in 2017. Feedback from this was incorporated into the current document.

Policy Overview Committee comments

None at this stage.

6. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

Corporate Finance has reviewed the report and concurs with the financial implications set out above.

Hillingdon Council Legal comments

The Borough Solicitor confirms that there are no specific legal implications arising from this report.

APPENDIX 1

Delivery Area, Transformation Programme and Progress Update - June 2018
DA 1 Radically upgrading prevention and wellbeing
T9. Public Health and Prevention of Disease and ill-health • **The Early Intervention, Self Care and Prevention working group has been established and has reviewed local action against the Public Health Outcomes framework. Key "red" issues for further work relate to Obesity in Children and physical activity in Adults.** • **The 2018/19 public health core offer to the HCCG will support commissioning and especially focus on MSK commissioning, diagnostics, substance misuse/ dual diagnosis and multi- morbidity needs.** • **The updated Hillingdon Carers Strategy and Memorandum of Understanding was agreed by the Council's Cabinet in May and is being taken through partner governance processes.** • **The Hillingdon Suicide Prevention steering group has agreed an Action Plan. Key focus of effort will be on defining points of referral for support, publicising these and ensuring frontline professionals have training to spot early signs of distress.**
T7. Integrated care for Children and Young People **There are three initiatives underway that support integrated care for children and young people:** **Paediatric Integrated Community clinics – Clinics offering a joint GP and Paediatrician consultation are now available in the north, south and middle of the borough. The GP confederation is continuing to engage and recruit more practices to take part in the scheme.** **Hillingdon Children's Asthma service – Engagement and collaboration between GPs, hospital staff and schools is helping to improve asthma care for children and young people. More children are being seen in the community and early indications suggest a reduction in missed school days through earlier identification and support for CYP to better manage their asthma.** **Integrated Therapies – Recent engagement events with parents, schools and service providers is helping to shape the development of a new service specification. This joint CCG / Council project is on schedule to commence a procurement exercise in July.**

Delivery Area, Transformation Programme and Progress Update - June 2018

T2. <u>New Primary Care Model of Care</u>

- **Having rolled out the care co-ordinator teams across Hillingdon the focus has now shifted to address variation across practices via the Integrated Care Programme contract managed by the Hillingdon Primary Care Confederation.**
- **As part of the commissioning at scale programme, the CCG is working with Hillingdon Primary Care Confederation and developing plans to commission locality level population health management. This will incorporate prevention, pro-active care, integrated care and risk stratified approaches to different segments of the population with localities. This work is supported by Hillingdon's public health locality profiles.**
- **In order to improve access now the three extended GP access hubs are operational across Hillingdon. A new key development is that the 111 service and the Urgent treatment centre now are able book GP appointments directly into the hubs. The hubs operate from 6.30 to 8 p.m. weekdays and 8 to 8 p.m. week-ends.**
- **Also, a review is underway of all the primary care contracts (e.g. diabetes, end of life, prostate cancer, wound dressing etc.) to develop a single outcome based contract for general practice that will support the population health management approach**
- **In addition, the CCG is about to launch a new primary care contract entitled 'Increasing clinical capacity' that will support general practices in the introduction of new roles and functions such as sign-posting (care navigation) and the management of clinical correspondence (part of the strategy to release clinicians from administrative tasks). In addition, this contract will also focus on encouraging GPs to undertake physical health checks for patients with severe mental health conditions and people in the learning disabilities registers.**

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DA2 Eliminating unwarranted variation and improving LTC management
T4. <u>Integrated Support for People with Long Term Conditions</u> **A key development has been the piloting of Multi Morbidity Clinics which focus on managing complex patients in a holistic manner in primary care. The service will be integrated to support all LTC pathways with a strong focus on self supported care with a "Year of Care" approach. If successful, it is expected this model will be rolled out across Hillingdon and the consequent commissioning of Multi Morbidity clinics by next year.** **Also supporting the strategy is the establishment of new referral mechanisms to encourage GPs to refer patients with long-term conditions to the Myhealth programme. This involves investment in financial incentives for GPs and the introduction of Patient Activation Measure (PAM) assessments in general practice.** **In addition :** • **Hillingdon operates an integrated service for Respiratory with a focus on COPD management, admissions avoidance and sees people outside of hospital setting in community and at home.** • **Hillingdon offers early diagnosis and prevention of stroke through managing AF and Hypertension in Primary Care.** • **Hillingdon offer an integrated community diabetes service, with a focus on management in the community as well as providing education and supporting Primary Care manage complex patients at practice level.**
T5. <u>Transforming Care for People with Cancer</u> **Our key priorities in 18/19 are to improve GP awareness and access to early diagnostics as well as follow-ups in the community, and to improve early diagnosis through improved screening. Progress has been made through programmes of testing, research and piloting of safety-netting in GP practices currently underway to support improved awareness and timely, early diagnosis of cancer. This will further support evaluation of screening and outreach to identify best practice.** **Additionally, direct access (DA) and straight-to-test (STT) pathways are being improved to support access and maintain the high standard of care in Hillingdon. For survivors of prostate cancer, follow-ups in the community are being implemented with good initial take-up from GPs as from December, with the potential to develop community self-support models being reviewed as part of a survivorship model. Focus areas for 18/19 are colorectal and lung cancer for which Hillingdon has poor early diagnosis and health outcomes. This is after work in 17/18 to improve breast, bowel and prostate cancer early diagnosis and survivorship.**

