APPENDIX 1

NHS
Hillingdon
Clinical Commissioning Group

FINAL Commissioning Intentions 2019-2021

September 2018

NHS
Hillingdon
Clinical Commissioning Group

Contents

1. Foreword

Ian Goodman
Clinical Chair

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Welcome to NHS Hillingdon Clinical Commissioning Group's (CCG) Commissioning Intentions 2019–2021. This document informs our partners in health and social care, our local population and other stakeholders about our plans for NHS services in Hillingdon (including changes to service provision). Under **NHS England's Improvement and Assessment Framework**, all CCGs are evaluated and given a rating according to performance, delivery, outcomes, finance and leadership. Hillingdon CCG was rated **"Good"** by NHS England in the 2017/18 annual CCGs' assessment. We want to build on the CCG's excellent progress to date.

Hillingdon CCG, along with other CCGs in London and nationally, faces real challenges in its delivery of improved outcomes and high quality health care for patients. These challenges include: increased demand and constrained financial resources. We recognise that we can only achieve our ambitions by working together with the other CCGs in NW London; and also moving towards ever closer alliance with our health and social care partners to develop **better and more "joined up" care for patients** as part of an **Integrated Care System** (ICS). **The NW London Sustainability and Transformation Plan** (NWL STP) sets out how working together across eight boroughs (Hillingdon, Harrow, Hounslow, Hammersmith & Fulham, Ealing, Brent, Kensington and Chelsea and Westminster CCGs), will enable us to address the triple aims of the Five Year Forward view: improving people's health and wellbeing, improving the quality of care and addressing the financial gap. This document should be read in conjunction with the **NW London Sustainability and Transformation Plan** and the Hillingdon Health and Wellbeing strategy.

As part of our Commissioning Intentions, NHS Hillingdon is striving to meet the demands on local Primary Care - increasing convenient access to GP services, supporting the GP Confederation to provide more services in the community and working with our GP membership to improve local NHS services. We would like to thank everyone who has contributed to the developing of these intentions and look forward to working with patients, local people and providers to secure the best outcomes in healthcare for everybody in Hillingdon.

2. Aim of the Commissioning Intentions

These Commissioning Intentions (CI) outline our plans to commission high quality healthcare to improve the health outcomes for Hillingdon patients for 2019-20 and 2020-21.

CCGs have a duty under the Health and Social Care Act 2012 to publish their plans to commission services with respect to:

- s14R - Continuously improving the quality of services
- s14T - Reducing inequality of access and health outcomes
- s14Z2- Ensuring public involvement and consultation
- s223H-J - Responsibly commissioning services within budget

The CI is a living document that will evolve over time based on further engagement activities with the public, partners and providers, in line with current national, regional and local strategies to 2021, and discussed in further detail in The Strategic Context section (4). We will continue to develop, embed, and scale commissioned services outlined in our 2018-19 CI. These CI for the next two years will therefore highlight our plans for new programs of work.

This document should also be read in conjunction with the CI stated for NHS England (NHSE) and for the NW London Collaboration of CCGs.

3. About Hillingdon CCG

Hillingdon Clinical Commissioning Group (CCG) is the organisation responsible for purchasing most of the health services for the people of Hillingdon in line with the Health and Social Care Act 2012. We ensure that the commissioned health services in Hillingdon are of high quality and meet the needs and reasonable expectations of our population now into the future.

We operate within a financial budget and are responsible for the discharge of funds to purchase safe, effective and sustainable health services. We are required to meet statutory financial obligations to remain in balance and maintain a 1% surplus. This document sets out how we aim to achieve these requirements over the two financial years 2019-20 and 2020-21.

The population of Hillingdon includes all patients registered with a Hillingdon based GP and unregistered people resident in Hillingdon. Some elements of healthcare are commissioned by the London Borough of Hillingdon (LBH) and other bodies such as NHS England (NHSE).

Hillingdon CCG now has Level 3 delegated commissioning responsibility: which enables local ownership of strategic investment decisions in primary care that encompasses the totality of resources available; brings together previously disparate national and local commissioning initiatives to plan in a more coherent way; draws on local leadership and expertise to commission primary care in a way that addresses local health needs; and aims to deliver the greatest scope for influencing health and system outcomes in the borough.

4. The Strategic Context & plans towards working as an Integrated Care System (ICS)

In developing our local CI, we are considering our local challenges and needs as well as those of the wider NW London health economy and national policy. This section outlines the national, NW London and local strategic context and response to challenges.

4a. The National Strategic Context

In 2015, the NHS Five Year Forward View (FYFV) articulated a major shift in policy towards place-based systems of care through Sustainability and Transformation Partnerships (STPs). The approach envisions health and care organisations taking joint responsibility for local populations within a geographic area. The policy context requires organisations to recognise their strategic role as central hubs in place-based systems of care.

The FYFV further sets the Triple Aims of improving people's health and wellbeing, improving the quality of care that people receive and addressing the financial gap between the cost of expected services and planned budgets. This 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 organised itself into 44 Sustainability and Transformation Partnerships (STP) across England. Hillingdon is a member of the NW London STP. Through STPs, the NHS will address health and wellbeing needs through: aligned public health and prevention of ill health; joined up services across health and social care; empowering patients and communities; strengthening primary care; and achieving efficiencies in health and care services.

Celebrating the 70th Anniversary of the NHS with staff
Sarah Walker *(Associate Director for QIPP, Transformation & Planning)*
Joe Nguyen *(Deputy Managing Director)*

4b. Plans to work towards an Integrated Care System (ICS)

The CCG has been working with our health and care partners across Hillingdon to further develop our local Integrated Care System (ICS)[1].

Our local partners (including THHFT, CNWL, Hillingdon GP Confederation and Hillingdon4All) have come together to form a partnership called Hillingdon Health Care Partners (HHCP) to help enable the integration of services. The ICS will allow us to work as one whole system to implement population health and person-centred care models. Our focus for 18/19 (current year) is focused on 18+ population focusing on five following priority areas:

1. Extending active case management to the 15% of the adult population most at risk of a non-elective episode by optimizing the following programmes:
    a. Further Development of Care Connection Teams (CCT) including Self Care
    b. Implementing a High Intensity User Service for the top 50 'Frequent Attenders' to A&E
    c. End of Life Care Pathway
    d. Falls Service and Frailty Pathway
    e. Better Support to Care Homes (Non Elective admissions).
2. Transforming the MSK Pathway
3. Hospital Interface (Front Door): Effective Same Day Emergency Care (ACSC)
4. Intermediate Care, Rapid Response/GP Visiting including Discharge arrangements
5. Integrated multi-disciplinary 'Locality Neighbourhood' Team working built from and led by general practice as the basic delivery unit of integrated care

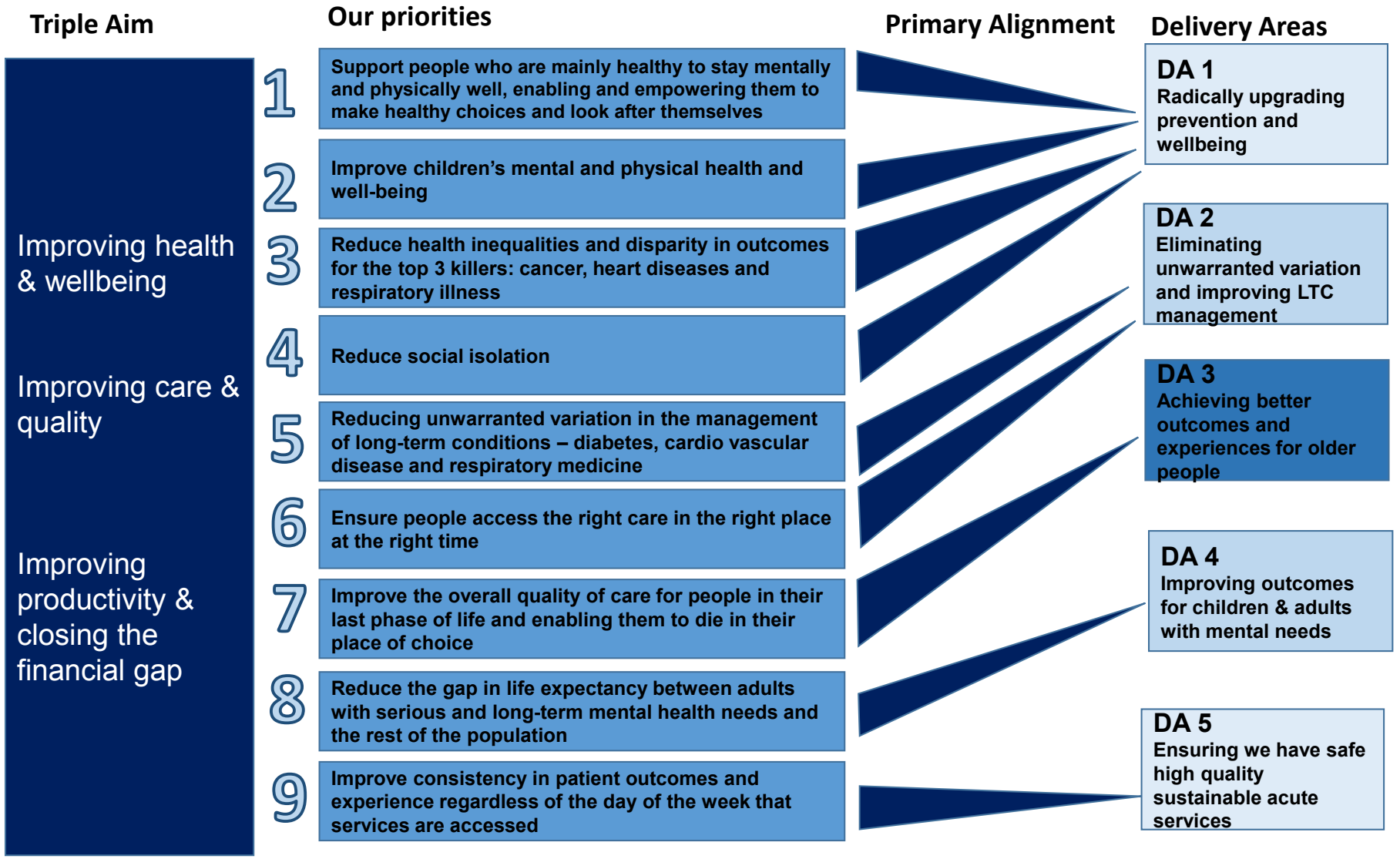
During 2019/20 onwards we will be using this as an approach and vehicle to deliver the CI set out in this plan.

4c. The North West London STP

NHS organisations and local authorities of NW London STPs have developed Sustainability and Transformation Plans, taking as our starting point the ambitions and knowledge in the national NHS FYFV strategy and applying them to the needs of the NW London STP. The NW London STP plan is characterised by broad and overarching themes common to each of the local areas to align local and regional goals. It aims to bring together local organisations to address the challenge of delivering better health and care services according to the Triple Aims of the FYVF through nine priorities and five Delivery Areas.

[1] Refer to NHS England website for more information on ICS: https://www.england.nhs.uk/integratedcare/integrated-care-systems/

North West London Priorities and Delivery Areas



4d. The North West London Local Digital Roadmap

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

- To automate clinical workflows and records, particularly in secondary care settings, and remove the reliance on paper so organisations become paperless and transfers of care are supported through interoperability
- To build a shared care record across all care settings, again through interoperability, to deliver the integration of health and care records that are required to support emerging and new models of care, including the transition away from hospital care to new settings in the community and at home
- Extend access to shared patient records to patients and carers, to help them to take an active role in their own care
- Provide people with tools for self-management and self-care, further supporting digital empowerment and the shift away from traditional care to new channels
- Use dynamic data analytics to inform care decisions, and support integrated health and social care through whole systems intelligence.

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

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

There is also a need to address how data is transmitted. In the last five years there has been a huge increase in the amount of data being transmitted to and from services. To allow for this growth to continue we will have to address the limits being imposed by the current service provider (N3). We will accelerate and strengthen the use of data by working with partners across the system and ensuring commissioning and contracting are aligned with these priorities.

