NHS
Hillingdon
Clinical Commissioning Group

V.08 Draft Strategic Intentions

2020-2022

13th September 2019

NHS
Hillingdon
Clinical Commissioning Group

Contents

1. Foreword

Welcome to our Strategic Intentions 2020–2022 for Hillingdon. This sets out our shared plans for NHS services in Hillingdon in partnership with our local health and care organisations to deliver high quality care and outcomes for our residents.

We are facing real challenges in delivering improved outcomes and high quality health care for patients, driven by increasing demand and constrained financial resources. We recognise that we can only achieve our ambitions by working together across NW London. We are moving ever closer to an alliance with our local Hillingdon health and social care partners to develop better and more "joined up" care for patients as part of an Integrated Care Partnership (ICP). We are also taking steps to more closely align to the NW London Integrated Care System (ICS).

Our shared goals are to keep our residents well, ensuring people that do need treatment to get the right care and treatment at the right time, and to have the right systems and functions in place to support when there is a life threatening or very urgent accident or emergency requiring swift treatment. These themes are reflected through these intentions as:

- **Keeping People Well**
- **Right Care, Right Time**
- **Managing in Times of Crisis**

Keeping People Well

We have a strong prevention agenda to support early access to primary and community care. We have been implementing new models of care, including Neighbourhood Teams and community based clinics. These are being delivered by an empowered nursing and health care assistant workforce led by GPs and Consultants as part of multi-disciplinary teams to manage long term conditions. Conditions, that we have now long known, can and should be better addressed through supporting patients to proactively manage their condition at home. We are further developing our MyHealth programme, which has directly helped people to manage their own health with support and guidance from our health and care professionals. These programmes are supporting people with identified needs avoid future health exacerbations, preventing their health from deteriorating, helping those with a life-long condition to plan and live better with their health status, and in these ways prevent hospitalisations.

Right Care, Right Time

While the NHS is made up of a number of individual organisations, our goal is to deliver a seamless experience for anyone who becomes a patient. Through our developing ICP Hillingdon health and care organisations have developed strong collaborative functionalities between our hospital, community, primary, ambulance, 111 and

social care services so patient treatment plans and care records are accessible by the multi-disciplinary teams that will support them.

We think that the best outcome we can pursue for our residents is to avoid ill-health and thereby avoid invasive treatments in hospital. However, when someone does have a diagnosis that leads to an invasive treatment, best practice indicates that the best outcomes happen from a planned care pathway to treatment and recovery.

Over the past year we have worked with NW London partners to update planned care pathways according to latest best practice and clinical guidance. Many years ago diabetes was treated in hospital. Now, diabetes can be managed at home by people themselves. The same developments have happened in a number of other areas and conditions. Not all can be treated at home yet, but many can be diagnosed and treated in primary care and the community, completely avoiding a hospitalisation. We have brought together our clinical workforce of GPs, clinicians, nurses and allied health staff to deliver community clinics led by the expertise our residents expect, but in a different setting. Our paediatric community clinics are a pioneering local example of this. Our ophthalmologists are working with high street optometrists to improve access to eye care. Our pharmacists in the high street too are able to answer questions about health and guide people to the right care. Into the future we will be looking to set up digital appointments to catch up to the technology revolution the rest of the world has experienced over the past decade. There is much to be done, and we have the enthusiasm and initiative to achieve it.

Managing in Times of Crisis

We have worked very diligently together in Hillingdon and NW London to ensure that our residents can get emergency and urgent care help through our 111 telephone service as a first point of call.

In an urgent situation, our residents can call 111 for help. If the situation is a life-threatening emergency, 111 is able to call upon our ambulance services to send help immediately. If it is not immediately life-threatening, but does require immediate treatment such as a broken bone, 111 will advise going to hospital straight away. If the situation is urgent but not life threatening, 111 is able to book an urgent appointment to a GP as soon as possible. This appointment may be at a primary care practice, one of our GP Hubs, or on-site at the Urgent Treatment Centre, depending on which site has the earliest available appointment and the right person or equipment to treat the issue. At times the situation is found to be a fairly normal health issue that can be routinely treated by a GP, then it will be recommended that an appointment be made with your GP.

We have also created a Single Point of Coordination for people we know to have conditions that result in ongoing health emergencies. Our Neighbourhoods model means that multi-disciplinary teams can help people and put health care plans in place to manage these conditions and reduce the number of health emergencies a person

experiences. This means a better quality of life living with these conditions and fewer hospitalisations.

The National Context

Critical to the priorities set out in our local Strategic Intentions is the publication of the NHS Long Term Plan in January 2019. The Plan builds on the work achieved since the NHS Five Year Forward View (5YFV) of the move towards place-based systems of care and to integrate are to meet the changing needs of the population who are living longer with more complex needs. The Plan sets out in 7 Chapters:

1. A new service model for the 21st Century
2. More NHS Action on Prevention and Health Inequalities
3. Further Progress on Care Quality and Outcomes
4. NHS Staff will get the backing they need
5. Digitally enabled care will go mainstream across the NHS
6. Taxpayers Investment will be used to maximum effect
7. How the NHS Long Term Plan supports wider social goals

In reviewing the Plan we are assured that Hillingdon is already enabled to deliver many of these priorities through building on the work that has been done to enhance local services, access, systems and joined up working in recent years.