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DA3 Achieving better outcomes and experiences for older people
T3. Integrating Services for People at the End of their Life **We continue to implement the End of Life Strategy, with focus on integrated working with local partners around an EOL Single Point of Access and Palliative Overnight Nursing Service. Implementation of the new integrated service model has been delayed due to the scarcity of skilled palliative and end-of-life care health workforce to support palliative overnight nursing care. Action is currently being taken to address the staffing complement to prevent further delay to this service. Enhanced focus in this area has nevertheless seen improve access and use of the Coordinate My Care (CMC) Record, and improving coordination between existing services as part of efforts to achieve integration goals.**
T1. Transforming Care for Older People **Integration between health and social care and/or closer working between the NHS and the Council, is contributing to meeting the needs of residents and is reflected in the BCF plan. Details of the next steps in the Government's integration agenda are awaited and it is expected that these will be reflected in the Social Care Green Paper and ten year plan for the NHS that are due for publication in July. The BCF performance report on the Board's agenda explores some areas for consideration.**
DA4 Improving outcomes for children & adults with mental health needs
T6. Effective Support for people with a Mental Health need and those with Learning Disabilities **To support the focus of local work for people with a Learning Disability the CCG undertook a Learning Disability consultation from January to May 2018; the consultation aimed to understand the current experience of people using or working with Learning Disability Community Health Teams to identify good practice and make recommendations for future developments. The consultation included an online survey and a number of events held with people with Learning Disabilities, their families and key staff working in the Borough** **In response to the Mayor's consultation on pan-London health based place of safety provision NWL is developing a evidence based model of Health based Place of Safety and Crisis Care provision that will inform locally led discussions and development of a fit for purpose service response that meets the needs of Hillingdon residents and is supported by all stakeholders. Currently the data (including local 136 presentations) is being collated by NWL, and will be presented to local stakeholders including Police, Local Authority, CNWL and service users and carers to inform the discussions.** **Hillingdon continues to make progress in delivering the commitments in the Local Transformation Plan for children and young people. 13% more young people with mental health problems have been seen than last year. The THRIVE framework model is being rolled out in partnership with all providers, schools and community groups and a network established. A fuller report is included in the Board's agenda.**

Delivery Area, Transformation Programme and Progress Update - June 2018
DA5 Ensuring we have safe, high quality, sustainable acute services
T10. <u>Transformation in Local Services</u> **2017/18 DTOC targets imposed on Hillingdon by NHSE were exceeded, despite the challenges of winter and increased demand affecting A&E waiting times.** **Intensive work between partners to transform the hospital discharge model is in progress that will result in all people who require assistance to return home from Hillingdon Hospital being referred to a single integrated discharge team. Proposals for ensuring the sustainability of the hospital discharge model are due to be considered by the Discharge Executive, i.e. Chief Operating Officers from the Hospital and CCG, CNWL's Deputy Chief Operating Officer and the Council's Corporate Director of Adult, Children and Young People's Services, in June 2018. The BCF report separately on this meeting's agenda contains more detail about this area.** **Work with partners is also underway to address delayed transfers of care (DTOCs) attributed to mental health, which represent the greatest proportion (60%) of delayed days for Hillingdon. Partners are currently working on an updated Mental Health DTOC action plan which will be completed by the end of June. It is anticipated that this will need to be submitted to NHSE to comply with requirements for the second year of the BCF plan (2018/19), which have not yet been published.** **Work is underway within North West London to align and standardise pathways to acute care for top referring specialities. We are currently working with primary care to support improved understanding and early diagnostics to improve patient access to the RightCare the First Time.**

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T8. <u>Integration across Urgent & Emergency Care Services</u> **Hillingdon is participating in the development of a new NWL wide integrated urgent care approach and, in particular, the rollout of the new 111 service model. Additional resource has been invested in the 111 service to increase clinical advice for patients and appointments can be booked directly by 111 into the Urgent Treatment Centre (UTC) or extended access hubs.** **The UTC has been re-commissioned with enhanced KPIs to national guidance and the service will continue with the current provider.** **Guidance encouraging greater focus on Ambulatory Care Pathways is supporting existing and ongoing local efforts. Regular workshops are in place to develop services further and to ensure that, whenever appropriate, patients follow this pathway and avoid an unnecessary admission to hospital.** **Unplanned attendances to A&E are nevertheless rising and greater community awareness to access earlier care and clinical guidance from GPs, nurses, and other health staff will support improved population health outcomes.** **The CCG has invested in extended primary care hours to support enhanced, non-emergency care access and capacity in Hillingdon (see T2 above), through the three hubs and extended hours.**

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Enablers
E1. <u>Developing the Digital Environment for the Future</u> **Hillingdon is seeing improved access to shared care records, with the focus turning to support stakeholder organisations to use these in day-to-day operations to support personalised care. The local system is also implementing a 'Paper Switch Off' date in line with national guidance/timelines and NWL plans for the delivery of a paperless system. New priorities are developing plans for self-care as well as clinical decision support tools.** **Some specific examples are as below;** • **Development to allow Pan-Hillingdon MIG users to have access to free text consultation information in the GP record. This additional functionality will help to enhance the quality of service being delivered and working towards integration of shared information across care settings.** • **EMIS and SystemOne interoperability - SLIP (Supplier Lead Interoperability Programme). Giving capability for community clinicians to access EMIS GP system to view the patients' medical records, via their TTP system, and for the EMIS GP to review consultation notes/reports on the TTP system. Thus saving time by not having to wait for written reports to be posted or emailed back to the patient's surgery.** • **Improving Patient care, right treatment first time, save time and reduce clinical costs. Unfortunately there have been some delays but we are now starting to make progress, we should start to see some success when testing restarts.** • **111 direct appointments booking into Extended Hubs has been successful tested. This functionality has been enabled since 24/03/2018.** • **Patient Online access (PoL) - Empowerment for the patients to manage booking / repeat prescriptions - work is progressing at pace to support GP practice to engage and enable patients to make all referral booking online. The CCG are on target to achieve national targets set by NHSE.** • **Development of standardised clinical systems templates across care setting and systems across North West London – work is progressing in collaboration with NWL CCG's and providers , this will enhance the quality of data across disparate systems and organisations.** • **GP WiFi - Benefits to Patients - Deliver WiFi for Patients and Guests to all GP Practices within Hillingdon .The Practice can use the home page to announce new services or changes to the Practice and improve the overall Patient Practice experience. The projected timescale is to complete end of July 2018.**
E2. <u>Creating the Workforce for the Future</u> **HHCP and HCCG are starting to develop a joint workforce strategy and a learning and development plan that focuses on shared behaviours and values across the partnership. Self Care and Self management will be a first priority.**

Delivery Area, Transformation Programme and Progress Update - June 2018
E3. <u>Delivering our Strategic Estates Priorities</u> **Separate report is included in part 1 setting out progress in developing the North of Hillingdon and the Uxbridge and West Drayton hubs together with issues regarding GP provision at Yiewsley, Hayes and Heathrow Villages.**
E4. <u>Delivery of our Statutory Targets</u> **Hillingdon has a robust performance management structure in place that is delivering updated demand modelling as part of 18/19 operational planning.**
E5. <u>Medicines optimisation</u> **Latest progress against the annual programme to assure medicines optimisation is :** • **Increased support to Care Homes to work towards reducing unplanned admissions in relation to medicines.** • **Rollout of practice level specialised pharmaceutical support for medicines reviews and clinics – supporting medicines optimisation agenda.** • **Increased support for virtual clinics for CVD, Respiratory and Diabetes.** • **Reviewing and streamlining repeat prescription processes in practices to further support NWL initiatives** • **Focussed practice support to manage inappropriate usage of antibiotics.** • **Focus on patient education related to medicines for LTCs via various portals e.g. Health videos**
E6. <u>Redefining the Provider Market</u> **Hillingdon Health and Care Partnership (HHCP) has now moved from the 'testing' year in 17/18 and commencing its operational year starting April 2018. The Council continues to work with HHCP through their joint board and at an operational level to help shape the business plan, financial modelling and the model of care.** **HHCP is moving the focus from older people (65+) to all adults (18+) care in 2018/19. The partnership is using the joint governance and joint delivery approaches developed last year to further galvanise whole system transformation around self-Care, urgent care, falls and frailty, end of life, care Home, enhanced case management (physical & mental health), integrated MSK and prescribing. The aim is to deliver continued improvements in year and further developing integrated models for 2019/20 and beyond. Additional work has been focused on developing partnership and joint approaches to workforce development and business intelligence to support ACP working across all partners in Hillingdon.**