4e: The North West London Transforming Care Partnership Plan

The NW London Transforming Care Partnership Plan (NWL TCP) focuses on improving the quality of life, life chances and expectancy and range of local services for children, young people and adults with LD and/or autism, who have mental health needs and / or display challenging or offending behaviour. This covers:

- **Community Support**: the development of Community LD Teams to provide specialist clinical and social care support to reduce the reliance on inpatient services. Also key is the development of a NW London housing strategy and the utilisation of more skilled staff to support people with complex and challenging needs
- **Improving Access to Mainstream Mental Health Services including Crisis Services:** ensuring practitioners working in liaison psychiatry, Crisis Assessment & Treatment Team (CATT)/Crisis Response Home Treatment Team (CRHTT) and health based places of safety can respond effectively to people with LD and autism who present in crisis including when the crisis occurs outside of the standard working hours
- **Community Forensic Pathway**: Development of a NWL service providing the specialised clinical support required for adults with LD and / or autism who have a forensic history and present a high risk of offending
- **Autism Diagnostic Services:** exploring the feasibility of developing a regional /sub-regional autism diagnostic service, to ensure adults have timely access to diagnosis, intervention and support.
- **Developing local specialist LD inpatient pathways**: ensuring adults with LD have access to local inpatient services in the least restrictive setting. The overarching outcomes of the NW London TCP are to:
  - Reduce the reliance on inpatient services and strengthen support in the community
  - Improve quality of life for people in inpatient and community settings
  - Build up the community capacity to support the most complex individuals in a community setting and avoid inappropriate hospital admissions.

This is with view to:

- Supporting a universal level for positive access to, and effective response from mainstream services
- Targeted work with individuals and services enabling others to provide person centred support to people with LD and their families/ carers
- Responding effectively to crisis presentation and urgent demands
- Direct specialist and clinical therapeutic support for people with both behavioural and health support needs.

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

4f. Our Local Joint Health and Wellbeing Strategy 2018-2021 and alignment with NWL STP Improvement Areas

Our Joint Local Health and Wellbeing Strategy 2018-2021 (JHWBS) is a key strategic document informing our priorities for the next two financial years. It outlines what we have collectively agreed to do locally in Hillingdon CCG, in collaboration with health and care partners, and through consultation with Hillingdon residents. These CI are built around the 10 Transformation Themes and 6 Enabling Themes contained therein. These Themes (Transformation & Enabling) area also aligned to the 22 Improvement Areas stated within the NWL STP.

Hillingdon Transformation and Enabling Themes

10x **Transformation Themes**
T1. Transforming Care for Older People
T2. New Primary Care Model of Care
T3. Integrating Services for People at the End of their Life
T4. Integrated Support for People with Long Term Condition (LTCs)
T5. Transforming Care for People with Cancer
T6. Supporting People with Serious Mental Illness and those with Learning Disabilities
T7. Integrated Care for Children & Young People
T8. Integration across the Urgent & Emergency Care System
T9. Public Health and Prevention of Disease & Ill-Health
T10. Transformation in Local Services
6x **Enabling Themes**
E1. Developing the Digital Environment
E2. Creating the Workforce for the Future
E3. Delivering Our Strategic Estates Priorities
E4. Delivering Our Statutory Targets Reliably
E5. Medicines Management
E6. Redefining the Provider Market

Hillingdon Alignment with NWL STP Improvement Areas

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

4g. Hillingdon Financial Challenge

In June 2018 the government set out a new multi-year funding plan for the NHS, setting real terms growth rate for spending in return for the NHS agreeing a new long-term plan with the government later this year. The main elements of the funding package are as follows:

- NHS will receive an average 3.4 per cent a year real-terms increase in funding over the next 5 years
- Increased funding will support a new 10-year long-term plan the NHS will bring forward
- The long-term plan will help the NHS tackle waste and improve services

The NHS will receive increased funding of £20.5bn in real terms per year by the end of the five years compared to today. An average 3.4% per year overall. The increase will mean the NHS can regain core performance and lay the foundations for service improvements. The funding will be `front-loaded' with increases of 3.6% in the first 2 years, which means £4.1 billion extra next year. This long-term funding commitment means the NHS has the financial security to develop a 10-year plan. The plan will be developed by the NHS, working closely with government and be published later this year. The priorities include:

- To get back on the path to deliver agreed performance standards, locking in and further building on the recent progress made in the safety and quality of care
- Transforming cancer care so that patient outcomes move towards the very best in Europe
- Better access to mental health services, to help achieve the government's commitment to parity of esteem between mental and physical health
- Better integration of health and social care, so that care does is not compromised when patients are moved between systems
- Focusing on the prevention of ill-health, so people live longer, healthier lives

It will be essential that every pound in the NHS budget is spent wisely. The government will set the following NHS five financial tests to show how the NHS will do its part to put the service onto a more sustainable footing:

- Improving productivity and efficiency
- Eliminating provider deficits
- Reducing unwarranted variation in the system so people get the consistently high standards of care wherever they live
- Getting much better at managing demand effectively
- Making better use of capital investment

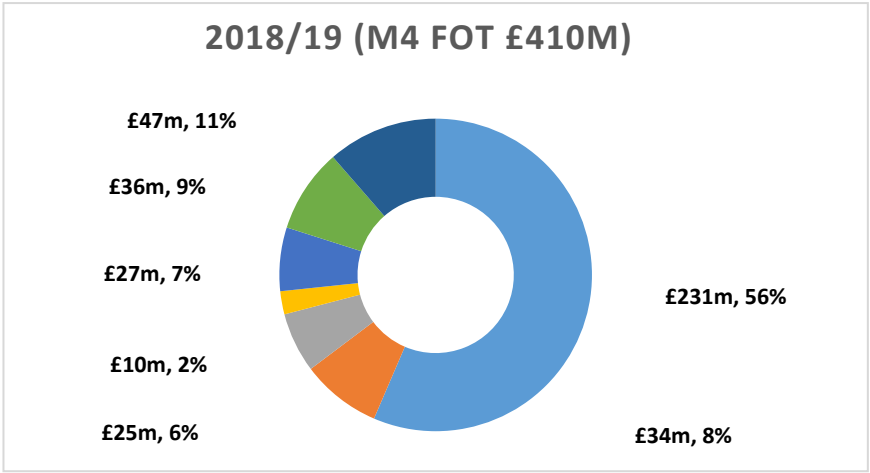
Whilst the impact of this funding change is not yet known locally the CCG will need to continue to plan to deliver value for money given the likely expansion in demand for services.

In the next five years it is expected that demand for services in Hillingdon will increase by c20%. This is made up of the expected growth in the population (called demographic growth) of c.7% and

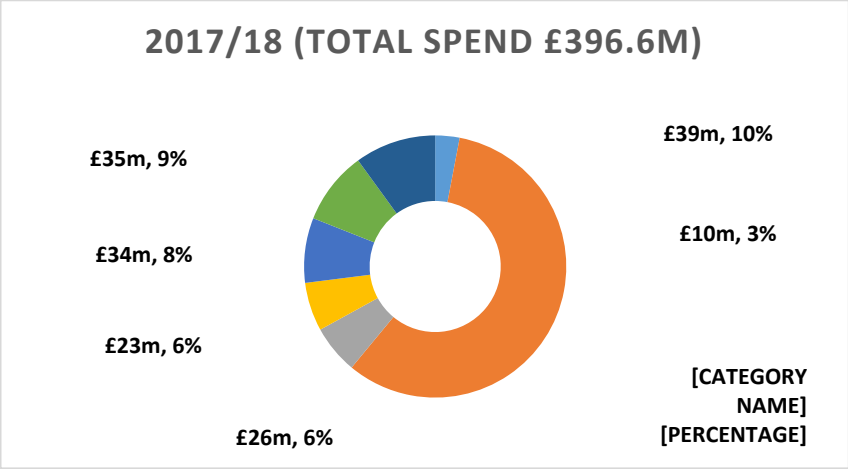
the growth in the prevalence of disease and ill-health through such things as increasing rates of diabetes (called non-demographic growth) of c.13%. In addition the government has also now agreed a pay increase for the majority of NHS staff of a minimum of 6.5% over the next three years, which will need to be financed from within this financial settlement.

It is therefore essential that our plans include a range of approaches to address this growth in service demand and cost, including preventing people becoming ill in the first place. These approaches relate to: encouraging healthier lifestyles, ensuring that the services we commission are truly delivering the outcomes we expect, in a way that provides best use of resource, integrating where appropriate and reducing duplication and improving coordination of care.

The CCG's QIPP planned requirement for 18/19 is £12.4m which is c3% of the CCG's overall budget allocation. The QIPP improvements and efficiencies required to ensure the CCG is sustainable will be aligned to 10 Transformation Themes described in Section 9. It is difficult to fully disaggregate the expenditure for e.g. Urgent & Emergency Care from the expenditure on Children & Young People as there is a significant overlap between transformation themes.



The pie chart above shows Financial Outturn (FOT) 2018/19 at M4



The pie-chart above shows CCG historic spend in 2017/18

5. The Hillingdon Health Landscape

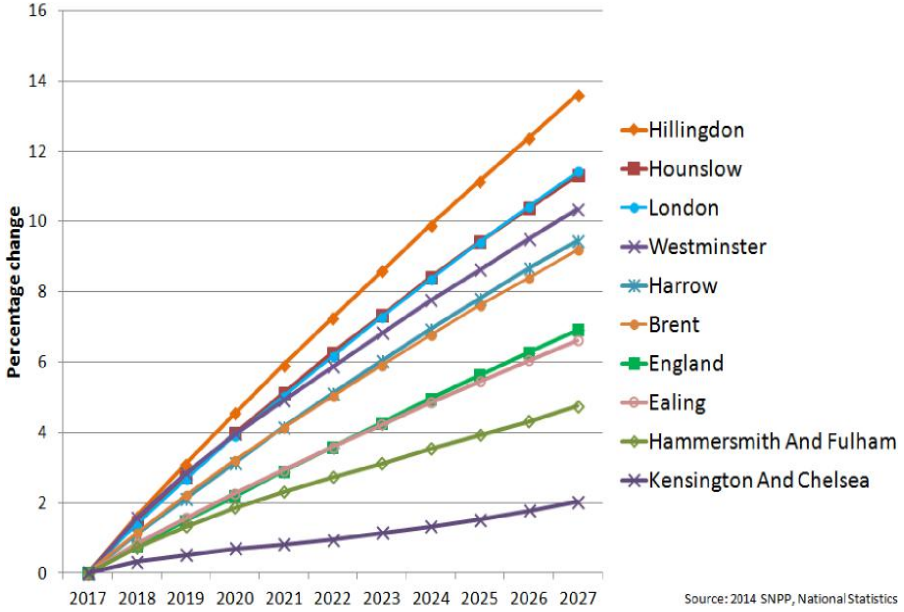
5a. Population Demography

Hillingdon is the second largest London borough by area, located 14 miles from central London. It has the 12th largest population out of the 32 London Boroughs.

Information from the Office for National Statistics (ONS) indicate the Hillingdon population in 2018 will be 314,300 with 23,200 (7.4%) aged 0-4 years, 41,500 (13.2%) aged 5-14 years, 208,400 (66.3%) aged 15-64 years, 21,700 (6.9%) aged 65-74, 13,100 (4.3%) aged 75-84, and 5,800 (1.8%) aged over 85. According to the GLA 2017, the proportion of men to women in the borough is 50.1% to 49.9%

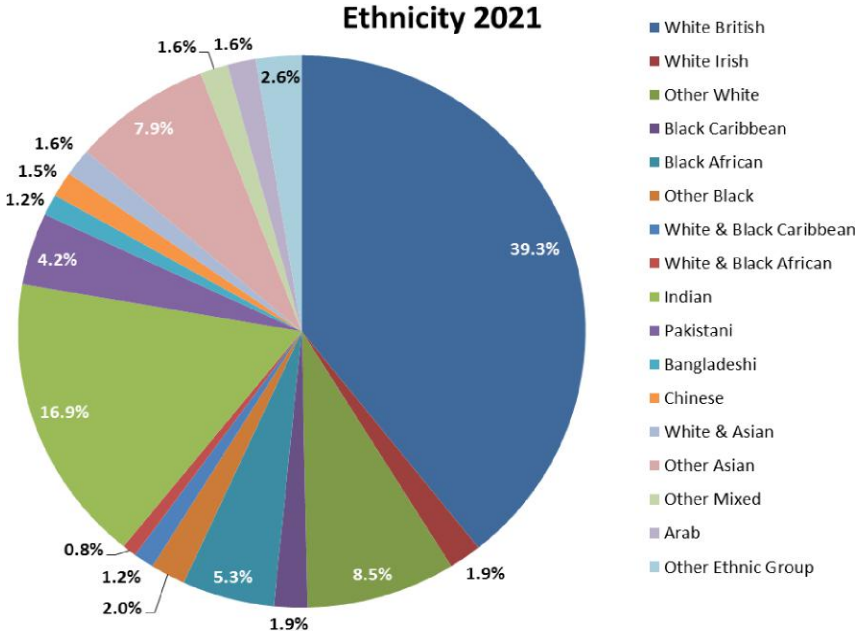
Population growth of just over 13,300 residents is projected between 2018 and 2021, with the largest growth being those aged 15-64 (9,300 [4.5%]) and 5-14 (3,700 [8.8%]). However, by proportion older people aged 75-84 (11.3% [1,500]) and aged 85 and over (15.6% [900]) will grow faster than other age groups. Comparatively, the population growth in Hillingdon is projected to be higher than any other NWL CCG, and will be above both the average for London and England.

The age structure of the population in Hillingdon is intermediate between London and England, with a distribution that is slightly older than London as a whole but younger than England. Among children and young adults however, there is a larger proportion resident in Hillingdon than for both London and England.



The graph above shows the percentage change in the population for boroughs in NW London compared with London and England (Source: JSNA 2017)

"…population growth in Hillingdon is projected to be higher than any other NWL CCG and will be above both the average for London and England."



Hillingdon is an ethnically diverse borough with 46.9% of residents in 2017 projected to be from Black and Minority Ethnic (BAME) groups. Population projections for Hillingdon suggest that BAME groups are increasing as a proportion of the population, with 50.4% of residents from BAME groups by 2021.

Christianity is the predominant religion in the borough with 49.2% from this faith. 8.0% are Hindu, 10.6% are Muslim and 17.0% have no religion, 6.7% are Sikhs and 6.4% chose not to state a religion. The preferred language in the borough is English with 81.2% residents stating this as their main language. Of the remaining 18.8% the majority speak English 'very well' or 'well'; 8,240 residents (16.8%) stated they cannot speak English well or at all. Apart from English, the most spoken languages in the borough are Panjabi (8,837 residents, 3.4%) and Polish (3,994 residents, 1.5%) (*Census, 2011).*

5b. Health profile – Joint Strategic Needs Assessment

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 programmes and priorities are able to respond to the changing needs of our population. Our JSNA is available to read online at https://www.hillingdon.gov.uk/jsna. The JSNA is a key document informing the priorities and outcomes in this strategy. The JSNA underpins Hillingdon's JHWBS which is the overarching local strategy roadmap to addressing health and wellbeing needs and outcomes in Hillingdon.

The life at expectancy at birth in 2016 for males in Hillingdon is 80.8 years and for females is 83.8 years, and is higher than the England average. However, health status is not the same in all parts of Hillingdon, there are health inequalities, i.e. differences in life expectancy, depending on where people are living in the borough. As a result that there is a difference of around eight years in the life expectancy of people living in Botwell ward compared to people living in Eastcote and East Ruislip wards. 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. The population is ageing and living longer due

to which there will be a higher proportion of frail older people in the population. 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. The prevalence of long-term conditions is predicted to increase and years spent in good health are not increasing at the same rate as life expectancy. Therefore, it is important to maintain focus on keeping people well for longer.

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
- Lower levels of prevalence compared to other boroughs nationally in London for learning disabilities, mental illness and cancer
- Adults in contact with secondary mental health services tend to live in stable and adequate accommodation
- levels of breastfeeding, which provides the best start in life for babies, and leads to a healthier life, are higher in Hillingdon than the national average
- Lower proportion of pregnant women in Hillingdon smoke, compared to the rest of England
- Rates of teenage pregnancy in Hillingdon are similar to the England average
- Fewer people are admitted to hospitals in Hillingdon with an alcohol-related condition than the England average
- Early death rates (under age 75) from respiratory diseases are lower than the England average
- Lower rates of sexually transmitted infections compared with other London Boroughs
- The proportion of people killed and seriously injured in road accidents is significantly lower than then England average.

Hillingdon **compares less well** on the following indicators:

- According to QOF measures 2016/17, the prevalence of the following health conditions are higher in the borough of Hillingdon compared to the London average:
    - Coronary Heart Disease (CHD)
    - Atrial Fibrillation (AF)
    - Cardio Vascular Disease (CVD)
    - Peripheral Arterial disease (PAD)
    - Stroke/Transient Ischaemic Attack (TIA)
    - Asthma
    - Chronic Obstructive Pulmonary Disease (COPD)
    - Dementia
    - Depression

- Rates of social isolation among social care users and their carers are too high

- Accommodation and employment needs of adults with learning disabilities are not being adequately met
- A higher proportion of children aged 10-11 are overweight / obese as compared to the national average
- Proportion of 5 year old children free from dental decay are significantly worse than the national average
- Rates of childhood vaccination are lower than the England average
- Higher rates of Tuberculosis (TB)
- Higher recorded prevalence of diabetes
- Proportion of adults who are physically active is lower than the national average
- Cancer screening rates are low
- The percentage of population being offered an NHS health check is low
- Lower birth weight for babies at term is significantly higher than the England average.

Winners of Aggie the Alien Competition

The successful launch of the "Aggie the Alien" short story competition as part of the CCG's activities to engage the next generation (i.e. children 5-11 years old) in self-care and the appropriate use of NHS Services.

Indices of Multiple Deprivation (IMD)

IMD are a group of measures of relative deprivation primarily for small areas (lower super output areas (LSOAs)) in England. They provide deprivation scores for each LSOA, ranked from 1 (most deprived area) to 32,844 (least deprived area). The scores are calculated from 37 indicators grouped under seven different domains or themes, each measuring a different type of deprivation to produce an overall indicator, the IMD.

These statistics are a measure of relative deprivation, not affluence, so not every person in a highly deprived area will themselves be deprived. Likewise, there will be some deprived people living in the least deprived areas. Three in five (61 per cent) of the 326 local authorities in England contain at least one neighbourhood which is in the most deprived decile nationally according to the Indices; Hillingdon contains no neighbourhoods in the most deprived decile.

Hillingdon is ranked number 23 out of 33 London Boroughs (including City of London), and number 153 out of all 354 authorities in England.

The graphics on the page following show variation in deprivation in Hillingdon by ward area.

Indices of Multiple Deprivation 2015 – Hillingdon

Ruislip & Northwood

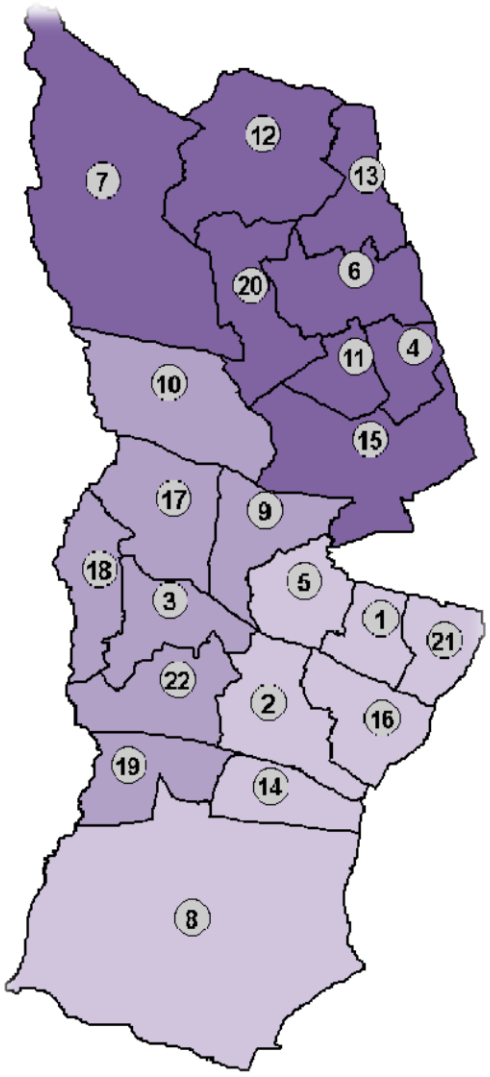
4 Cavendish
6 Eastcote & East Ruislip
7 Harefield
11 Manor
12 Northwood
13 Northwood Hills
15 South Ruislip

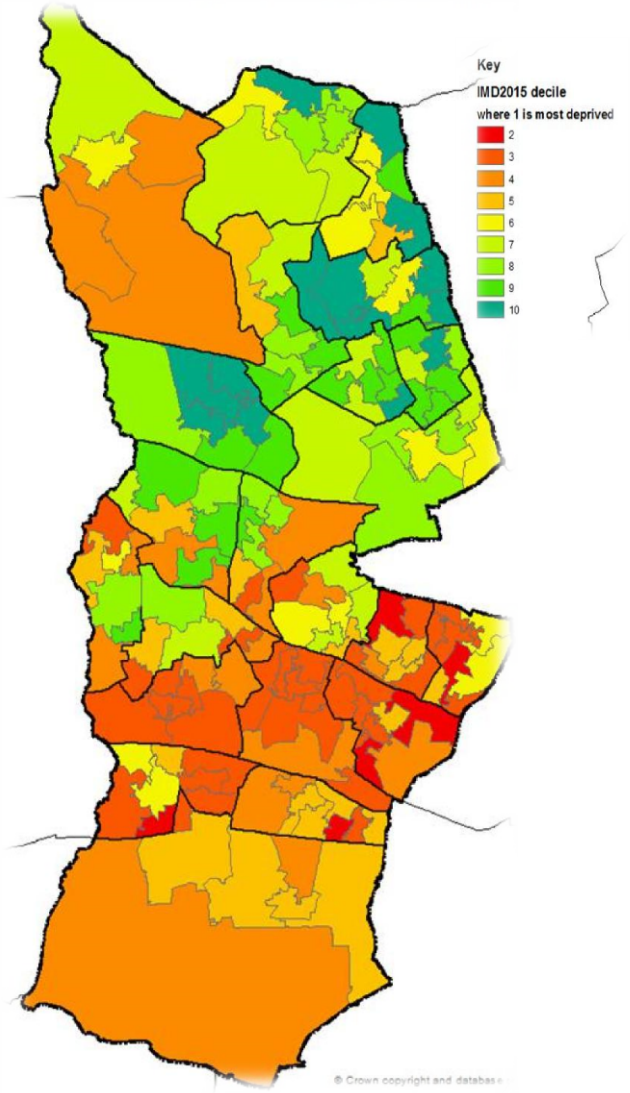
Uxbridge & West Drayton

3 Brunel
9 Hillingdon East
10 Ickenham
17 Uxbridge North
18 Uxbridge South
19 West Drayton
22 Yiewsley

Hayes & Harlington

1 Barnhill
2 Botwell
5 Charville
8 Heathrow Villages
14 Pinkwell
16 Townfield





5c. Hillingdon Local Health and Care Providers Landscape

Primary Care

Primary Care services are predominantly those delivered by GPs in practices commissioned by Hillingdon CCG.

The CCG took on level 3 delegated commissioning of primary care in 2018/19. Hillingdon GPs have inaugurated a GP Confederation to represent their interests in the borough. This is with the exception of two practices that we continue to engage with to ensure all patients in Hillingdon have equitable access to services and health initiatives.

Through the GP Confederation, Hillingdon CCG can deliver priorities for primary care transformation, extended hours access hubs, 24 hour blood pressure monitoring services and an integrated care home extended access and visiting service in line with the GP FYFV.

The Hillingdon Primary Care Confederation continues to develop and support general practice to work at scale to improve organisational resilience, deliver services across Hillingdon, and provide a strong primary care voice within HHCP. Our primary care services programmes also include pharmacy, dental, and optical, among other services.

Hospital Based Acute Care

Our hospital based care is provided predominantly by The Hillingdon Hospitals NHS Foundation Trust (THHFT), for which Hillingdon CCG is the lead commissioner on behalf of all CCGs who commission services from the Trust.

THHFT provide planned and unplanned care services, supported by an Urgent Treatment Centre on site at the front door of our A&E, which is managed by Greenbrook. The Hillingdon Hospital is the place where most Hillingdon patients have their in-hospital needs met. We work closely with THHFT to continuously improve the quality of acute care services and to transform care, where appropriate, in alignment with our Local Service Strategy and linked projects, as part of NW London Shaping a Healthier Future (SaHF) programme.

Hillingdon CCG is also the lead commissioner for some services with Royal Brompton & Harefield NHS Foundation Trust (RBHFT). However, NHS England commissions the majority of services from RBH due to their specialist nature and national priority. In addition to being the leads on the contracts for THH FT and RBH FT, Hillingdon CCG is also an Associate Commissioner on the contracts for other acute trusts where our residents receive care. We work closely with the lead commissioners of those trusts to ensure that the commissioning intentions laid out here are applied across all providers from which our residents access care.

Community Services

Community services is a broad title covering a wide range of support that is delivered in a person's home, from District Nursing, Therapies, End-of-Life to Wheelchair services. For people who need additional support between home and the hospital, we also commission a range of services to support the transition back to their homes.

The vast majority of Community Services are delivered by our partner Central and North West London NHS Foundation Trust (CNWL) and Hillingdon CCG is the lead commissioner for CNWL's Community Services, acting on behalf of other Clinical Commissioning Groups who are party to the same contract with CNWL.

Other aspects of community services, such as the provision of home care and community equipment, are jointly commissioned by the CCG with the LBH through a shared funding arrangement called a Section 75 Agreement. Whereas items such as Pressure Relieving Mattresses, Wheelchairs and Non-Emergency Patient Transport, amongst others, are commissioned directly by the CCG from a range of other providers.

Mental Health and Learning Disability Services

CNWL also delivers the bulk of Mental Health services in Hillingdon. Hillingdon CCG also works with MIND to deliver community support and with a range of other providers to support people as part of their rehabilitation. In the case of these services, Harrow CCG is the lead commissioner for the Mental Health Contract with CNWL and Hillingdon CCG is an Associate Commissioner.

Hillingdon CCG is an active partner in the NW London Mental Health Transformation Programme and works with other CCGs in NWL to develop joint standards and explore how we can adopt best practice and improve services locally. We also work jointly with LBH in a shared care management for some people with learning disabilities.

Voluntary & Third Sector

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

A key local partner is Hillingdon 4 All (H4ALL), a collaborative of local charities including Hillingdon Carers, Hillingdon MIND, Hillingdon Age UK, Dash and Harlington Hospice. We also directly commission other charities to support our BAME patients and residents and our social prescribing programme, which empowers people with the tools to manage their own health.

Local Authority Commissioned Services

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

Carers, Families and Patients

We must not forget the valuable contribution made by carers and families of all types who support individuals of all ages and greatly add to their quality of life and the outcomes they experience when their loved ones need extra support and care. Working in partnership with all health and care organisations across Hillingdon, we have signed a Carers Memorandum of Understanding to implement consistent set of support to carers across our borough that addresses our holistic approach to support carers and also additional support through our voluntary sector partners.

The most important person in our health system is you. We aim to empower and support you so that you have the confidence to make informed decisions about your health and wellbeing. You are the author of your health story, and we aim to help you make it a good one!

Refer to Sections 12 & 13 for full list of Providers and GP Practices

The Big C Event – Raising Awareness for Cancer

Dr Kuldhir Johal *- GP Governing Body Member*

6. Engaging with local residents, families and carers

NHS Hillingdon CCG is passionate about and committed to continuous engagement with local residents, families and carers throughout its commissioning cycle. We use a range of tools to involve and engage local residents: Some of these include online surveys, events, and community outreach and partnership initiatives with local advocates and voluntary sector groups. Our engagement is overseen by lay members of the Patient & Public Involvement & Equality (PPI&E) Committee. We aim to continue an on-going dialogue and conversation with local people about NHS plans and proposals; the targeted gathering of feedback to inform these CCG's commissioning intentions should be considered within this context. The CCG's engagement activity includes the **co-production of new contract arrangements** with local people as part of our journey towards an **Integrated Care System**. We are also **empowering local people** to take **control of their own health** through our **MyHealth programme**.

Highlights from our engagement activity over the year include:

- Pro-active work with local advocates and groups to reach marginalised communities, and educate local people regarding the appropriate use of NHS services especially during the winter months
- Patient/ Carer Interviews to better understand the impact of the CCGs Empowered Patient Programme
- Outreach work at clinics to use patient experience to shape the new MSK pathway
- Focus groups with Carers and parents of disabled children using Integrated Therapies to inform a jointly commissioned service with the local authority.
- The introduction of workshops about Childhood Asthma in local schools
- Continued partnership with British Red Cross to deliver first aid training for parents of young children (0-5 years)
- Reaching 4,400 residents in 2017/18 as part of our MyHealth programme
- `Aggie the Alien' short story competition to engage 5-11 year olds in Hillingdon in self-care and prevention.

We intend to continue our engagement activities as part of the development of the CCG's CI through community outreach and a `Health Summit' in the following months.

Our themes for engagement are:-

- **Keeping well**
- **Managing in times of crisis; and**
- **Appropriate stay in hospital / right care/ right place**

We are also improving our mechanisms for giving feedback to residents and participants in the CCG's engagement activity through the development of a residents' contact database, and a website area, to publish post-engagement reports and demonstrate how the CCG's commissioning activity continues to be shaped and influenced by the views and experiences of the local population in Hillingdon.

7. Our Local Quality Priorities and Principles

7a. Our Quality Priorities

We believe that the people of Hillingdon are entitled to a high quality and safe experience in any of the healthcare services commissioned by Hillingdon CCG.

At Hillingdon CCG, we will listen to our patients and carers, and work with all our service providers to achieve continuous improvement and reduce variation in the quality of their services.

We will work closely with our commissioning colleagues to ensure new models of care in line with the FYFV, the multi-year STP and the development of more integrated health care systems that have quality at their core.

This model embraces the NHS definition of quality as defined under Section 1 of the Health and Social Care Act 2015 – Reducing Harm in Care, the NHS Outcomes Framework, and the CQC inspection protocol that has been further developed and refined since 2015

7b. Our Quality Principles

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

- Ensure quality and that patients are at the heart of commissioning to promote continuous improvement in the safety and quality of commissioned services
- To ensure that commissioned services are safe, effective and patients have a good experience
- Provide assurances that services are meeting their contractual quality outcomes and recommend action if this is compromised
- Have open relationships with our Providers to share Quality Improvement work
- Ensure that learning from our quality and safety assurance processes is triangulated from a variety of sources, to inform what high quality, safe and effective care looks like across the LBH.

Hillingdon CCG will ensure the following principles are embedded within all quality and safety assurance systems and processes:

- Use of a systematic approach to monitoring and improving quality with the patient at the centre
- Use of Quality Improvement methodologies with Providers to improve quality of care
- Identifying and addressing any organisational barriers which hinder quality of care
- Fostering an open and transparent culture across the local health system
- Maintaining a systematic and proactive approach to early identification of service quality failures

- Ensure there are robust links between commissioning priorities, the STP and quality
- Prioritise our quality assurance and improvement efforts, so as to develop an integrated approach with social care that reflects the BCF plans
- Drive effective engagement with key stakeholders across BHH to achieve the delivery of robust measurable outcomes that reflect "what matters most to patients"
- Ensure that evidence based guidance and learning from assurance processes across Health and Social Care underpin and inform the design of outcomes to support Place Based/Integrated Care
- Hold joint meetings and aligning complaints, Serious Incident and Never Event data, as well as feedback from quality assurance processes such as Clinical Quality Assurance Visits, Clinical Quality and Review Group (CQRG) meetings. This will involve the co-production of systems and processes to enable the timely sharing of such information
- Maintaining commitment to gain feedback from patients, their families and carers to inform quality indicators.

7c: Safeguarding

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

Hillingdon CCG will ensure the following principles are embedded within everyday safeguarding assurance systems and processes:

- Continue to be active members of Hillingdon Safeguarding Adults Boards and Safeguarding Children's Boards and ensuing task and finish groups
- Continue to commit to our responsibility of working in partnership with the Local Authority and the Police, in developing Safeguarding Children systems and processes in line with recent legislative changes
- Continue to work together with Quality and Safety colleagues to ensure valuable learning and triangulation of data is effectively utilised, alongside Safeguarding referrals and concerns
- Work in close affiliation to the Continuing Healthcare team who manage and support some of the most vulnerable people in the community
- Participate in any Reviews relating to Adults or Children e.g. Domestic Homicide Reviews (DHR), Serious Adult Reviews or Child Safeguarding Practice Reviews (CSPRs) and ensure that the CCG and Provider organisations complete all actions.

Our Safeguarding Priorities

Priority Area	What We Will Do
Listening to children & young people and adults at risk	• Work with children's services to review the needs of all Hillingdon's children and young people especially those with additional needs; looked after children, and those involved with the youth offending services. • Make Safeguarding Personal (MSP) by involving adults at risk in safeguarding decision making. • Ensure compliance with The Mental Capacity Act 2005; The Deprivation of Liberty Safeguards (DOLS, 2009/2014), and The Care Act 2014. • Ensure that this vulnerable group is consulted when new or changes in existing services are being considered/planned.
Safeguarding Education and Training (Adults & Children)	• Continue to monitor and challenge Providers of contracted services to comply with safeguarding responsibilities and achieve expected targets e.g. Training. • Safeguarding Children and Adults training should also include Child Sexual Exploitation (CSE), Female Genital Mutilation (FGM), Domestic Violence and Abuse, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) and `PREVENT.' • CCG staff will also be compliant with the required safeguarding training. • Gain assurance that lessons learnt from DHRs, SARs, LeDeR reviews and CSPRs, Incidents and complaints are disseminated throughout organisations. • Support the Safeguarding Adult Board in the provision of a multi-agency training programme and continue to support further development of multi-agency Safeguarding Children training.
Safeguarding Medicals	• Continue to work with the commissioner and Providers (community and acute) to ensure that robust arrangements are in place.
PREVENT	• Ensure training is delivered to staff that is commensurable to their level of responsibility as per the NHS England competency Framework. • Ensure that both Commissioner and Provider organisations are compliant with the Counter Terrorism and Security Act (2015) and the related PREVENT Duty Guidance. • Ensure compliance with DHR actions and NICE Guidance for anti-social personality disorder prevention and management.

Priority Area	What We Will Do
Domestic Violence and abuse	• Monitor compliance with NICE Guidance (2014/ph50; 2017) to ensure that staff are trained and that victims and families at risk are identified, assessed and referred for appropriate care. • Monitor number of victims identified by all providers, ensure that a system is in place to flag high risk victims and ensure that their policy reflects locally agreed pathways. • Work towards the implementation of the IRIS programme and the introduction of IDVAs in Healthcare settings.
Child Sexual Abuse/Child Sexual Exploitation (CSA/CSE) and Emotional Wellbeing Service	• Monitor newly established North West London CSA/CSE and Emotional Wellbeing service to ensure that this service is comprehensive and easily accessible to children and young people who are at risk of, or suffering as a result of, Child Sexual Exploitation (CSE), Child Sexual Abuse (CSA) or Female Genital Mutilation (FGM).
Information Sharing	• Continue to highlight responsibilities and importance of information sharing and support the CCG and providers to share information appropriately. Adhere to the Multi agency Safeguarding information sharing guidance and the relevant GMC Guidance.
Young Offenders, Looked After Children and Children with Disabilities and Additional Needs	• Work with children's services (Health and Social Care) to ensure their health needs are identified and met. • Work with the providers to ensure they understand their roles and responsibilities.
Reduce the incidence of Pressure Ulcers	• Monitor compliance of the Department of Health and Social Care Safeguarding Adults Protocol – Pressure Ulcers and the Interface with a Safeguarding Enquiry.
Ensure adults at risk are protected from avoidable harm.	• Monitor Providers' adherence to the Care Act 2014 in relation to prevention of harm, promoting an outcomes approach to safeguarding and compliance with NHS England Safeguarding Vulnerable People in the NHS Accountability & Assurance Framework 2015.
Medication	• Monitoring providers through Quality Review meetings, in relation to adult safeguarding concerns being considered for medication incidents.
Learning Disability Mortality Reviews	• Ensure providers have the correct processes in place to be compliant in carrying out a Learning Disability Mortality Review. • Monitor providers regarding NHS England Learning Disability Mortality Review Programme and embedding any lessons learnt.

8. Key Achievements in 2017/18

Keeping People Well

- ✓ Set up a lung screening programme to diagnose lung cancer early
- ✓ Commissioned a new C&YP mental health on-line counselling service (Kooth). New schools network established which will pilot the role of 'Mental Health Champion' in schools to promote health and wellbeing interventions in schools
- ✓ Delivered `My Health Programme' a Hillingdon wide self-management / education programme for patients to self-care and manage their LTC
- ✓ As part of annual winter campaign we undertook screening for AF and identified patients suitable for follow-up with their GP practice
- ✓ MyHealth programme delivered summer Wellness Workshop and provided education to public about keeping well during the summer season.

Right Care, Right Time/Appropriate Time in Hospital

- ✓ Implemented `Discharge to Assess' through collaborative work between Hillingdon hospital and our community provider, social services and the voluntary sector to develop a pathway to support patients to be discharge from hospital as soon as clinically appropriate
- ✓ Implementation of three GP extended hour hubs that are operational seven days a week across Hillingdon to provide longer weekday appointments and at the weekend.
- ✓ A 24 hour blood pressure monitoring service is available in four sites across Hillingdon
- ✓ AF Virtual Clinics established that enable GPs to discuss complex patients with consultants and avoid patients attending out-patient appointments
- ✓ Enhanced `Straight-to-Test' pathway for patients with colorectal and prostate cancer patients to have diagnostic tests before their appointment with a Consultant
- ✓ Rolled out a Paediatric Integrated Community Clinics across Hillingdon enabling CYP to be seen by a GP and hospital consultant in a joint appointment
- ✓ A community hernia repair service has been launched under which inguinal hernias are repaired under local anaesthetic
- ✓ An interim six month solution for an integrated MSK service is being piloted with HHCP
- ✓ Access to Shared Care Records to support integrated care has been improved across NW London with increased use of the Care Information Exchange
- ✓ Improve use of digital analytics, through use of NW London WSIC system, for population-level health management
- ✓ 100% compliance with eRS (electronic referrals to hospital) across Hillingdon to eradicate use of paper referrals
- ✓ Expansion of access to (IAPT) now embedded in services for patients with long-term conditions e.g. diabetes and COPD

- ✓ Review of LD completed with LBH to deliver a community-led service
- ✓ Completed a joint review of Integrated Therapies (Speech & Language, Occupational Therapy and Physiotherapy) provision with LBH, stakeholders and service users.

At times of Crisis

- ✓ Fully implemented Care Connection Teams, embedded within GP practice settings, to proactively case manage patients with complex health needs to avoid unnecessary admission to hospital
- ✓ An integrated Urgent Care system is now partially developed across stakeholders. NHS 111, LAS and the UCC is able to directly book into our primary care extended hours hubs
- ✓ UCC Health connectors are successfully educating and sign-posting patients to alternative places to receive care and treatment
- ✓ Implemented a Single Point of Access for End of Life care and a Palliative Overnight Nursing Service to support patients and clinicians with 24/7 expert palliative and last stage of life care and advice. (Start date due 11 September 2018)
- ✓ Improved `Coordinate My Care' record use amongst staff across primary, community and hospital settings enabling patients to express their holistic needs, once, so that NHS staff have awareness of their wishes
- ✓ Increased support to care homes by providing pharmacist led medication reviews for older people that has shown a reduction in unplanned admissions.

Integration

- ✓ Developed a shadow outcome based commissioning model for older people via an Accountable Care Partnership (ACP) working with HHCP
- ✓ Enhanced the BCF plan with LBH to deliver longer term alignment.

Enablers

- ✓ Developed a new contract to increase clinical capacity in primary care to maximise opportunities for all staff to work more efficiently and release clinicians time to care for patients
- ✓ Established the `Transition Academy' to coordinate recruitment and training of staffing in primary care
- ✓ Increased the training, mentorship and student placement capacity in general practice (95 student placements, 5 GP trainers, 19 nurse mentors)
- ✓ Recruitment of new staff into general practice including through apprenticeship programmes e.g. ST3s & GPNs (recruited 5 pharmacists, 14 apprentices, up-skilled 15 healthcare assistants and retained 15 ST3/returners)
- ✓ Progressed work to develop our three out of hospital hubs to build capacity in the community to provide care for patients
- ✓ Use of clinical NHSE clinical pharmacists to deliver better management of prescribing in general practice and release GP time.

9. 2019-2021 Commissioning Intentions

These sections provide a high level overview of our Commissioning Intentions for 2019-20 and 2020-21 Financial Years.

T1. Transforming Care for Older People

Key Strategic Health Outcomes and Actions	Commissioning Intentions 2019-20 and 2020-21
By 2020/21 we will be delivering the following outcomes: • Fewer hospital admissions due to cold/flu related illness • Improved dementia diagnosis and support • Fewer emergency admissions due to falls • Greater participation in screening programmes for 55 years and over • Enhanced reablement outcomes and reduced need for long term care • Fewer permanent admissions of older persons to assisted care homes, enabling them to live independently and in the family home for longer • Embedding use of Connect to Support service • Further reduce delayed transfers of care • Reduced frequency of unplanned events • Reduction in Non-Elective Admissions & ZLOS Admissions • Single point of access implemented to simplify referral pathways **Key strategic actions to achieve these include:** • Coordinated Care for Older Peoples' Planned & Unplanned Care Needs • Coordinated services for carers receiving respite and support • Integrated Health & Social Care support for those patients who need it • Improved Health Outcomes for LTCs and complex conditions • Reduced frequency of unplanned events and rapid response to needs **Key local aims to achieve by 20/21:** • Improved health Outcomes and reducing Unplanned Care needs through focusing on LTCs and age related complicating factors such as frailty • Integrated Health & Social Care support for those patients who need it • Empowering people to plan for their own care. • Diverse market of quality care providers maximising choice for local people who have complex needs covering both older people and other vulnerable groups	**Keeping People Well** • Embed the integrated model of care for older people for self-care and their carers • Access to advice and support for carers and families and advocacy services • Improve coordination between health and social care around support from CHC, including shared care records • Consolidate patient and family/carer feedback and service satisfaction mechanisms to ensure quality and avoid 'questionnaire fatigue' • Implement new 'Core Offer' for Care Homes and LBH extra care sheltered housing, to support people with dementia, challenging behaviour, elderly mentally ill (EMI) and people with serious mental illness (SMI) **Right Care, Right Time** • Integrated commissioning and brokerage with partners, including joint projects and specifications to deliver a diverse market of quality care • Commission a single integrated system of care across primary, voluntary, community, mental health and acute care via a full capitated payment model and risk share and outcome based commissioning • Integrate EoL Care with Older Peoples community models, including dementia, to ensure changing needs in later years are supported with nuanced integrated service transition to appropriate care **Care at times of Crisis** • Develop and implement frailty pathway aligning with emergency same day care and revised discharge pathways, including community based specialist support and interventions

T2. New Primary Care Model of Care

Key Strategic Health Outcomes and Actions	Commissioning Intentions 2019-20 and 2020-21
By 2020/21 we will be delivering the following outcomes: • Increasing number of patients managed outside of hospital setting across Primary, Community & Secondary Care Services and Social Care • Reduction in the mortality gap • Reduction in the unplanned care events for vulnerable people, and those with a mental health condition or learning disability • Greater access to primary care and GP services, with more appointments available **Key strategic actions to achieve these include:** • Proactive Case Finding in Primary Care, with a focus on those at risk of developing Long Term Conditions (LTCs) • Supporting investment in Primary Care At Scale • Implementation of Primary Care Model of Care • Develop GP Hubs in Hillingdon • Extended GP out of hours working implemented • Integrated urgent and primary care services • Expand access to and use of online information and advice • Explore opportunities for diagnostics in the community and primary care **Key local aims to achieve by 20/21:** • Strengthened primary care provider landscape able to deliver new primary care models of care primary care services at scale • Increasing number of people cared for and supported outside of the hospital setting with integration across Primary, Community & Secondary Care Services and Social Care • Improved access to routine and unplanned services in primary care during the week, evenings and weekends • Reduced variation in service and patient outcomes in primary care via outcomes based commissioning and contracting • Sustainable primary care workforce and improved access for patients	**Keeping People Well** • To provide holistic management for patients through the roll out of multi-morbidity clinics to support patients with LTC to manage their condition • To maximise self-care via the My Health Programme for patients with LTC to empower them with strategies to manage their conditions through an increase in knowledge and skills **Right Care, Right Time** • To improve access to early diagnostics for patients and staff in primary care and the community • To create a single outcomes based contract for primary care to be implemented from April 2019 in line with our vision for integrated outcomes based commissioning. • To continue to expand access to primary care access for patients 7 days a week through use of our extended hours hubs across Hillingdon. • To work with GP Confederation to develop a sustainable workforce to deliver our primary care transformation strategy. • To work with GP practices to ensure appropriate referrals to secondary care in line with national and local guidance. • To work with our GP Confederation to reduce unwarranted clinical variation in order to maximise evidence based clinical care. **Care at times of Crisis** • To pilot a dedicated SPA for patients with a LTC who are at risk of an unplanned admission to hospital to manage their care at home and in the community • To pilot a transport system for patients to attend GP practices to avoid GP home visiting and make efficient use of their time to care for patients • To work with partners to pilot NHS 111 service to have the facility to book patients into GP practices during core hours to improve access for patients

T3. Integrating Services for People at the End of their Life

Key Strategic Health Outcomes and Actions	Commissioning Intentions 2019-20 and 2020-21
By 2020/21 we will be delivering the following outcomes: • 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 **Key strategic actions to achieve these include:** • 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 **Key local aims to achieve by 20/21:** By 2020/21 we will be delivering the following outcomes: • Increasing number of people able to die in their preferred place • Reducing number of admissions for people in the last 30 days of their life • Improve information access for clinicians and professionals supporting people at End of Life to anticipatory care plans • Coordination of support to people at End of Life and their families/carers on a 24/7 basis and across all care settings • Supporting Hillingdon residents to come to terms with dying and to enable families and friends to support their loved ones in their last days. We need to start the conversation on what it means to die with dignity so people can plan ahead for their most vulnerable moments. • Improved consistency in management of patient care and coordination with services outside of Hillingdon but provided to Hillingdon patients. • Improved access to patient care wishes for local authority and third/voluntary commissioned services to support integrated working across health, wellbeing and social care services. • Improved training and skills development to identify and support non-acute palliative needs at home and in care homes. • Information/access to palliative drugs (list of pharmacies out of hours and in hours).	**Keeping People Well** • To supporting people to prepare for dying and to enable families and friends to support their loved ones in their last days to die with dignity and have their holistic physical, mental and spiritual needs met • Increase the percentage of people in the last phase of life with an Anticipatory Care Plan to greater than 60% of those in their last 12 months of life (measured via CMC usage) **Right Care, Right Time** • To review commissioning of specialist palliative acute hospital needs and provision of services for patients • Improved access to training to develop skills of staff to patients requiring palliative care to be card for at home and in care homes • Improved training availability and skills development to identify and support non-acute palliative needs at home and in care homes • To enable staff to have information to access pharmacy services for palliative drugs for patients • Clarify palliative and end of life medicines in/out of hours pharmacies provision **Care at times of Crisis** • To implement and embed the SPA for EoL care and a Palliative Overnight Nursing Service to support patients and clinicians with 24/7 expert palliative and last stage of life care and advice • Ensure access to hospice and continuing care beds reflects local need

T4. Integrated Support for People with Long Term Condition (LTCs)

Key Strategic Health Outcomes and Actions	Commissioning Intentions 2019-20 and 2020-21
By 2020/21 we will be delivering the following outcomes: • Reducing prevalence growth for core LTCs and significant progress made in closing key prevalence gaps • Improved outcomes for people with multiple LTCs and complex needs • Reduced mortality from cardiovascular and respiratory diseases • Reducing unplanned care needs and events arising associated with LTCs • Significant progress in patient activation and the numbers of patients self-managing elements of their care • Increase access to and usage of Personal Health Budgets (PHBs) • increase in people with an LTC who self-manage elements of their care • Increase in people with an LTC who have an anticipatory care plan **Key strategic actions to achieve these include:** • Embed approach to tackling co-morbidities and complex needs • 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 • New AF and stroke pathways and services targeting those with high need • Expand the MyHealth programme (Empowered Patients Programme) • We will expand Personal Health Budgets in Hillingdon • Expand the usage of Patient Activation Measures (PAMs) to gauge impact of support • Mental health and well-being support to people with long-term conditions will be fully embedded within Hillingdon health systems • Expand ICP to wider cohort **Key local aims to achieve by 20/21:** • Improved outcomes and support for people with multiple LTCs and complex needs • Reducing unplanned care needs arising associated with LTCs • Reduced variation in care received by people with LTCs with a particular focus on variation in Primary Care • Increasing focus on improved outcomes through preventative measures (primary, secondary and tertiary prevention) • Pro-active and co-ordinated care for people with Multi-morbidities	**Keeping People Well** • Active health promotion, screening and education for the population to support in reducing health inequalities • To provide holistic management for patients through the roll out of multi-morbidity clinics to support patients with LTC to manage their condition • To maximise self-care via the My Health Programme for patients with LTC to empower them with strategies to manage their conditions through an increase in knowledge and skills • Promote online local directory of services for people with LTCs to keep them informed and supported • To provide person-centred care through use of care plans as part of multi-morbidity clinics **Right Care, Right Time** • To improve access to early diagnostics for patients and staff in primary care and the community • To create a neighbourhood team that is designed to support people in managing their long term conditions, staying healthy and working towards self-care/management • To work with our GP Confederation to ensure prevalence reporting is accurate in general practice for LTCs • To work with our GP Confederation to reduce unwarranted clinical variation for LTCs in order to maximise evidence based clinical care. • To enhance mental health integration within the LTC programme **Care at times of Crisis** • To pilot a dedicated SPA for patients with a LTC who are at risk of an unplanned admission to hospital to manage their care at home and in the community

T5. Transforming Care for People with Cancer

Key Strategic Health Outcomes and Actions	Commissioning Intentions 2019-20 and 2020-21
By 2020/21 we will be delivering the following outcomes: • Reduced mortality from cancer • Improved screening coverage for breast, cervical and bowel cancer • Greater proportion of cancers diagnosed at Stage 1 or 2 • Holistic pathways covering both medical and nonmedical care elements • Integrated cancer rehabilitation programme • SPA survivorship service model • Reduction in unplanned events • Early identification of Cancer patients in primary care/community settings • GP DA and STT community diagnostics **Key strategic actions to achieve these include:** • Ongoing rollout of actions from our Hillingdon Cancer Improvement Plan leading to earlier diagnosis and improved treatment. • We will continue delivery of the National Cancer Vanguard Programme • Roll out clinical protocol for the follow ups in community • Develop Single Point of Access rehab model • Implementation of DA and STT • Rollout outstanding actions from Cancer Improvement Plan • Evaluation of cancer screening outreach programmes **Key local aims to achieve by 20/21:** • Increasing rates of cancer prevented and increasing survival rates • Reduction in the rates of reoccurrence • Reduction in variation rates in the quality of care • Patients and their families better informed, empowered and involved in decisions around their care • Improved health, wellbeing and quality of life for patients after treatment and at the end of life • Increase in early diagnosis of cancer evidenced by reducing number of patients identified as having Cancer following a non-elective presentation	**Keeping People Well** • Promotion of Cancer awareness and availability of testing • Continue the rolling education programme in partnership with Cancer Research UK • Ensure supported links between primary care and acute services in maintaining skills and latest intelligence to identifying and managing cancer, • Enhancing survivorship support and pathways through continued working with cancer clinicians, sector partners and Macmillan • Empowering patients with cancer with the relevant information and offer of support networks to help them feel more in control of decisions about their cancer care treatment and management **Right Care, Right Time** • Continue to improve cancer screening programmes with a focus on reducing variation in patients accessing services • Promoting Cancer Decision Support Tools in primary care with emphasis on EMIS interaction enabling immediate digital alignment • Increasing GP direct access to cancer screening in line with NICE guidance, building on recent developments to deliver straight to test pathways • Improve efficacious use of diagnostic capacity to meet prevalence growth rates and `Two Week Wait' outcomes • Explore use of Shared Care Records across the London Cancer Network in the clinical management of cancer • Scale stratified cancer care pathways for bowel, lung, breast and prostate • Achieve the 28 day standard for cancer diagnosis in breast, urology and lung cancer **Care at times of Crisis** • Develop enhanced wraparound support to people and families with a loved one living with cancer

T6. Supporting People with Serious Mental Illness and those with Learning Disabilities

Key Strategic Health Outcomes and Actions	Commissioning Intentions 2019-20 and 2020-21
By 2020/21 we will be delivering the following outcomes: • Greater 'Parity of esteem' through holistic care management approach for physical health, mental health and social care needs • Improved support for people with an urgent mental health need • Progress to closing the mortality gap for those with a learning disability and with a serious mental illness • Reduction in the unplanned care events for people with a known mental health condition and/or learning disability • Improved rates of adults with a learning disability or mental health need living in stable and appropriate accommodation • Improved Access to Psychological Therapies (IAPT) and maintaining the recovery rate Reduction in risk of harm to vulnerable CYP and adults • Reduction in risk of harm to vulnerable CYP and adults • More Children and Young people receiving earlier access to mental health illness and emotional distress support services **Key strategic actions to achieve these include:** • Expand integrated care delivery models to include adults, children and young people with MH needs • Full operational delivery the strategy for adults and children with autism • Re modelled Children and Young People's (CYP) Mental Health end emotional wellbeing pathway and further integration with mainstream Children's support services commissioned by CCG and LBH **Key local aims to achieve by 20/21:** • Increasing support for people with an urgent mental health need • Significant progress in closing the mortality gap between people with an LD and with a serious mental health illness and the wider population • Full Implementation of Five Year Forward plan for Mental Health & Future in Mind • 35% of the prevalence of CYP with a mental health illness receiving treatment and support • 100% of people with a Learning Disability and 60% of people with a serious mental illness receiving a full health a check and appropriate ongoing care	**Keeping People Well** • Extend and develop a holistic and coordinated primary care mental health service that enables more people to recover and stay well in the community, including those with substance abuse • Further integrate our LD service with the LBH LD services and provide a holistic community service response that supports people to remain safely in the community in the least restrictive environment • Work with LBH and school to expand access to strategies to manage anxiety and depression for CYP and improve their overall health and wellbeing • Increase support for CYP and their families who are experiencing emotional distress to build resilience and improve mental health and wellbeing • Increase access for people who require Talking Therapies (IAPT) to support them with strategies to manage anxiety and depression and improve their overall health and wellbeing • Review and improve the personality disorder pathway for patients with complex mental health needs **Right Care, Right Time** • Develop an integrated community based model in partnership with LBH that provides: rehabilitation, promotes self-care and return to employment opportunities to support people to maintain mental well-being **Care at times of Crisis** • Introduce active case management and personalised care plans for people with MH needs and ensure rapid access to treatment and support through joint working with our partners including LBH and police • Improve access, quality and safety for people in mental health crisis to a Crisis/Safe Haven response and Health Based Place of Safety (HBPOS) through joint working with partner organisations • Provide coordinated care for CYP and Adults with a LD and/or autism to avoid an unnecessary admission to hospital • Deliver a rapid response service for CYP and Adults with a LD and/or Autism when experiencing a mental health crisis and avoid unnecessary hospital admission

T7. Integrated Care for Children & Young People

Key Strategic Health Outcomes and Actions	Commissioning Intentions 2019-20 and 2020-21
By 2020/21 we will be delivering the following outcomes: • Coordination of support for children and young people across all health and social care services and working with early year settings and schools • 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 • Increase 0-4 year olds dental health to England average • Reduced childhood excess weight rates • Reduced teenage (under 18) conceptions **Key strategic actions to achieve these include:** • 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 • Delivery of wellbeing training programme for schools • Improved access to consultant led paediatric services • Introduce Single point of Access for CYP **Key local aims to achieve by 20/21:** • Coordination of support for children and young people across all health and social care services • Shifting common health support into holistic and multi-disciplinary support in early years and school settings • Improved outcomes for children and young people with one or more LTCs • Reduction in the risk of harm to children and young people	**Keeping People Well** • Improve the uptake of childhood immunisations • Raise awareness and provide children with knowledge and tools to help improve their dental health (via Aggie the Alien themed My Health programme in schools) • Raise awareness and equip CYP with knowledge, skills and tools to achieve and maintain a healthy weight (via Aggie the Alien themed My Health presentation in schools assembly) • Collaborate and support Young Healthwatch to engage and respond to the health and well-being needs of CYP via a 'Best you' campaign **Right Care, Right Time** • Improve access to Integrated Therapies through new model of care • Expand the Paediatric Integrated clinics to include joint GP / Community Paediatrician consultations for CYP with complex needs and Transition Clinics • Development and implementation of shared care plans **Care at times of Crisis** • Develop pathways and support young people with LTC and complex needs as they transition to adult services (by working with THH and CNWL to pilot a Transition nurse(s) • Develop a responsive, needs led pathway to support CYP affected by Autism (including My Health Aggie the Alien themed Autism support workshop).

T8. Integration across the Urgent & Emergency Care System

Key Strategic Health Outcomes and Actions	Commissioning Intentions 2019-20 and 2020-21
By 2020/21 we will be delivering the following outcomes: • Coordinated Urgent & Emergency Care services across system partners • More patients having their unplanned care needs met before attendance and supported at home • Increased community awareness to access urgent care services and advice • Reduction in rate of growth for unplanned attendances at hospital • Reduction in Zero-Length of Stay and Unplanned Admissions • Reduction in Length of Stay following an unplanned admission • Reduction in the number of emergency readmissions **Key strategic actions to achieve these include:** • Develop Integrated Urgent Care approach, aligning urgent care services across social, primary, community and acute settings • Rollout new 111 Service and Primary Care Triage Model aligned to national guidelines • Robust monitoring of individuals discharged from hospital to monitor success in avoiding emergency readmissions • Develop and enhance ambulatory care pathway services in out of hospital settings **Key local aims to achieve by 20/21:** • Coordinated support across all Urgent & Emergency Care services • Increased number of patients who have their unplanned care needs met outside of a hospital setting • Increased awareness in the community about how to access appropriate services • Increased number of people supported to avoid an admission and those supported home with a reduced Length of Stay • Deliver the Ambulance Handover Time targets consistently • Reduce the number of alcohol related presentations	**Keeping People Well** • Enhanced NHS 111 service developed across NW London, including NHS 111 digital on-line platform to provide information for patients and increase patient access to clinicians including community pharmacists • Health connectors will work with patients to refer to the MyHealth Programme, empowering patients with the information and support to manage their condition(s) **Right Care, Right Time** • To continue programme of Health Connectors working with our Urgent Care Centre to sign-post and re-direct patients, as appropriate, to alternative health and social care services • To expand and build on work with LAS and partners to support enhanced See and Treat to reduce the numbers of conveyances and A&E attendances • Embedding access to more primary care appointments for non-emergency, non-urgent needs through use of GPOOH and Primary Care hubs • Continue to embed and scale ambulatory care services in line with national standards to provide specialist support for patients who present at hospital requiring urgent acute intervention. Therefore, to avoid unnecessary hospital admission with planned discharge home with support from follow-up services arranged in a timely manner **Care at times of Crisis** • Integrating early first response services such as Rapid Response and local teams to respond swiftly to patients in their home environment when they become very unwell and need urgent care that can be delivered at home • To undertake a review of the MIU at Mount Vernon Service to ensure it delivers in line with national quality standards • To standardise and improve the front door triage of patients in A&E to ensure patients are appropriately triaged and directed to the Right Care, whether it is in hospital, in the community, primary care, or returned home with support and/or advice

T9. Public Health and Prevention of Disease & Ill-Health

Key Strategic Health Outcomes and Actions	Commissioning Intentions 2019-20 and 2020-21

By 2020/21 we will be delivering the following outcomes:
• Integrated approach to addressing the wider determinants of health in the borough though the Self Care and Prevention Steering Group.
• Improved rate of adults engaging in physical activity to England average
• Reduce obesity rates for children (10-11 years)
• Reduced suicide rate
• To reduce social isolation and increase access to the amount of social contact for adult social carers and care users
• Reduced admissions related to alcohol Increased numbers of patients successfully accessing and completing drug and alcohol rehabilitation courses and reduced deaths from drug misuse
• Better reporting and follow up of reported domestic abuse related incidents and crimes
• Reduced smoking prevalence in young people
• Reduced air pollution levels in Hillingdon
Key strategic actions to achieve these include:
• Joint Early Intervention and Prevention Services Plan
• Physical Activity Strategy
• Develop Suicide Prevention Strategy
• Address smoking prevalence in young people and adults
• Embed Patient Education Programme
• Review of Air Quality action plan.
Key local aims to achieve by 20/21:
• Hillingdon wide self-management/education programme aligned to MyHealth programme for all patients regardless of their length of diagnosis for a number of conditions
• Reduction in rate of growth and prevalence gap for key LTC conditions
• Fully informed, engaged and activated patients taking control of the process of care for their own conditions
• Reduced variation in management of conditions to reduce the number of exacerbations that occur for people and ultimately improve their long term outcome
	Keeping People Well
	• Co-production of a new accredited Diabetes Prevention workshop with a new approach towards high-engagement group coaching and further development of skills of the MyHealth facilitators
	• The opportunity to expand range of services that can make referrals to the MyHealth Programme other than GPs to include self-referrals from patient themselves
	• Use of NWL `Health Help Now' App as a key enabler to empower patients to manage LTC
	• Self-Care workshops
	  ○ Prioritise new workshops pertaining to approx. ten areas to expand scope and reach of MyHealth programme
	  ○ Engage with provider trusts workforce in self-care workshops/agenda
	• Joint working between LBH and CCG in relation to reducing adult and children obesity linking strategic actions from physical activity plans, MyHealth and Children's strategy
	• Improve uptake of vaccinations
	• Improve access to smoking cessation support to reduce health inequalities
	• Joint working to address social and mental health issues related to tobacco, drugs and alcohol use
	• Explore opportunities for social prescribing to address poor mobility and social isolation/loneliness as part of holistic health and wellbeing approach, as well as interlinking with integrated systems such as `High Intensity User Service' (see p. 6)
	• Early preparation for discharge (Hillingdon Independent Living, aids and equipment for discharge)
	• Joint working to manage re-admissions and DToC between health and wellbeing services
	• Expanding access to Sexual Health services

T10. Transformation in Local Services

Key Strategic Health Outcomes and Actions	Commissioning Intentions 2019-20 and 2020-21
By 2020/21 we will be delivering the following outcomes: • Reduction in prevalence gap for key conditions • Reduction in the rate of growth in prevalence • Reduction in the variation in management of conditions • Reduction in the prevalence gap for key conditions • Reduction in the rate of growth of prevalence • Reduction in the management of people with LTCs **Key strategic actions to achieve these include:** • Implement NWL Local Services Strategy • Provide medical retina services at Mount Vernon hospital to treat macular degeneration • Enhanced progression of BHH RightCare Programme in line with strategic plans developed in October 2016 • Full implementation of 7 Day Standards • Enhanced progression of BHH RightCare Programme • Rollout of Prevention Strategy • Rollout of Proactive Case Finding in Primary Care • Work to close prevalence gap • Explore opportunities for diagnostics in the community **Key local aims to achieve by 20/21:** • Reduced rate of growth in hospital attendances and admissions for people with planned care needs • Increasing scope and amount of activity delivered Out of Hospital and closer to home for patients • Reduction in Length of Stay following a planned admission • Increased use of alternative services to deliver planned care support • Deliver the 4 Priority Acute Standards for 7 Day Services	**Keeping People Well** • Work to improve care pathways with primary care to support symptom identification, diagnosis and earlier health management/prevention • Improved bariatric surgery outcomes through integrated NWL work • Targeted support for urological conditions management in primary care • Extension of clinical decision support in primary care with access to interventional diagnostics to reduce ineffective testing and opportunities for primary care/community-based diagnostics • Proactive case finding in primary care and 'lessons learned' to improve identification of under-recognised conditions and prevention **Right Care, Right Time** • Enhanced neurology community service to incorporate: epilepsy, headaches and other neurological conditions including MS • Progress plans for minor surgery for carpal tunnel syndrome to be carried out in community; adopting a similar model to current hernia service • Redesign CATS to improve clinical triage, treatment and discharge pathways to address FA discharges and deliver Advice & Guidance; a national priority • Supported MSK conditions management in primary care, including scoping of FCP opportunity and self-referral to physiotherapy. • Enhanced dermatology pathway and condition management in community and primary care • Reduce ophthalmological appointments for glaucoma, cataract and procedures delivered in an acute setting and support management of these in in primary care and by optometrists for minor eye conditions • Reduce variation in surgical decisions through service reviews, updated access policy, including patient choice, supported decision making; to address variations in days case and follow-up discharge pathways **Care at times of Crisis** • Improve clinical pathways and outcomes of 2 Week Wait referrals to enhance access and address first appointment discharges • Piloting enhanced access to planned care pathways from unplanned care as part of conservative conditions management care model approach

E1. Developing the Digital Environment

Key Strategic Health Outcomes and Actions	Commissioning Intentions 2019-20 and 2020-21
By 2020/21 we will be delivering the following outcomes: • Become paper free at the point of care (subject to availability of sufficient capital funding from NHS England to automate providers' systems) • Digitally enabled transfers of care between all healthcare settings • Improve access to Shared Care Records to support integrated care • Make progress towards shared digital care and support plans (which meet the standards developed in 2018/19 by the Professional Records Standards Board in conjunction with NHS NW London and NHS Digital) to enable better integrated care across care settings, integrated with Primary care clinical systems, and including End of Life care planning and digitally enabled self-care • Develop plans for use of real time data in decision making • Additional promotion of assistive technologies e.g. telecare and telehealth • Eradicate use of fax in care services • Real time use of data used to inform patients **Key strategic actions to achieve these include:** • Relevant information safely and appropriately available from all clinical IT systems when needed to coordinate care for people – all providers must procure systems that have open interfaces for sharing patient information • Clear information available to aid planning of services through Business Intelligence and analytical systems fed by each provider • High utilisation of Shared Care Record across settings by provider clinicians, and promotion to patients by providers **Key local aims to achieve by 20/21:** • Effective and efficient integrated care services enabled by shared health and care records • Relevant information, safely and appropriately available when needed to coordinate care for people Clear analytical information available to aid planning of services	We will: • Encourage secondary care to move towards paperless operation at the point of care (subject to availability of sufficient capital funding from NHS England to automate providers' systems) • Complete development of a shared care record across all care settings including social care fed by all providers' clinical IT systems, facilitating integrated out of hospital care, including the NW London and pan-London Care Information Exchanges • Extend patient records (from all settings) to patients and carers, and provide them with digital self-care and management tools such as apps, to help them become more involved in understanding and managing their own care; to include implementation of common digital identity and consent management functions across NWL and where possible, pan-London • Use dynamic analytics to inform care decisions and support integrated health and social care across the system through whole system intelligence

E2. Creating the Workforce for the Future

Key Strategic Health Outcomes and Actions	Commissioning Intentions 2019-20 and 2020-21
By 2020/21 we will be delivering the following outcomes: • A workforce that meets the evolving needs of health and social care • A service with the capacity and capability to meet our population needs • Reducing sickness and absence rates • Improving skills and competences within the workforce **Key strategic actions to achieve these include:** • Develop recruitment and retention strategy with multi-professional workforce plans • Brunel University London (BUL) with THH, NHSFT and CNWL NHSFT establishing an Academic Centre for Health Sciences • Develop workforce plans with Buckinghamshire New University • Rollout recruitment and retention strategy and workforce plans **Key local aims to achieve by 20/21:** • A workforce that grows new roles and skills to support patient care • New systems and processes to release clinical time • A sustainable primary care workforce that is competent and confident to work in new models of care delivery and new provider structures. • A supported workforce environment that promotes Hillingdon as an attractive place to work.	We will: • Increase the training, mentorship and student placement capacity in general practice and look to make this equitable across the borough • Continue to provide staff forums, training and education opportunities to all general practice staff and others in the health and care arena • Support consistent ways of working to improve and standardise processes in general practice (signposting, clinical correspondence) • Offer supported, and sometimes targeted, recruitment of new staff into general practice including through apprenticeship programmes (ST3s, GPNs) • Establish the Transition Academy to coordinate these activities and engender quality and consistency of staffing and general practice offer • Create quality and consistent ways of working in general practice for GP Confederation membership. Enable cross-organisational working within the GP Confederation and the ICP • Working with our NHS partner organisations – we will implement a system workforce strategy that addresses shared values, behaviours and coaching approach to work as an ICP • Resource local practice managers groups for peer support in IT, HR and general business sustainability • Support practice teams to find the space and time to work better for themselves and together • Establish inter-professional, multi-organisational and multi-HEI packages of student placements and apprenticeships for joint learning • Establish training hubs and peer support for multi-disciplinary forums, training and education within the GP Confederation membership • Create a targeted, multi-professional, multi-organisational pipeline of new staff for recruitment • Develop a more generically skilled, multi-professional workforce managing patients across multi-morbidity packages of care • Continue to properly evaluate and develop new workforce functions and competency frameworks with HENWL and HEIs

E3. Delivering Our Strategic Estates Priorities

Key Strategic Health Outcomes and Actions	Commissioning Intentions 2019-20 and 2020-21
By 2020/21 we will be delivering the following outcomes: • Deliver Local Estate Strategy for Hillingdon **Key strategic actions to achieve these include:** • Better utilise estates with a view to integration of health and care services **Key local aims to achieve by 20/21:** • An estate portfolio that meets the needs of our Transformation Themes.	We will: • Deliver a local service Hub in North of Hillingdon by 2020/21 • Deliver a local service Hub in the Uxbridge and West Drayton area by 2020/21 • Determine a long-term solution for Yiewsley Health Centre by 2019/20 • Deliver a new health facility on the existing Vinyl Factory site • Deliver a new health facility on a redeveloped Woodside development • Invest in primary care infrastructure through supporting practice improvement grant applications

E4. Delivering Our Statutory Targets Reliably

Key Strategic Health Outcomes and Actions	Commissioning Intentions 2019-20 and 2020-21
By 2020/21 we will be delivering the following outcomes: • Continued, consistent and sustained achievement of our mandatory and statutory targets for A&E, RTT, Cancer and LAS handovers **Key strategic actions to achieve these include:** • 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 **Key local aims to achieve by 20/21:** • Achievement of NHS Targets for Referral to Treatment (RTT), A&E and Cancer Waits and Diagnostics as well as our other statutory targets associated with Mental Health. • Reduction in waiting times in all specialities including cancer	We will: • Ensure demand management programmes are robust and well-led for unplanned and planned care • Seek assurance and accountability for delivering to national standards, offering support and proactive engagement to around matters arising as well as horizon scanning to mitigate risks to delivery of targets • Work with stakeholders to come to a shared view of service delivery and baselines toward joint visioning and integrated system response to shared challenges • Agree trajectories and milestones for recovery where needed • Apply robust, nuanced, contract and performance oversight and management • Ensure the focus is on patient experience and quality of care outcomes • Seek to engage patients in decisions regarding their care pathways and experiences, actively listening and applying learning

E5. Medicines Management

Key Strategic Health Outcomes and Actions	Commissioning Intentions 2019-20 and 2020-21
By 2020/21 we will be delivering the following outcomes: • Reduction in overall medicines expenditure per capita including reduced wastage taking into account growth in costs • Improved outcomes for people utilising medicines **Key strategic actions to achieve these include:** • Focus on medicines optimisation and rollout of practice level pharmacy support with medicines reviews and repeat prescriptions • Implement Prescribing Wisely **Key local aims to achieve by 20/21:** • Supporting in reducing unplanned admissions related to medicines • Increased use of skilled workforce e.g. specialised clinical pharmacists in GP practice setting	We will: • Increase pharmacist led medication reviews focusing on long-term conditions • Support workforce issues in Primary Care by using pharmacist IPP skills • Improve primary care and community Integration for prescribing • Support Hillingdon GP Confederation with the NHSE Clinical Pharmacists pilot scheme • Improve the care of Care Home residents through the NHSE Medicines Optimisation in Care Homes initiative • Improve the discharge pathway by use of integrated pharmacist team – quality & safety and releasing time in general practice • Ensure ICS Medicines Optimisation – overall pharmacy spend across all partners (primary care, CNWL & THH) and creating one set of protocols and processes • Work towards use of Pharmacy Technician to support work in care homes • Integrate with secondary care consultants and MDT through virtual clinics e.g. respiratory • Undertake domiciliary medication reviews by specialist pharmacists for the frail and elderly • Undertake domiciliary medication review of newly discharged patients by specialised pharmacists • Clarify palliative and EoL medicines in/out of hours pharmacies provision • Developing shared care for protocols for prescribing MH & LD medicines (CNWL + primary care) • On-going implementation of prescribing national guidance

E6. Redefining the Provider Market

Key Strategic Health Outcomes and Actions	Commissioning Intentions 2019-20 and 2020-21
By 2020/21 we will be delivering the following outcomes: • 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 and locally led Integrated Care system **Key strategic actions to achieve these include:** • Rollout and trial Integrated Case System model approaches and develop plans for future cohorts – including 0-16, 17-25, 26-64 and 65+ to address the needs, requirements and support models for those age groups • Develop neighbourhood and locality care delivery models that are primary care-led and working in multi-disciplinary approach with community assets, voluntary sector and health and care professionals • Implement recommendation of THH master planning exercise **Key local aims to achieve by 20/21:** • Improved capability across the system in meeting the health needs of the local population within the financial constraints • Payment and risk share arrangements that incentivises innovation, quality and sustainability, based on delivery of defined patient-centred outcomes in order to improve quality and demonstrate system transformation • Improvements in clinical quality, integrated care systems and financial sustainability • System incentivised to work together to enable the needs of the whole person to be met	We will: • Health & Care Joint Commissioning with LBH to further develop BCF for 19/20 plans to build on prevention, early intervention and older people support working with LBH to further commission outcomes-based support around Children's, Learning Disability & Mental Health • Joint market shaping and development for 'Tier 3' and ' Tier 4' for people with complex needs and working across NWL collaborative • Explore Integrated Care Partnership (ICP) approaches through working with Hillingdon Health Care and Partners (HHCP) and LBH • Develop primary care-led integrated models of care e.g. Neighbourhood teams • Shared transformation and delivery - building on Active Case Management, MSK, EoL, Older People, Urgent Care and Primary & Community Care • Shared digital and business intelligence • Shared workforce development • Align financial and operational strategies and plans • Deliver 7 Day Services through working with our HHCP partners to jointly deliver 'out-of-hours' support and 'hub-based' working for health and care services – including planned and urgent care

10. North West London System Transformation Partnership – to be updated

The information for this section is currently unavailable; the CCG is awaiting information from NWL.

11. List of Abbreviations Used

Term	Meaning	Term	Meaning	Term	Meaning
A&E	Accident & Emergency	CSPR	Child Safeguarding Practice Reviews	HHCP	Hillingdon Healthcare Partners
ACO	Accountable Care Organisation	CVD	Cardio-Vascular Disease	HRG	Healthcare Resource Group
ACSC	Ambulatory Care Sensitive Conditions	CWHHE	Chelsea & Westminster, West London, Hounslow, Hammersmith & Fulham and Ealing CCGs	IAPT	Improving Access to Psychological Therapies
AF	Atrial Fibrillation	DA	Direct Access	IAPT	Improving Access to Psychological Therapies
AIDS	Acquired Immune Deficiency Syndrome	DASH	Disablement Association Hillingdon	IBD	Irritable Bowel Disease
BCF	Better Care Fund	DES	Directed Enhanced Service	IBS	Irritable Bowel Syndrome
BHH	Brent, Harrow, Hillingdon CCGs	DH/DoH	Department of Health	ICO	Integrated Care Organisation
CAMHS	Children & Adolescent Mental Health Services	DHR	Domestic Homicide Reviews	ICP	Integrated Care Programme
CATS	Clinical Assessment & Treatment Service	DNA/s	Did Not Attend/s	IM&T	Information Management & Technology
CATTS	Clinical Advice & Triage Service	DTOC	Delayed Transfer of Care	IPP	Independent Pharmacist Prescriber
CATT	Crisis Assessment & Treatment Team	ED	Emergency Department	IT	Information Technology
CCG	Clinical Commissioning Group	ENT	Ear, Nose & Throat	IV	Intravenous
CHC	Continuing Health Care	EoL	End of Life	IUC	Integrated Urgent Care
CHF	Chronic Heart Failure	FCP	First Contact Practitioners	JHWBS	Joint Health & Wellbeing Strategy
CHD	Chronic Heart Disease	FCT	Faecal Calprotectin Testing	JSNA	Joint Strategic Needs Assessment
CHF	Chronic Heart Failure	FT	Foundation Trust	LA	Local Authority
CKD	Chronic Kidney Disease	FUP	Follow Up (Appointment)	LAS	London Ambulance Service
CI	Commissioning Intentions	FY	Financial Year	LD	Learning Disability
CIE	Care Information Exchange	FYFV	Five Year Forward View	LeDeR	Learning Disability Mortality Reviews
CIP	Cost Improvement Programme	GP	General Practitioner	LIS/LES	Local Incentive Scheme Locally Enhanced Service
CMC	Coordinate My Care	GB	Governing Body	LBH	London Borough of Hillingdon
CNWL	Central & North West London NHS Foundation Trust	GPN	General Practice Nurse	LIS/LES	Local Incentive Scheme Locally Enhanced Service
COPD	Chronic Obstructive Pulmonary Disease	GPwSI	GP with a Special Interest	LNWH	London North West Hospitals NHS Foundation Trust
COTE	Care of the Elderly	GLA	Greater London Authority	LTC	Long Term Conditions
CQC	Care Quality Commission	HAI	Healthcare Acquired Infection	MDT	Multi-Disciplinary Team
CQG	Clinical Quality Group	H4All	Hillingdon 4 All	MH	Mental Health
CQRG	Care Quality Review Group	HCCG	Hillingdon Clinical Commissioning Group	MIU	Minor Injuries Unit
CSA	Child Sexual Abuse	HENWEL	Higher Education North West London	MMT	Medicines Management Team

Term	Meaning	Term	Meaning	Term	Meaning
MS	Multiple Sclerosis	STP	Sustainability and Transformation Plans		
MSK	Musculo-Skeletal	STT	Straight To Test		
NEL	Non-Elective	TB	Tuberculosis		
NEPTS	Non-Emergency Patient Transport Service	TFC	Treatment Function Code		
NES	Nationally Enhanced Service	THH FT	The Hillingdon Hospital NHS Foundation Trust		
NHSE	NHS England	TIA	Transient Ischaemic Attack		
NICE	National Institute Clinical Excellence	UEC	Urgent & Emergency Care		
NWL	North West London	UCC	Urgent Treatment Centre		
OBC	Outline Business Case	VTE	Venus Thromboembolism		
OOA	Out of Area	WSIC	Whole System Integrated Care		
OOH	Out of Hours or Out of Hospital	WTE	Whole Time Equivalent		
PAD	Peripheral Artery Disease	ZLOS	Zero Length of Stay		
PCC	Primary Care Contract				
PCI	Practice Commissioning Initiative				
PH	Public Health				
PHB	Personal Health Budgets				
PHE	Public Health England				
PPE	Public & Patient Engagement				
PTS	Patient Transport Service				
Pt/Pts	Patient/s				
PYLL	Potential Years Life Lost				
QIPP	Quality, Innovation, Productivity & Prevention				
RBHFT	Royal Brompton & Harefield Hospitals NHS Foundation Trust				
RTT	Referral To Treatment				
SaHF	Shaping a Healthier Future				
SARs	Safeguarding Adult Reviews				
SCR	Shared Care Record or Summary Care Record				
SMI	Serious Mental Illness				
SPA	Single Point of Access				
SSoC	Shifting Settings of Care				
ST3	(GP Registrar Year)				
STPs	Sustainability and Transformation Partnerships				

12. List of Providers

1. Age Uk
2. Ashford and St Peter's Hospitals NHS Foundation Trust
3. Barts & The London NHS Trust
4. BMI Healthcare Ltd
5. British Pregnancy Advisory Service
6. Buckinghamshire Healthcare NHS Trust
7. Camden & Islington Mental Health Trust
8. CarePoint
9. Care UK
10. Central & North West London NHS Foundation Trust
11. Central North West London Mental Health Trust
12. Concordia Health
13. Direct Healthcare Services
14. East & North Hertfordshire NHS Trust]
15. Egton MIG Healthcare Gateway
16. Frimley Park Hospital
17. Great Ormond Street Hospital for Children NHS Foundation Trust
18. Greenbrook
19. Guy's & St Thomas' NHS Foundation Trust
20. Harlington Hospice
21. Hayes Cottage
22. Healthshare
23. Hertfordshire Partnership University NHS Trust
24. H4All
25. Hillingdon GP Federation
26. Hillingdon MIND
27. Imperial College Healthcare NHS Trust
28. Kingston Hospital NHS Trust
29. King's College Hospital NHS Foundation Trust
30. Language Line Ltd
31. London Ambulance Service
32. London North West Healthcare NHS Trust
33. Marie Stopes International
34. Medical Information Systems Ltd
35. Moorfields Eye Hospital NHS Foundation Trust
36. North Middlesex University Hospital NHS Trust
37. NUPAS (formerly Fraterdrive Ltd)
38. Opcare
39. Royal Brompton & Harefield NHS Foundation Trust
40. Royal Free London NHS Foundation Trust
41. Royal National Orthopaedic Hospital NHS Trust
42. Royal Surrey County Hospital NHS Foundation Trust
43. St George's Healthcare NHS Trust
44. South West London and St George's Mental Health NHS Trust
45. Tavistock & Portman NHS Foundation Trust
46. The Hillingdon Hospitals NHS Foundation Trust
47. The Royal Marsden NHS Foundation Trust
48. The Whittington Hospital NHS Trust
49. Trinity Hospital
50. University College London Hospitals NHs Foundation Trust
51. West Hertfordshire Hospitals NHS Trust
52. West London Mental Health NHS Trust
53. Wexham Park Hospital

13. Hillingdon CCG GP Practices

1. The Mountwood Surgery
2. Kingsway Surgery
3. The New Medical Centre
4. Oakland Medical Centre
5. The Devonshire Lodge Practice
6. Harefield Health Centre
7. The Belmont Medical Centre
8. Yiewsley Health Centre
9. Oxford Drive Medical Centre
10. Wood Lane Medical Centre
11. Cedars Medical Centre
12. Uxbridge Health Centre
13. The Pine Medical Centre
14. Dr CB Patel's Practice Hayes Medical Centre
15. Townfield Doctors Surgery
16. The Warren Practice
17. Yeading Court Surgery
18. Abbotsbury Practice Eastcote Health Centre
19. King Edwards Medical Centre & Swakeleys Medical Centre
20. The Parkview Surgery
21. Otterfield Medical Centre
22. Eastbury Surgery
23. The Cedar Brook Practice
24. Brunel Medical Centre
25. St Martin's Medical Centre
26. Church Road Surgery
27. Hillingdon Health Centre
28. Dr HG Campbell's Practice Glendale House Surgery
29. Acre Surgery
30. The High Street Practice
31. Ladygate Lane Surgery
32. North Hyde Surgery
33. The Willow Tree Surgery
34. Shakespeare Health Centre
35. Acrefield Surgery
36. Carepoint Practice Northwood Health Centre
37. Wallasey Medical Centre - Dr K Patel
38. West London Medical Centre
39. Dr AN Goud's Practice Kincora
40. Queens Walk Medical Centre (Dr C M Solomon)
41. Dr MLR Siddiqui's Practice 'The Surgery'
42. Acorn Medical Centre
43. Heathrow Medical Centre
44. Southcote Clinic
45. HESA Medical Centre (merger of Orchard and Hayes Town)