We are excited to share these Strategic Intentions, recognising that the goals and actions outlined here are not the end of the journey, but a fresh chapter continuing the good work begun at the birth of the NHS over 70 years ago. This 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 2022. We will continue to develop, embed, and scale up commissioned services.

We would like to thank everyone who has contributed to the development of these intentions and look forward to delivering the best outcomes in healthcare for everybody in Hillingdon.

Ian Goodman
Clinical Chair
Hillingdon CCG

Caroline Morison
Managing Director
Hillingdon CCG

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

In developing our local Strategic Intentions (SI) we are incorporating 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 to take forward population health commissioning to deliver personalised and integrated care through our Integrated Care Partnership (ICP).

2a. The National Strategic Context

The NHS Long Term Plan' (the Plan) was published setting out the ambitions for NHS over the next ten years. The `*Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan*' 31 January 2019 was also published alongside the Plan.

The Plan builds on the work achieved since the NHS Five Year Forward View (5YFV) of the move towards place-based systems of care and to integrate care. This is to meet the changing needs of the population who are living longer with more complex needs and to improve care outside hospitals in primary care and the community. The Plan confirms the shift towards integrated care and place-based systems which has been a defining feature of recent NHS policy. Integrated Care Systems will be the main vehicle to achieve this and will focus on addressing population health needs. The Plan sets out in 7 Chapters:

8. A new service model for the 21st Century
9. More NHS Action on Prevention and Health Inequalities
10. Further Progress on Care Quality and Outcomes
11. NHS Staff will get the backing they need
12. Digitally enabled care will go mainstream across the NHS
13. Taxpayers Investment will be used to maximum effect
14. How the NHS Long Term Plan supports wider social goals

Chapter 1 sets out the new service model to deliver joined up care. Key to this will be general practices joining together to form PCNs, that will be expected to take a proactive approach to managing population health. From 2020/21 these Networks will assess the needs of their local population to identify people who would benefit from targeted, proactive support.

> *Over the next five years, every patient will have the right to online 'digital' GP consultations, and redesigned hospital support will be able to avoid up to a third of outpatient appointments*
>
> *The NHS Long Term Plan (2019)*

Chapter 1 also commits to developing fully integrated community-based health care to support new urgent service channels and relieve pressure on A&Es. This will involve developing multidisciplinary teams working across multiple sites. The long-term plan calls for a radical change in the way that the NHS works

alongside patients and individuals. It highlights the need to create genuine partnerships between professionals and patients. As part of this shift, the plan focuses on personalisation. There is a commitment to rolling out the NHS comprehensive model of personalised care (supporting a whole population, person-centred approach.

Chapter 2 supports the prevention agenda to help cut smoking rates, manage weight loss, improve Diabetes Type 2 prevention, address alcohol-related A&E admissions, and support lowering air pollution.

Chapter 3 targets variation in health outcomes, extending the NHS Five Year Forward View focus from cancer, mental health, diabetes, multimorbidity and healthy ageing, to also include children's health, cardiovascular and respiratory conditions, learning disability and autism, amongst others.

Chapter 4 lays the foundation for addressing workforce pressures with a number of specific actions to be overseen by NHS Improvement as part of a national drive to train, retrain, and retain valuable NHS staff.

Chapter 5 promotes the use of technology and digitally enabled care across the NHS. This includes at home devices for patients, and access to Clinical Decision Support systems for GPs and clinicians.

Chapter 6 anticipates the need to continue to drive efficiency gains in the NHS in order that the NHS achieve financial sustainability, whilst also feeding through the 3.4% five year NHS funding settlement monies to enable transformation.

Chapter 7 provides a supporting framework for implementing the changes set out within the Plan, and key milestones and timelines for delivery to assist in priority setting.

The NHS has been marking its 70th anniversary, and the national debate this has unleashed has centred on three big truths. There's been pride in our Health Service's enduring success, and in the shared social commitment it represents. There's been concern – about funding, staffing, increasing inequalities and pressures from a growing and ageing population. But there's also been optimism – about the possibilities for continuing medical advance and better outcomes of care.

In looking ahead to the Health Service's 80th birthday, this NHS Long Term Plan takes all three of these realities as its starting point. So to succeed, we must keep all that's good about our health service and its place in our national life. But we must tackle head-on the pressures our staff face, while making our extra funding go as far as possible. And as we do so, we must accelerate the redesign of patient care to future-proof the NHS for the decade ahead. This Plan sets out how we will do that

The NHS Long Term Plan (2019)

2b. Plans to work towards a NW London Integrated Care System (ICS) and our local Hillingdon Integrated Care Partnership (ICP)

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

The NW London Integrated Care System

Carrying forward the work founded in the System Transformation Partnerships (STPs), NW London NHS organisations are moving toward an Integrated Care System (ICS), as outlined in the national guidance and The Plan, with further detailed guidance still emerging as regional and local NHS organisations work together to deliver to the policy vision.

NWL CCGs in particular are working ever more closely together and toward a single CCG model, including shared and joint priorities with regional and local responsibilities for delivering high quality care and transformation. Further work is expected over the next two years to deliver this single model and provide population-based healthcare for the residents of NWL in partnership with Health and Care organisations, including our local borough council partners. This will be a complex process with many stakeholders involved, but all with the enthusiasm for the same goal – to deliver a better and more effective health and care system through integration and joined up care between services!

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

The local Hillingdon Integrated Care Partnership

The CCG has been working with our health and care partners across Hillingdon to further develop our local Integrated Care Partnership.

Our local partners (THHFT, CNWL, HPCC and Hillingdon4All) have come together to form a partnership called Hillingdon Health Care Partners (HHCP) to help enable the integration of services. The ICP 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 on the 18+ population with an emphasis on the 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 Including development of an Acute Home Visiting service that will be incorporated into the Care Home model (Care home & acute visiting service)
2. Transforming the MSK pathway

3. Intermediate Tier development – incorporating integrated HHCP and LBH urgent community response and follow up; same day emergency care at THHFT and integrated discharge from THH, Hawthorne Intermediate Care Unit (HICU) and Oaktree ward

4. `Local Neighbourhod Teams' aligned with PCNs comprised of integrated multi-disciplinary teams 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 SI set out in this plan.

One of our key aims locally is to prioritise the System Transformation Programme to create a comprehensive plan to address the system deficit and operational performance issues either in full or in part - with each element becoming an additional chapter to the existing HHCP Integrated Business Case (IBC). This will involve expanding the current IBC to incorporate: planned care, mental health and CYP which will therefore create a 'whole population IBC' that will be essential to meeting the requirements for ICP development. This will also require putting in place a Virtual Strategic Transformation Team from existing redeployed resources where possible to support the Transformation and Organisational Development Programme including Neighbourhood Development.

Proposed future forms of local teams/ICPs are currently being developed at NW London. The emergence of NWL ICS 'ways of working' is already requiring system accountability which developing a local ICP will enable and enhance.

Hillingdon is often cited as leading the way with ICP development providing an opportunity for us to shape the future locally.

It is therefore a critical part of our plans to ensure there is a credible Hillingdon ICP in place and operating, given that this is both a national and local requirement.

Neighbourhood Network Event 23rd January 2019

Martin Hall (GP) & Kathleen Sadler (Chief Operating Officer) from the Confederation, Hillingdon CIC & Claire Eves (Head of Adult Services) & William Sakala (Assistant Director of Nursing) from CNWL

2c. The North West London Local Digital Roadmap

The NW London Local Digital Roadmap (NWL LDR) is critical to supporting the identified STP priorities and harnessing technology to accelerate change, as the NW London health care community moves towards greater digital maturity in delivering clinical services, and digitally connecting citizens and health and social 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, 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 of 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
- To facilitate GP Practices to become GDPR (General Data Protection Regulation) compliant
- 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 increase time for patient-facing activity for clinicians and staff
- To ensure that current and newly procured IT systems take into account the ease of accessibility for users and those with a physical/learning disability.

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 outdated technologies and systems across the patch. 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.

2d: The North West London Transforming Care Partnership Plan

Transforming Support for people with Serious Mental Health Needs and those with Learning Disabilities: The NW London Long Term Plan 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.

In delivering this plan locally, we outline below how we will keep those with serious mental health needs well, to provide them with the right care at the right time when they need it, and how we will respond in times of crisis when our residents urgently need our support and intervention.

Keeping People Well

- Build up community capacity in neighbourhoods to support the most complex individuals in a community setting and avoid inappropriate hospital admissions
- 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
- Ensure that people with LD can access care and support to remain in the community, reduce hospital admissions and support the Stop Overmedication of PwLD agenda working with Medicines Management and providers
- Work with LBH, Primary Care, Hospital Trusts and providers to support introduction of reasonable adjustments for people with LD and/or Autism
- Work with LBH and schools 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
- Extend our co-commissioning with the local authority to support people with Mental Health, Autism and/or Learning Disability to access social networks and community support that contributes to a healthy lifestyle.

Right Care, Right Time

- Develop an integrated community based model in partnership with LBH, CNWL and people who use services so that it provides: rehabilitation, promotes self-care, return to employment opportunities and access to education to support people to maintain mental well-being
- Key is the development of a NW London community strategy and the utilisation of more skilled staff to support people with complex and challenging needs in local communities
- Targeted work with individuals and services enabling others to provide person centred support to people with LD and their families/ carers
- Extend our co-commissioning to include PHBs for people (adults and Children) entitled to section 117 aftercare
- Use information from LeDeR reviews to support earlier intervention for PwLD around their ongoing conditions and acute healthcare needs
- Identify PwLD at risk of admission through WSIC data and risk registers – develop a stratification tool to support with identifying individuals and decisions around their care and support early in the LD pathway

Care at times of Crisis

- Ensure practitioners across primary care/secondary care services/social care and third sector partners can respond effectively to people who may require a range of support in order to avoid unnecessary admission to acute and crisis beds, and to ensure reasonable adjustments for people with LD and/or autism through development of PCNs across NWL (Neighbourhoods)
- 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 Cafe/Safe Haven response service 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
- Develop an all age at risk of admission register for LD/Autism cohorts
- 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

2e. Our Local Joint Health and Wellbeing Strategy 2018-2021 and alignment with NWL STP Improvement Areas

Our local Joint 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. Our plans are built around the 10 Transformation Themes and 6 Enabling Themes contained therein. These Themes (Transformation & Enabling) are also aligned to the 22 Improvement Areas stated within the NW London 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 NW 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 NW London Productivity Programme	All Transformation & Enabling Themes

2f. 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 starting in 2019/20
- 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

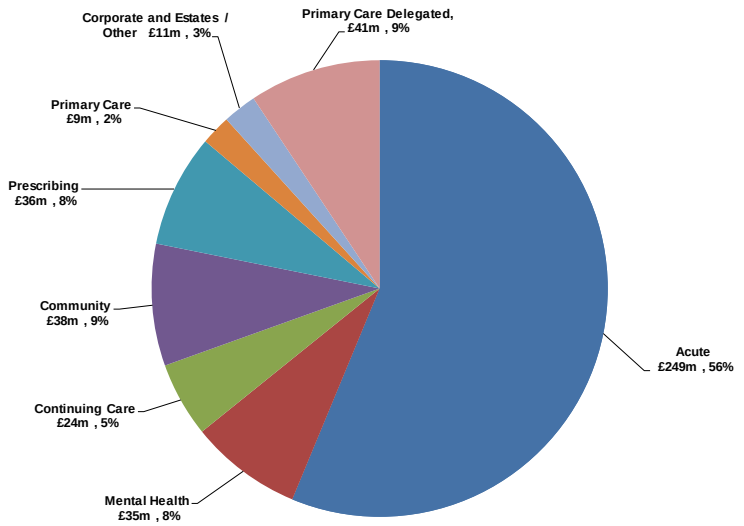
From 2019/20 it is expected that demand for services in Hillingdon will increase by c20%. This is made up of the expected growth in the population (called demographic growth) of c.7% and the growth in the prevalence of disease and ill-health through such things as increasing rates of diabetes (called non-demographic growth) of c.13%. In addition, the government agreed a pay increase for the majority of NHS staff of a minimum of 6.5% over three years, starting

in 2019/20 which will need to be financed from within this financial settlement.

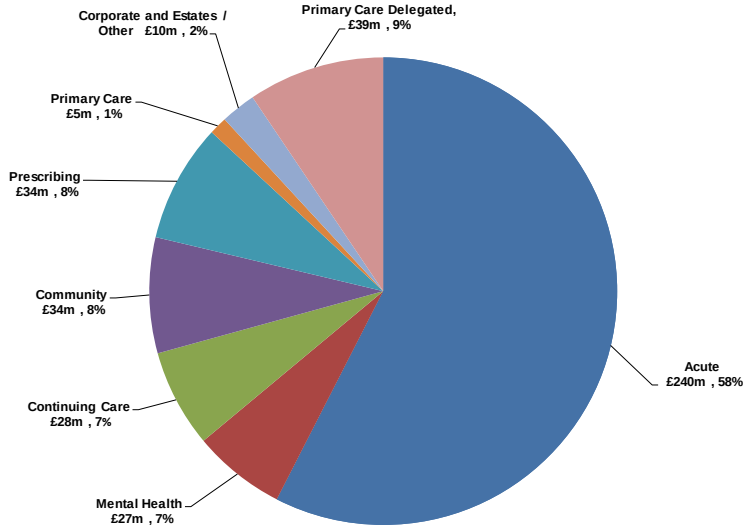
It is therefore essential that our plans include a range of approaches to address this growth in service demand and cost, including preventing people becoming ill in the first place. These approaches relate to: encouraging healthier lifestyles, ensuring that the services we commission are truly delivering 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 19/20 is £9m which is c2% of the CCG's overall budget allocation. 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.

Forecast outturn at M4 of 2019 /20 Net Expenditure by Service (£m)



2018/19 Net Expenditure by Service (£m)



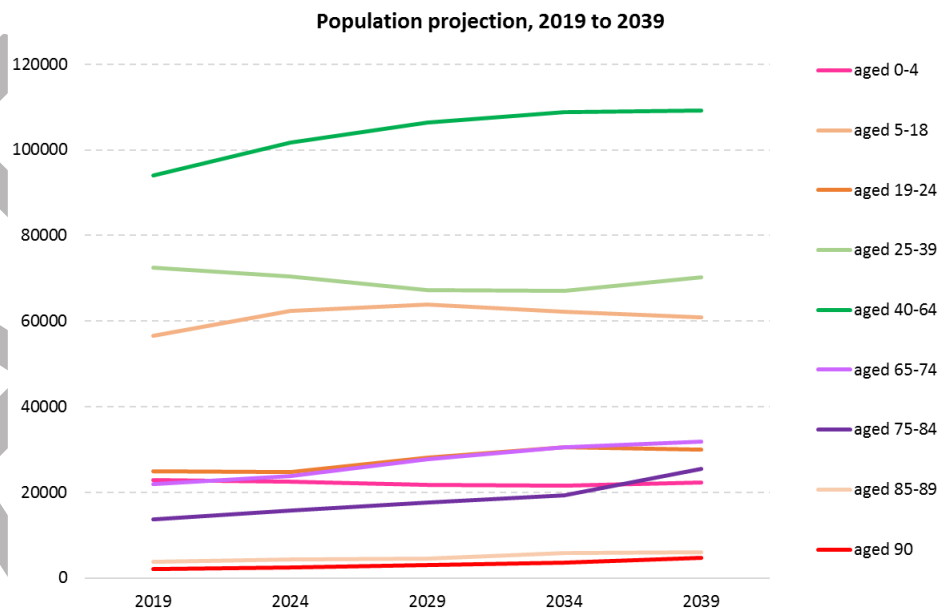
3. The Hillingdon Health Landscape- - Section to be updated

3a 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.

Using data from the Office of National Statistics' Mid-Year Population Estimates (2018) indicates Hillingdon population to be 304,850 with 22,490 (7.4%) aged 0-4 years, 40,690 (13.3%) aged 5-14 years, 201,030 (65.9%) aged 15-64 years, 21,420 (7.0%) aged 65-74, 13,460 (4.4%) aged 75-84, and 5,760 (1.8%) aged over 85. According to the same source, the proportion of men to women in the borough is 50.2% to 49.8%.

Population growth of approximately 14% is predicted for Hillingdon between 2019 and 2039. The larger proportion of this growth will be front-loaded occurring between 2019-2029 and slowing after this to 2039. Current estimates suggest a decrease in the 0-4 and 25-39 age bands (by 640 and 2,365 respectively) but a growth in all others age groups – the most pronounced of which will be the 40-64 age group (+15,189) and 75-84 (+11,764).



The graph above shows the relative growth of the different age groups in Hillingdon between 2019-2039

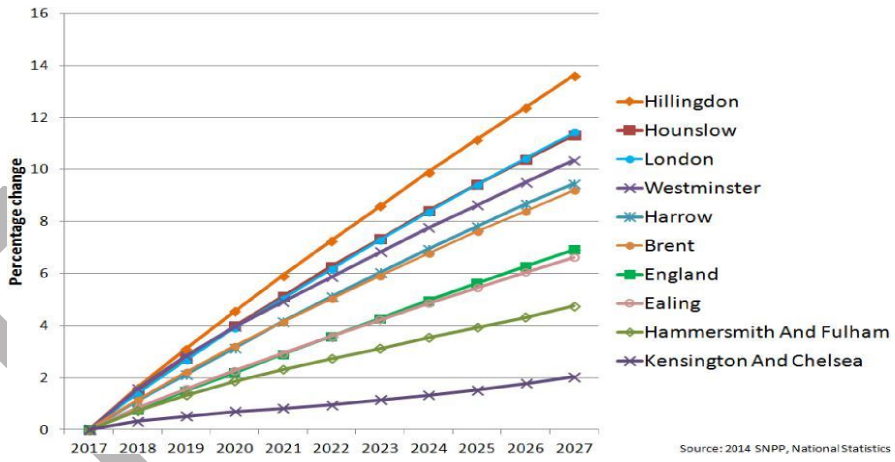
Comparatively, the population growth in Hillingdon is projected to be higher than any other NWL borough, and will be above both the average for London and England.

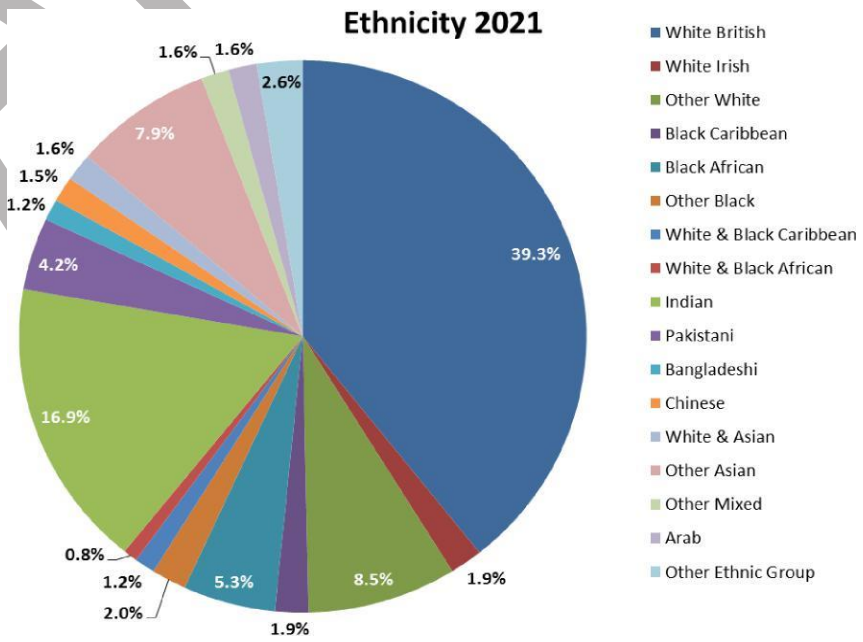
The age structure of the population in Hillingdon is intermediate between London and England, with a distribution that is slightly older than London as a whole but younger than England. Among children and young adults however, there is a larger proportion resident in Hillingdon than for both London and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

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. 10.6% are Muslim, 8% are Hindu, 6.7% are Sikhs, 17% have no religion 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).*

Population Growth Projections





3b. 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. 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 health status and unhealthy lifestyle choices further 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:

- Overall, people living in Hillingdon live longer lives compared to the average for England but life expectancy varies within the borough
- 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, although higher than the England average
- 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)
    - Chronic Obstructive Pulmonary Disease (COPD)
    - Asthma, Dementia and Depression

  While the overall detection of the former conditions are good, they could be improved.

- 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
- Admission rates for alcohol related conditions for people aged 65 and over are higher than both London and England 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.

Indices of Multiple Deprivation

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).

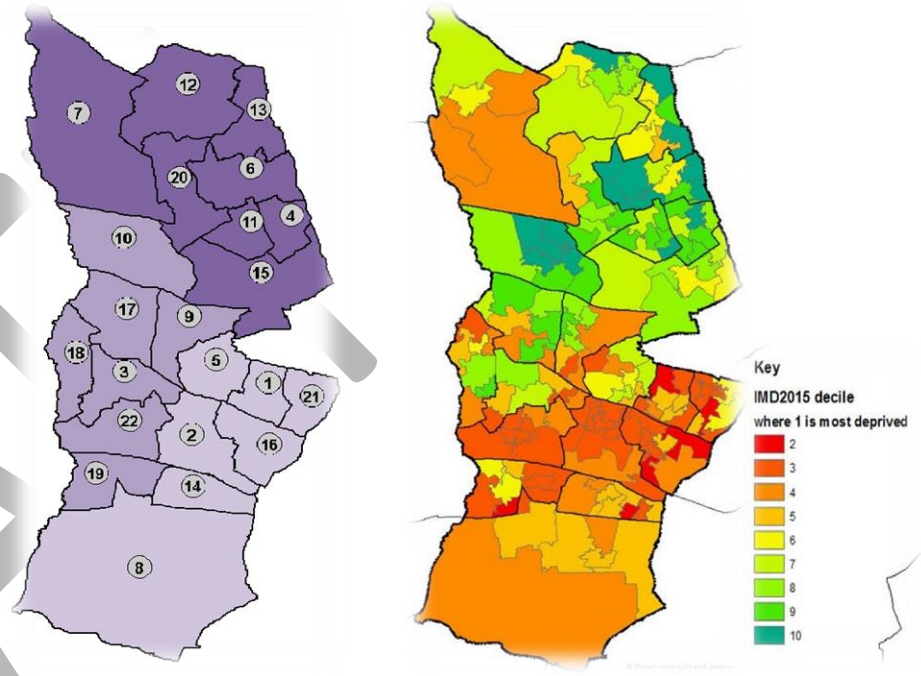
The scores are calculated from 37 indicators grouped under seven different domains or themes, each measuring a different type of deprivation to produce an overall indicator, the IMD.

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 show variation in deprivation in Hillingdon by ward area.



Ruislip & Northwood 4 Cavendish 6 Eastcote & East Ruislip 7 Harefield 11 Manor 12 Northwood 13 Northwood Hills 15 South Ruislip 20 West 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 21. Yeading

3c. 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 formed The Confederation, Hillingdon CIC (The Confederation) enabling general practice to work at scale and to provide a strong primary care voice within their organisation. Their specific aims are: `*to improve care for patients through further collaboration across general practice and will support practices to work together to deliver high quality services, release clinical time and develop the primary care workforce.'*[2] 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. The Confederation is a key partner in Hillingdon's Integrated Care Partnership (ICP). Through The Confederation, Hillingdon CCG can continue to deliver priorities for primary care transformation including: extended access hubs, 24 hour blood pressure monitoring services, integrated paediatric clinics, Weekend Care Home Service and Care Connection Teams and work together in the future to deliver additional integrated care services. Our primary care services programmes also include working with other partners such as pharmacy, dentistry and ophthalmic.

Hospital Based Acute Care

Our hospital based care is provided mostly 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 NW London and local strategic plans.

Hillingdon CCG is also the lead commissioner for some services with Royal Brompton & Harefield NHS Foundation Trust (RBHFT) who ae the largest specialist heart and lung centre in the UK. However, NHS England commissions the majority of services from RBHFT due to their specialist nature. In addition to being the leads on the contracts for THHFT and RBHFT, 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 SI intentions laid out here are applied across all providers from which our residents access care.

[2] http://www.hillingdonprimarycare.co.uk/page1.aspx?p=3&t=1

Carers, Families and Patients

We are grateful for 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. Partnership working across health and care partners has contributed to 30% of the estimated number of Adult Carers and 45% of the estimated number of Young Carers being registered with the Hillingdon Carers' Partnership, which is above the target of 24% for both groups. This is so important because the first step towards supporting Carers is identifying them.

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!

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.

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, Wheelchair and Non-Emergency Patient Transport, amongst others, are commissioned directly by the CCG from a range of other providers.

Throughout 2020/22 our providers as HHCP (THHFT, CNWL, H4All and The Confederation) will continue to work together through Hillingdon ICP to deliver integrated care to deliver population based outcomes and personalised care.

RM Partners (RMP) West London Cancer Alliance

The RM Partners (RMP) is the West London Cancer Alliance hosted by The Royal Marsden NHS Foundation Trust and covers both North West and South West London of which Hillingdon CCG and THH are partners. RMP as part of the Vanguard New Care Models Programme to redesign the NHS, as described in the NHS Five Year Forward View strategy, works collaboratively with partners to deliver the NHS national cancer strategy and to improve survival, quality and safety, patient experience and recruitment to clinical trials covering a population of 3.5 million people. RMP pump primes a number of projects across the Alliance. For example, Hillingdon is one of the national pilot sites for the Lung Low Dose CT case finding projects which entails inviting specific patient groups at high risk of lung cancer for a lung health check and if needed a low dose CT scan to detect lung cancer early.

Mental Health and Learning Disability Services

CNWL also delivers the majority of mental health services in Hillingdon. Hillingdon CCG also works with the mental health charity 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 NW London 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 LD.

Voluntary & Third Sector

Hillingdon's voluntary and third sector 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.

4. Engaging with local residents, families and carers

NHS Hillingdon CCG is passionate about and committed to continuous engagement with local residents, families and carers in developing our SI. We use a range of methods to tailor the way in which the CCG involve and engage its diverse population. This includes, but is not limited to community outreach, partnership working with local advocates and voluntary sector groups, close working with GP surgeries. This is further supported by a range of tools including online and paper based surveys, interviews (with trained interpreters where appropriate) and smaller focused group working. Our engagement is overseen by lay members of the Patient & Public Involvement & Equality (PPI&E) Committee and aligned to programme specific equality impact analysis where available. 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 SI 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
- Utilisation of Patient Activation Measure (PAM) to better understand the impact of the CCGs MyHealth Programme and identify areas for continued support to patients on the programme
- Consulted with patients and GP staff to gain a better understanding of their experiences and where improvements could be made with regards to the CCGs translation service in Primary care
- Continued work with primary schools to educate parents and their children on how to manage Asthma
- Working with GP practices and local voluntary sector groups to engage and encourage BAME women to take up cervical screening
- Educated approximately 3000 residents in 2018/19 as part of our MyHealth programme
- `Aggie the Alien' school assemblies to educate 5-11 year olds on how to stay well through the winter months, this included information on correct utilisation of NHS services
- Communicated to both members of the public and GP staff the introduction of Health Help Now App. Provided training and demonstrations at the CCGs public roadshows as well as in GP surgeries

We intend to continue our engagement activities as part of the development of the CCG's CI through community outreach public events over 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 to demonstrate how the CCG's commissioning activity continues to be shaped and influenced by the views and experiences of the local population in Hillingdon.

Cervical Cancer Screening Event, Townfield Community Centre
Anjumara Hussain (Communications and Engagement Officer) HCCG & Marso Abdi from Family Care (Qoys Daryeel)

5. Our Local Quality Priorities and Principles

5a. Our Quality Priorities

NHS Hillingdon CCG believe that the people of Hillingdon are entitled to a high quality care which is based on best practice principles and guidelines which is safe and provides users to the service to have a good experience.

Listening to the users of the service is key to achieving continuous improvement and reduce variation in the quality of services that have been commissioned by the CCG

The CCG Quality Team will continue to work closely with our commissioning colleagues to ensure new models of care in line with the NHS Long Term Plan and in particular, the development of the Integrated Care Partnership (ICP) and the development and implementation of the Primary Care Networks (PCNs) In doing this we will set clear outcome measures to monitor the new provision on care against to ensure we are achieving the best models of care and patients are involved and satisfied. We intend to do this in conjunction with the ICP to create an integrated quality agenda which meets the needs of our population. We will do this by developing a joint Quality Improvement and Clinical Effectiveness based approach to reviewing the quality of services and when developing new models of care.

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

PATIENT STORY

A lady who had attended one of the MyHealth roadshow stalls explained to the team that her son had something wrong with his eyes. Usually this lady explained that she would go to A&E with something like this, but decided on this occasion to seek advice from her local pharmacy as per the information from the roadshow.

The pharmacy told her that her son had conjunctivitis and needed some medication. She bought and used the medication and her son is now fine.

The lady explained to us that she was very impressed with the pharmacy and would definitely use them more for advice before going to A&E in the future.

5b. Our Quality Principles

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

- Patients and their families/carers are at the heart of commissioning
- Promote continuous improvement in the quality of commissioned services
- Have systems and process to ensure that commissioned services are safe, effective and patients have a good experience
- Provide assurances to the CCG Governing Body that services are meeting their contractual quality outcomes and recommend action if this these are compromised
- Have open relationships with our Providers to share Quality Improvement work
- 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 London Borough of Hillingdon.

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
- There are robust links between commissioning priorities, the development of the Integrated Care Partnership and the Integrated Care System and quality
- Prioritise our quality assurance and improvement efforts, so as to develop an integrated approach with social care that reflects the Better Care Fund plans
- Drive effective engagement with key stakeholders across NW London to achieve the delivery of robust measurable outcomes that reflect “what matters most to patients”
- Hold joint meetings with providers to seek assurance and align learning from complaints, Serious Incident and Never Event, as well as feedback from quality assurance processes such as clinical quality assurance visits. 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 better inform quality indicators.

5c. Addressing Equality & Diversity in the Health System

The Equality Act requires all Clinical Commissioning Groups – as public bodies – to comply with the Public Sector Equality Duty (PSED). The PSED came into force in April 2011 and covers 3 key aims:

- Eliminate unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those that do not
- Foster good relations between people that have protected characteristics and those that do not share them

Hillingdon CCG, as a public body, has a specific equality duty under Regulation 2 of the Equality Act 2010; (Specific Duties) Regulations 011, to provide information to our stakeholders and the public about how we deal with our general duties under Section 149 (1) of the Equality Act 2010.

The CCGs Governing Body Lay Member for Patient and Public Engagement has executive accountability for equality, supported by the Head of Communications and Engagement who holds operational responsibility.

The reporting and monitoring of equalities is embedded into the work of the CCG. All Commissioning staff take responsibility for the creation and continuous monitoring of Equality Impact Analysis's (EIAs).

The CCGs Equality Objectives (currently under review) provides further opportunity to focus on areas where inequalities to access / reach would benefit from a longer term commitment to make progress towards eliminating discrimination and advancing equality of opportunity for all in the borough. The CCGs equality objectives are supported by the NHS Equality Delivery System (EDS2).

Advancing Equality and Diversity to a level that will make a notable difference in the reduction or elimination of inequalities also require the efforts and commitment of each Borough's Clinical Commissioning Group, providers, local authority, voluntary sector organisations as well as its patients, carers and residents.

The CCG will continue to work in collaboration with partners and the public ensuring a link between commissioning, engagement and equalities are embedded into the health economy.

5d: 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 an reviews relating to adults or children e.g. Domestic Homicide Reviews (DHR), Serious Adult Reviews (SAR) or Child Safeguarding Practice Reviews (CSRRs) and ensure that the CCG and Provider organisations complete all sections.

HHCP Annual General Meeting on 26th June 2019
Annette Alcock (Education & Workforce Lead), The Confederation & Smita Patel (Practice Manager), Kingsway Surgery, at the Workforce Development Stand.

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 CYP 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 (MCA) 2005; The Deprivation of Liberty Safeguards (DOLS); and moving towards implementation of Liberty Protection Safeguards (LPS) due to come into effect Oct 2020 and The Care Act 2014. • Ensure that this vulnerable group is consulted when new or changes in existing services are being considered/planned. • Ensure compliance with DHR actions and NICE Guidance for anti-social personality disorder prevention and management.
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, MCA, 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.
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. • .

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 better arrangements to support survivors of domestic violence.
Child Sexual Abuse/Child Sexual Exploitation (CSA/CSE) and Emotional Wellbeing Service	• Monitor newly established NW London CSA/CSE and Emotional Wellbeing service to ensure that this service is comprehensive and easily accessible to CYP who are at risk of, or suffering as a result of, Child Sexual Exploitation (CSE), Child Sexual Abuse (CSA) or Female Genital Mutilation (FGM). • