HILLINGDON'S JOINT HEALTH AND WELLBEING STRATEGY 2018-2021

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

1. HEADLINE INFORMATION

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

2. RECOMMENDATIONS

That the Health and Wellbeing Board:

1. **considers the issues raised at 3.2. below setting out live and urgent issues in the Hillingdon health and care economy.**
2. **notes the performance issues contained at Appendix 1.**

3. INFORMATION

Background Information

3.1. Performance and Programme management of the Joint Strategy

The Board agreed and published Hillingdon's Joint Health and Wellbeing Strategy in December 2017. Since then the Transformation Group has supported the Transformation Board in monitoring progress against the 10 priorities and 6 enabling priorities identified in the strategy.

Key performance issues emerging from this process are identified in Appendix 1

3.2. Key Issues

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

3.2.1. The NHS Long Term Plan

As part of the NHS's 70th birthday celebrations, the NHS was allocated an extra £20 billion annually by 2023 and tasked with producing a ten year plan. On 7th January the NHS published its Long Term Plan for health. The Plan provides a blueprint for the NHS's priorities and ambitions over the next years. It focuses on building an NHS fit for the future by:

- Enabling everyone to get the best start in life
- Helping communities to live well
- Helping people to age well.

The plan has implications for the way health; social care and public health are delivered. The NHS long term plan ambitions for improving patient care can be grouped into five broad categories namely:

i. Health and Care transformation: Transforming the system through the creation of Integrated Care Systems (ICS) by April 2021. Through the formation of ICSs, the NHS hopes to encourage more collaboration between GPs, their teams and community services.

ii. Investing in prevention and tackling health inequalities: The plan says that the NHS will increase its contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.

iii. Creating a workforce that meets demand: Plan refers to a rise in investment in the NHS workforce, with the aim of increasing recruiting and training more professionals. This will include thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships.

iv. Making better use of data and digital technology: Invest in making available better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

v. Getting the most out of taxpayers' investment in the NHS: Working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS' combined buying power to get commonly-used products for less money, and reduce spend on administration.

The Long Term Plan also confirms that 2019/20 will be a transition year, during which the health system will be expected to produce a longer five year plan, which is expected to be in place for the Autumn. Related to this, it is not clear how the additional funding, including transformation funding, will flow, although it has been confirmed that around two thirds of additional investment will go into community and primary care.

The Long Term Plan recognises that investment in social care and public health are vital if the Plan is to fulfil its ambitions. The Adult Social Care Green Paper is still awaited, and at this stage is expected in the coming few months.

In November 2018 the Secretary of State for Health and Social Care published a vision for prevention, which included a commitment to bring forward a prevention Green Paper during the first half of 2019.

Notwithstanding the importance of resolving the financial sustainability of those areas where local government is critical, there are elements of the Plan where boroughs are clearly central to making progress.

Those areas include:

i. **The creation of Integrated Care Systems (ICS) by 2021 (local plans by April 2019)**: As reported elsewhere on today's agenda Hillingdon Health and Care Partners are moving apace to develop the Hillingdon ICS.

   Hillingdon Council has stated its commitment to working collaboratively with health partners to deliver improvements for residents. It has, however, expressed concerns regarding the underlying financial viability of the health system based on the starting deficit position and the need for robust business case to show how the ICS will become sustainable.

ii. The Board may wish to consider progress and whether, given the LTP expectation that Councils will be core partners in ICSs, we have the right conditions in place to develop the ICS in partnership.

iii. Blending (Pooling) health and care budgets and the BCF: The Long-term plan acknowledges the dependencies between social care and health and the need to have a well functioning social care sector. The plan also commits to support local approaches to blending health and social care budgets where councils and CCGs agree. Again elsewhere on today's agenda, under BCF update, the Board may wish to consider the approach taken in delivering Hillingdon's Better Care Fund plan and its strategic direction.

iv. Public health and prevention: As many of the preventative services delivered by local authorities are closely linked to NHS care, and in many cases are provided by NHS, the Government and the NHS are considering whether there is a stronger role for the NHS in commissioning sexual health services, health visitors and school nurses, and what best future commissioning arrangements might therefore be. In addition, in November 2018 Government published a vision for prevention, which included a commitment to bring forward a prevention Green Paper during the first half of 2019. We await further detail but on the face of it the LTP and promised green paper accords well with our approach so far to early intervention, prevention and self care and development of key projects such as My Health and a concerted focus on childhood obesity (see paper on today's agenda).

v. Mental health support for children and young people: Over the next five years the NHS will fund new Mental Health Support Teams working in schools and colleges, building on the support already available, which will be rolled out to between one-fifth and a quarter of the country by the end of 2023. These school and college-based services will be supervised by NHS children and young people mental health staff and

will provide specific extra capacity for early intervention and ongoing help. Again this development should reinforce good work undertaken in Hillingdon under the Thrive model in engaging schools and reducing delays in accessing CAMHs services.

vi. **Workforce:** The plan puts forward several proposals regarding the workforce. Including the publication of a workforce implementation plan, to be released later in 2019. NHS Improvement, HEE and NHS England will establish a national workforce group to ensure that such agreed workforce actions are delivered quickly.

3.2.3. End of Life (EOL)

The closure of the Michael Sobell House inpatient unit at Mount Vernon Hospital was discussed at a special meeting of the External Services Select Committee on 30 October and again on 11 December 2018. A key issue now is how hospice provision will be reinstated in the North of Hillingdon.

Michael Sobell House

The changes to Michael Sobell House Inpatient Unit (MSH IPU) continue to maintain a high profile as a point of significant concern for Hillingdon residents and NHS services from operational and patient experience perspectives. The service continues to be provided from Wards 10 & 11 in Mount Vernon Hospital (MVH) and is delivered by East and North Hertfordshire NHS Trust (ENH NHST). However, ENH NHST remains unable to accept non-cancer palliative patient referrals, impacting access for this cohort of patients.

There continue to be staffing issues as well as issues relating to the 24/7 MSH telephone helpline for NHS staff to access consultant input across Hillingdon, East and North Hertfordshire, Harrow and Herts Valley. Hillingdon palliative consultants have however worked with colleagues to ensure cover for Hillingdon clinicians.

Hillingdon CCG with associate CCGs has raised a formal concern with ENH NHST regarding the service and prolonged issues. ENH NHST has provided verbal assurance on service sustainability, quality and use of interim locums. The CCG is monitoring the situation closely and a further formal meeting is planned in February 2019.

HCCG is working closely with our local consultants and Hillingdon Health and Care Partners (HHCP) in considering practical options for reinstating the service in light of the prolonged service issues at ENH NHST.

Additionally, Hillingdon CCG intends to participate in engaging residents and patients on EOL care this year. Over the next 12 months HCCG will be working to ensure continued access to specialist palliative care and to retain the MSH service. In the longer term, we hope to retain the MSH services and to explore new models of EOL care, and incorporate future developments that can enhance our local EOL offer into our planning. The priority for the Hillingdon health system remains to ensure residents in the north of the borough have access to the necessary level of support from end of life services.

3.2.4. Health Based Places of Safety (HBPoS) Review

Work is still continuing on developing a final model for reconfiguring S136 provision. The expected options appraisal resulted in the three site model scoring highest in the scoring

exercise, the site configuration of Hillingdon (Riverside), Hounslow (Lakeside) and RBKC (St Charles). The NWL Mental Health Likeminded team ran a series of workshops in November and December.

There has been further consideration around funding agreement. If the work is to meet implementation timescales there is a need to move to business case stage, with a target to complete the case and approval stages no later than May 2019. It is still expected that the final decision about the HBPoS configuration in North West London will be taken by the Joint Committee of the 8 NWL CCGs by 30 September 2019.

There is significant opposition to the proposals from across local government. Whilst the NHS has led many events there had been no consideration of the impact of changes on finances and resources required by local authorities. There is also concern that when new venues become overloaded there will be a significant burden on A&E departments.

Hillingdon's Health and Wellbeing Board will wish to consider, on behalf of the whole health and care system, what response to the proposals it may wish to make.

3.2.5. Air Quality Action Plan

The Hillingdon Air Quality Action plan is being issued for public consultation shortly. This will be focused on reducing on reducing emissions and raising awareness of the issues surrounding poor air quality. Action will include reducing emissions from developments and buildings, awareness raising campaigns, promoting cleaner transport and promoting the AirText pollution alert system, a free service to all residents warning of approaching pollution episodes.

Poor air quality is thought to contribute to a sizable proportion of acute exacerbations of asthma and COPD as well as up to 90 deaths in Hillingdon annually. The Government's new air quality plan places greater emphasis on local authorities to tackle air pollution through a combination of planning and transport policies.

There are areas in the borough which are predicted to be above the air quality limits for annual mean nitrogen dioxide. These areas are mainly in the south of the borough close to Heathrow Airport, around the major road network traversing the borough (M4, A312, A40) and in our towns where traffic tends to be slow moving and congested. The Council remains vehemently opposed to airport expansion at Heathrow and has directly challenged assumptions of the impact of another runway on air quality in surrounding areas.

The conclusions of the consultation will be considered by the Council's cabinet, planned for April and the plan will then be published.

3.2.6. Public Health

The Chief Executive of Public Health England (PHE), Duncan Selbie visited Hillingdon on 14 January. He fed back that he saw Hillingdon as a well run authority with strong governance. He was encouraging regarding the opportunity for system leadership from the Council to drive Hillingdon's integrated care system. He also identified Childhood Obesity as the most significant Public Health issue facing Hillingdon (see paper on today's agenda).

4. Financial Implications

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

5. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

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

Consultation Carried Out or Required

Public consultation on the Joint Health and Wellbeing Strategy 2018-2021 was undertaken in 2017.

Policy Overview Committee comments

None at this stage.

6. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

Corporate Finance has reviewed the report and confirms that there are no direct financial implications arising from the report recommendations.

Hillingdon Council Legal comments

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

Appendix 1

Delivery Area, Transformation Programme and Progress Update – February 2019
DA 1 Radically upgrading prevention and wellbeing
T9. Public Health and Prevention of Disease and ill-health • **The Early Intervention, Self Care and Prevention working group has undertaken a mapping exercise of partnership early intervention and prevention activity so as to guide action planning.** • **The Hillingdon Air Quality Action plan is being issued for public consultation, the conclusions of which are due to come to Hillingdon's Cabinet in April 2019.** • **The Hillingdon Suicide Prevention action plan has promoted information and referral contacts for residents and identified training available for front line staff. The Group has reviewed issues around Hillingdon's train stations with partners.** • **The Health Help Now app, is now `live' in Hillingdon: https://www.healthiernorthwestlondon.nhs.uk/digitalhealth/apps/healthhelpnowapp A Communications plan has been developed and implemented to publicise the new app.** • **H4ALL is developing a support service for High Intensity Users of emergency services. This is a move away from the medicalised model of care and the function is focusing on coaching and personalised support to address peoples' needs.** • **The CCG are working with P3 to explore and develop an Early Intervention Navigator model bringing together both statutory and community support. This will look at expanding personalised emotional and wellbeing support for Children & Young people in Hillingdon.** • **The CCG's MyHealth team has developed a number of programmes with patients who have Long-Term Conditions to enable them to self-care and navigate services. The current programmes include `Health Heart and Chronic Obstructive Pulmonary Disease (COPD). New programmes in the co-production phase, include: 'Back, Neck and Knee Pain' for adult chronic pain and a school-based intervention for childhood obesity. In addition, a proposal to embed the patient activation measure (PAM), that describes the knowledge, skills and confidence a person has in managing their own health into primary care was agreed at the Early Intervention, Prevention and Self Care working group.**

Delivery Area, Transformation Programme and Progress Update – February 2019

T7. <u>Integrated care for Children and Young People</u>

- ***Paediatric Integrated Clinics*** **- from April to December 2018 a total of 748 Children & Young People (CYP) were seen in a joint GP / Paediatrician clinic and a total of 49 GPs have taken part in the scheme. The fourth rotation of the Paediatric Integrated Clinics is underway. The feedback from families and staff continues to be positive. Options for the future development of the clinics are being explored e.g. clinics for CYP with complex needs.**
- ***Paediatric Community Phlebotomy Service*** **- a phased roll out of the Paediatric Community Phlebotomy service commenced in December. Full service capacity for non-urgent bloods for CYP aged 2 – 18 years is expected from 1st March 2019.**
- ***Children's Integrated Therapies*** **- pending approval by LBH cabinet and HCCG Governing body a single tender award will be made to CNWL to provide a new service model with effect from 1 August 2019, coinciding with the new school year.**
- ***Transition of CYP to adult services*** **- preliminary work to identify a cohort of young people aged 15-17 years with complex needs is underway. A six-month Transition nurse pilot scheme is planned from 1 April. The remit will include case-management and development of transition pathways to better prepare and support CYP transitioning to adult services.**

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

- **A key goal for primary care transformation is to Implement a new fully integrated 24/7 neighbourhood-based model of health and social care built from the registered GP list. This will be which is based on the best available evidence, with an emphasis on prevention that will create the capacity and capability, in both primary and community care alternatives, to deliver the right care and support in or close to peoples' homes rather than in hospital.**
- **The new model of care for Hillingdon proposes a range of approaches to support the health and wellbeing of the 85% of the local population without chronic health needs, and intensive, highly integrated approaches for the 15% of the population with chronic health needs who are most at risk of a hospital intervention or long-term care. The vision builds on the view that people with complex or unstable long-term conditions benefit most from high quality, integrated multi-disciplinary care and support which is provided as close to their home environment as possible.**
- **There are three locality based extended GP access hubs operating from 6.30am to 8pm during weekdays and from 8am to 8pm at weekends. As of August 2018, the Confederation now operates a 12 hour 8am to 8pm bank holiday service. December 2018 data show there were 71% of patients who attended their appointment of which 90% of appointments were booked. GP Did Not Attend (DNA) rates were the highest on Saturday, reported as 20%. Nurse appointments have increased to 89% being booked with 69% utilisation. The Confederation continues to work on improving utilisation of slots and to reduce DNA rates.**
- **A comprehensive review of the Primary Care Contracts has been completed, so that for 2019-20, we have an outcome based contract encompassing all service specifications that are aligned to the CCG's strategic objectives and provide value for money.**

Delivery Area, Transformation Programme and Progress Update – February 2019

DA2 Eliminating unwarranted variation and improving LTC management

T4. <u>Integrated Support for People with Long Term Conditions</u>

- ***Respiratory*** **- a new Consultant for Respiratory Medicine will join THH in February and will implement a programme of virtual clinics for patients with Chronic Obstructive Pulmonary Disease (COPD).**
- ***Diabetes*** **- a new programme for Structured Education in Type 2 Diabetes for Hillingdon was launched in December 2018; the MyDESMOND (Diabetes Education and Self - Management for New and Ongoing Diabetes) education package. This is an on-line training tool for those with both new and existing type 2 diabetes. This will exist alongside the CCG gold standard face-to-face DESMOND for newly diagnosed people with Type 2 diabetes. NWL STP we are also working on the provision and access of education via: digital platforms, Apps, interactive models as well as face-to-face. Virtual Clinics for diabetes patients have commenced and are being implemented across all GP practices.**
- ***Accreditation*** **- QISMET Accreditation for MyHealth has now been approved and patients referred to the programme will form part of the reporting process.**
- ***NWL Programmes*** **- Hillingdon CCG is making good progress in all four NWL projects (Structured Education, Improving the three NICE Treatment Targets, rollout of the improved foot-care pathway and NDPP (National Diabetes Prevention Programme)) through effective engagement with our practices and service providers. The promotion of NDPP programme and Non-diabetic hyperglycaemia (NDH) register is improving and reported to NWL Transformation Board.**
- ***Heart Failure*** **- CNWL and Hillingdon hospital have collaborated to transfer 120 Heart Failure patients from hospital clinics to community clinics to manage their condition nearer to home.**
- ***Atrial Fibrillation*** **- Hillingdon is planning patient awareness initiatives for Atrial Fibrillation (AF) and hypertension through its Winter Wellness Roadshow events that started in October. The CCG is supporting national campaigns such as blood pressure testing in `*Know Your Numbers'* week and AF testing in Global AF awareness week.**
- ***Prevention*** **- Hillingdon offers early diagnosis and prevention of stroke through managing Atrial Fibrillation, Hypertension and Heart Failure in Primary Care.**

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T5. Transforming Care for People with Cancer

- ***Cancer survivorship*** **– The first meeting was held in January with providers and commissioners to scope current access to psychological support services e.g. IAPT for cancer patients. There was also strong interest to develop a Cancer MyHealth Programme, for patients discharged from hospital to primary care. This would act as a bridging service for patients between primary and secondary care. A mapping exercise is being carried out in January led by the CCG's Communication & Engagement Team to ascertain the services/resources available for patients across Hillingdon. This work will be shared with patients and any gaps in provision can inform the new MyHealth Programme. The second Cancer Survivorship meeting is taking place in early March.**
- ***Low Dose CT Pilot (Lung Cancer Detection)*** **– This is a national pilot and Hillingdon and Hammersmith & Fulham CCGs in NWL are involved as they have been identified as having higher rates of smoking and prevalence of lung cancer. The work is led by RM Partners and funding in place until end of March 2019. Eight GP practices have participated in the project and patients are assessed in primary care to ascertain if they are at high risk of lung cancer. Those that are high risk are referred for a scan. Patients who have the scan and are identified as having COPD are able to be referred to the CCG's MyHealth Programme. RM Partner leads will present their findings at the CCG Organisational Development Seminar Meeting on 13th February and to gain feedback from members to inform the evaluation and Phase 2 of the programme.**
- ***Cervical Screening*** **- It was `Jo's Cervical Cancer Trust' Prevention Week from 21-27 January. This feeds into the CCG screening programme to increase uptake levels of cervical screening in Hillingdon. NHS England are using text reminders for patients and work in progress to aim for 100% coverage of GP practices. Locality managers have worked with NHS England to engage with GP practices to sign up to the text messaging service. The CCG Communication and Engagement is also Team is working with local Somalian and Asian BAME communities to increase uptake.**
- ***Bowel Cancer Screening*** **- Northwick Park Hospital previously worked with GP practices to promote the bowel screening programme. The programme is now being run instead by Community Links a London-based charity funded by Royal Marsden Partners (RMP). LINKS who have undertaken similar projects in breast and bowel screening. On average they have improved screening rates by 5-10% where they have worked previously. Letter and Communications has been circulated to GP Practices at the end of January to increase uptake of bowel screening using Faecal Occult Blood (FOB) test. NWL CCGs are working together to plan for the introduction of the new NICE approved Faecal Immunochemical Test that will commence from 1 April 2019.**
- ***Transformation Funding*** **– NWL CCG's Primary Care Cancer Board submitted a number of primary care bids to access Cancer Transformation Funds in December 2018. Notification of outcomes of the bid process is due in March.**

Delivery Area, Transformation Programme and Progress Update – February 2019
DA3 Achieving better outcomes and experiences for older people
T3. Integrating Services for People at the End of their Life **This is covered in more detail in covering paper Section 3.2.5**
T1. Transforming Care for Older People **Integration between health and social care and/or closer working between the NHS and the Council, is contributing to meeting the needs of residents and is reflected in the BCF plan. The BCF performance report on the Board's agenda reflects these initiatives and progress to date.**
DA4 Improving outcomes for children & adults with mental health needs
T6. Effective Support for people with a Mental Health need and those with Learning Disabilities • ***Learning Disabilities*** **- The CCG undertook a Learning Disability consultation in 2018. The review highlighted a number of areas for improvement. This work is being progressed jointly by the CCG and the Local Authority. Managers are meeting in February to discuss developing more robust arrangements to deliver pathway improvement.** • ***CYP*** **- Hillingdon continues to make progress in delivering the priorities in the Hillingdon Local Children and Young People's (CYP) Mental Health and Wellbeing Local Transformation Plan refresh 2018/19. Hillingdon CCG's local CYP Mental Health and Wellbeing Local Transformation Plan 2018/19 has been approved by the Hillingdon Health and Wellbeing Board. The plan is currently being assured by NHSE and will be available to the general public in February 2019.** • ***CYP*** **- A full report on CYP emotional well-being and Mental Health was submitted to the Health and Well-being Board in December 2018.** • ***THRIVE*** **- The THRIVE framework model has been established in Hillingdon and Thrive network meetings have taken place with the Local Authority, schools and community groups, local partners and key stakeholders. The Network is currently working on the design and development of an Early Intervention and prevention model for emotional well-being mental and physical health. This year has seen increased engagement with local schools to in line with the requirements set out in the government Green Paper.** • ***CAMHS*** **- The CCG has commissioned KOOTH on Line Counselling service for children and Young People aged 11-19, in Hillingdon and for students at Harrow and Uxbridge College. The Service started on 9th July 2018. The service has increased the number of children that it sees from 30 in Q1/Q2 2018 to 70 children per month by Q3 2018, this number is expected to rise in 19/20. This service provides fast access, earlier intervention and support for children with emotional and well-being issues. Consideration is being given to extend provision of well-being services to support young people up to the age of 25.** • ***CAMHS*** **- Hillingdon CCG has been successful in bidding for non-recurrent waiting list monies from NHSE of £45k. These monies will be used to reduce the CAMHS waiting list for 90 children by 31st May 2019.**
DA5 Ensuring we have safe, high quality, sustainable acute services

Delivery Area, Transformation Programme and Progress Update – February 2019

T10. <u>Transformation in Local Services</u>

- ***Musculoskeletal*** **- HCCG are working with HHCP to deliver a pilot to transform MSK services and deliver an integrated service in Hillingdon. The aims of the project are aligned with the NWL local services strategy to provide more joined up care with care provided in the right place at the right time. The pilot aims to consolidate existing MSK services to act as a single service to provide triage, assessment and treatment for people with MSK conditions. The service will offer greater support for self-management and education and advice to primary care to improve the quality of care delivered across the wider MSK pathway. The outcomes of this pilot are currently being evaluated by the CCG.**
- ***Ophthalmology*** **- The CCG is working local partners to redesign our Ophthalmology services during 2019/20.**
- ***Dermatology*** **- The CCG plans to transform dermatology services to improve the integration of services and access to dermatology care in the primary care setting. This will involve teledermatology and an enhanced education program for the primary care workforce.**
- ***The Community Advice & Treatment Services (CATS)*** **–are being integrated with the North West London Outpatient Transformation programme pathways (see below), the first wave of which started on 2 January 2019.**
- ***The NWL Transformation Outpatient Demand Management Programme*** **– involves the introduction of standardised referral pathways in primary care in addition to clinical triage of referrals. This will support patients to access the right care first time and reduce variation across NW London. This commenced in January and is initially focusing on the following specialities: gynaecology; dermatology; MSK; gastroenterology and cardiology.**
- ***Neurology*** **- A Community Parkinson's Nurse Specialist (CNS) has been recruited and has been working closely with THH Parkinson's nurse to setup community clinics and conduct home visits for patients.**
- ***Gastroenterology*** **- An Irritable Bowel Syndrome/Irritable Bowel Disease CNS post has been recruited to. The service aims to start in April 2019.**
- **S*urgery*** **– Hernia Repair is to be carried out in the community in GP premises. A host GP practice site has been secured and the service aims to commence in February 2019.**

Delivery Area, Transformation Programme and Progress Update – February 2019

T8. Integration across Urgent & Emergency Care Services

- **The High Intensity Users Service is now in progress and a case worker has been recruited. The service will target the 50 most intensive users of A & E and London Ambulance Service through a health coaching approach proactively supporting people to address the underlying causes of their frequent requirement for unscheduled care.**
- **The re-location of the Urgent Care Centre (UCC) purpose built unit as part of the THH rebuild is planned to open in October 2019. To support the UTC until the opening, two additional consultation rooms have been opened to see and stream patients.**
- **The NWL NHS 111 procurement is being taken forward with the establishment of the NHS 111 Procurement Board. A market event has been planned for early March 2019. The newly procured integrated NHS 111 service is planned to commence in April 2020. Additional resource has been invested in the 111 service to increase clinical advice for patients and appointments can be booked directly by 111 into the UCC or extended access hubs. There is a new work-stream currently underway to enable 111 to have electronic access to book two appointments per day directly into each the GP practices.**
- **The Rapid Access Medical Unit (RAMC) went live in January 2019 and is based at the front of the new Ambulatory Emergency Care Unit (AECU) in Hillingdon Hospital. The UCC is referring patients to specialties through RAMU.**
- **New pathways have been implemented in the community and primary care to support those patients who may have previously require a follow up appointment at the AECU. This has enabled additional slots to be utilised for patient first attendances.**
- **The London Ambulance Service crews have been shadowing the Rapid Response team to understand the scope of practice and implement the new falls pathway for non-injured fallers, and reduce the need for the elderly fallers to be transferred and admitted to hospital.**
- **Winter funding has been made available to support the end of life winter resilience and assure capacity over the winter period to any unexpected change in acute specialist inpatient hospice care by ENH Trust and Michael Sobell House Inpatient Unit at Mount Vernon.**

Delivery Area, Transformation Programme and Progress Update – February 2019
Enablers
E1. <u>Developing the Digital Environment for the Future</u> **Hillingdon is seeing improved access to shared care records, with the focus turning to support stakeholder organisations to use these in day-to-day operations to support personalised care. The local system is also implementing a 'Paper Switch Off' date in line with national guidance/timelines and NWL plans for the delivery of a paperless system. New priorities are developing plans for self-care as well as clinical decision support tools.** **Some specific examples of key programmes are:** • **EMIS and SystemOne interoperability to provide capability for community clinicians to access EMIS GP system to view the patients' medical records, via their TTP system, and for the EMIS GP to review consultation notes/reports on the TTP system.** • **Patient Online access (PoL) - Empowerment for the patients to manage booking / repeat prescriptions. Work is progressing to support GP practice to engage and enable patients to make all referral booking online. The CCG are on target to achieve national targets set by NHSE. The CCG continues to work with GP practices to improve uptake in line with national targets.** • **GP WiFi for Patients and Guests to all GP Practices within Hillingdon infrastructure has been deployed to over 99% of Practices and the IT team are working with them to develop the service further and realise associate benefits in particular with staff mobility across the patch.** • **The Health and Social Care Network (HSCN) is a new data network for health and Care organisations which replaces N3. It provides the underlying network arrangements to help integrate and transform health and social care services by enabling them to access and share information more reliably, flexibly and efficiently. The CCG is working with the chosen supplier for North West London, Exponential-E, to install a fit for purpose and cost effective fibre circuits across all Practices within Hillingdon. The IT team are planning to have this completed for all practice by end of summer 2019.** **Hillingdon CCG will in 2019/20 develop specification for procuring a digital solution to optimise workflow. This will include e-consultation, online digital triage with the aim to reduce administrative burden for GP practice and in turn support the development of emerging neighbourhood service.**

Delivery Area, Transformation Programme and Progress Update – February 2019

E2. Creating the Workforce for the Future
Transition Academy Update

The Workforce Programme continues to provide the four programmes of: student placements, education and training, recruitment (Transition Academy) and admin development (practice capacity). In particular:

- **Clinical Correspondence and Signposting programmes are seeing results in practices reducing the number of letters to GPs; and the voluntary sector becoming more involved with practice staff, and therefore patients. Practice Managers and administrators continue to come to bespoke training and share best practice in peer learning groups.**
- **The 2018-19 student placements are currently: nine pre-registration nurses (bringing the total to 58); three physician associates (total 13) and four Independent Prescribing Pharmacists (IPP) trainees (total 9). Four new trainers have finished the course in the south of the borough and we await the approval of three new training practices in that area as a result. Six new trainers are currently on the course, three from new practices in the south of the borough.**
- **The Transition Academy has funded bursaries to practices to recruit four new nurses to train up as GP Practice Nurses (GPN) through the Bucks University transition course. This brings the total GPN transition numbers to 15, part of the 29 nurses recruited or retained through the Transition Academy.**
- **The Transition Academy has also helped secure the retention of six of the nine ST3 GPs who completed the Hillingdon Vocational Training Scheme last year. The six GPs are in regular Hillingdon practice work. The other 3 ST3s left London on completion of the scheme. This bring the total of GPs retained from ST3 or returned to work in Hillingdon to 20. Over the past three years, 50% of the ST3s have stayed and worked in Hillingdon.**
- **The Confederation pharmacists provide eight of the new practice-based pharmacists in Hillingdon, with the Transition Academy assisting a further eight mostly IPPs into GP practices. Five of these were trained up as IPPs on placements in our practices.**
- **Finally, six receptionist apprentices have completed their business administration apprenticeships and remain employed in their training practices. Along with a rolling programme of Masterclasses and CPPD training for GP practice staff and beyond, these are the programme outcomes up to January 2019.**

The CCG is also linked into the work of NWL CCGs and their strategic plans: *North West London Sustainability and Transformation Plan (STP) Workforce Transformation Strategy 2017 – 2022.*
https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/nwl_stp_workforce_strategy_2017-2022_0.pdf

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E3. <u>Delivering our Strategic Estates Priorities</u> **Separate report is included in part 1 setting out progress in developing the North of Hillingdon and the Uxbridge and West Drayton hubs together with issues regarding GP provision at Yiewsley, Hayes and Heathrow Villages.**
E4. <u>Delivery of our Statutory Targets</u> **Hillingdon CCG has a robust performance management structure in place to monitor providers' performance against our statutory national targets.** **In addition, NWL CCGS produce monthly integrated performance reports for CCGs that provides an update on CCG and related providers' operational performance against national standards. This includes achievement of the:** • **A&E four hour target** • **18 weeks Referral to Treatment Target for elective care** • **Cancer waiting times** • **London Ambulance Response Times** **This section also includes performance in key indicators for mental health and community services. Detailed information on underachieving indicators including recovery plans and mitigating actions are reviewed and monitored.** **NHS England has a statutory duty to undertake an annual assessment of CCGs through the Improvement Assessment Framework (IAF). HCCG also internally monitors and has action plans in place in relation to the IAF that also includes a number of the statutory targets. Hillingdon CCG was rated `Good' by NHSE England in the 2017/18 annual CCG's assessment.**

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E5. Medicines optimisation

- ***Care Homes*** **- there is pharmacist support to Care Homes to optimise medicines and streamline processes to reduce unplanned admissions.**
- ***Medicines optimisation*** **- rollout of GP practice level specialised pharmaceutical support for medicines reviews and diabetes and asthma clinics supporting medicines optimisation.**
- ***Long-term conditions*** **- there are two pilots taking place in the borough; Asthma and Diabetes that incorporate a two cycle approach to determine how prescribing pharmacists' interventions can improve management, avert crisis and reduce condition-related complications, hospitalizations and reduction in spend. These pilots are now in the second cycle. Focus on patient education related to medicines for LTCs via various portals e.g. Health videos. As part of the Respiratory Clinical Working Group Inhaler videos My Health website link was developed – available on link:**
  http://www.myhealthhillingdon.nhs.uk/inhaler-videos/
- ***Repeat Prescriptions*** **- reviewing and streamlining repeat prescription processes in practices to further support NWL initiatives. The project is continuing to streamline the repeat prescription processes in various GP practices i.e. addressing ordering unwanted items, duplicate items and non-adherence to treatment regimens and over-ordering.**
- ***Inappropriate usage of*** **antibiotics - focussed practice support to manage inappropriate usage of antibiotics. A Urinary Tract Infection (UTI) audit was undertaken by practices in July 2018 with the aim is to reduce inappropriate antibiotic prescribing for UTI Infections in primary care in line with Hillingdon CCG antibiotic guidelines. This supports the prevention of antibiotic resistance and antibiotic related infections such as MRSA and C.difficile.**
- ***Audits:***
  - **An audit on Trimethoprim prescribing for over 70 year olds was carried out between July 2018 – November 2018 by the Medicines Management Team Pharmacy Technician to assess and promote appropriate antibiotic prescribing in accordance with existing local/PHE guidelines and reduce the inappropriate antibiotic prescribing for UTI in primary care. The audit was undertaken in 15 of the highest prescribing surgeries in the borough. The results were shared with the respective practices on completion, to support clinicians in promoting quality improvements by reviewing antimicrobial prescribing within practice.**
  - **An audit on broad spectrum antibiotic prescribing has been sent to practices for completion in February 2019. The aim of this audit is to demonstrate adherence to HPA issued guidance and reduce prescribing of broad spectrum antibiotics which have been associated in community-acquired C. difficile & MRSA infections.**
  - **The Medicines Management Pharmacy Technician has undertaken audits on the appropriateness of vitamin and mineral prescribing, and prescribing of emollients according to *NHSE guidance: Guidance on conditions for which over the counter items should not routinely be prescribed in primary care.* This was undertaken in 2 practices per locality where the spend was highest.**

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E6. <u>Redefining the Provider Market</u>

The CCG is making positive progress working with health and care partners to further develop our local Integrated Care System (ICS). This work is in line with NHSE requirements to create five year plans by Autumn 2019 on how STP and ICS will improve quality of care and deliver financially sustainable services.

Hillingdon Health Care Partners (HHCP) partnership have been working to design, develop and plan the delivery of population health and person-centred care models.

The proposed changes in service delivery are ambitious and reflect the 5-year vision for health & care for adults in Hillingdon. However, the health and social care economy has agreed to phase and prioritise the implementation of the model of care to focus on those components which will best address deteriorating performance in the urgent care system. In particular, prioritising improvements in the quality of care for those people who are most at risk and as a result, reduce non-elective admissions (NEL) - unplanned hospital admissions.

An Integrated Business Case has been developed which lays the foundation for whole systems integration. Achieving the initial savings through the reduction in non-elective admissions is critical to enabling realignment of investment in pro-active and preventative services in the future, however through better co-ordination of existing services we can ensure that the benefits can start to be realised.

The focus in 18/19 has therefore been on five priority areas each of which has been clearly defined including specifying clear objectives, milestones, deliverables and anticipated delivery dates:

- **Neighbourhood Development - `Local Neighbourhood Teams' comprised of integrated multi-disciplinary teams led by general practice as the basic delivery unit of integrated care.**

Work has been undertaken to confirm the scope of this pivotal work-stream which includes:

- **Primary Care at Scale**
- **Weekday Visiting (GP Confederation)**
- **Wrap around services**

Active Case Management:

- **CCT Development**
- **High Intensity User Service**
- **Care Home Development**
- **End of life care**
- **Integrated MSK pathway**

Intermediate Tier - encompassing:

- **GP & Community based crisis response (physical and mental health)**
- **Integrated Discharge**
- **Falls *(also a cross-cutting work-stream spanning both Neighbourhood development and Intermediate Tier)***
- **Frailty *(overall frailty pathway)***

During 2019/20 onwards we will be using delivery of the five priority areas as an approach and vehicle to deliver the CCG's 2019-21 Commissioning Intentions. To enable the delivery of the proposed integrated model of care, Hillingdon CCG has stated its intention to move into a new contractual, delivery and performance model in order to allow resources to be joined up. The coproduction of the whole system transformation work with stakeholders, i.e. patients, carers and front-line staff, will continue to inform Phase 2 of the programme. This will include an ongoing focus on working with Local Neighbourhood Teams and stakeholders on further developing and refining the new model of care to meet the needs of the local population.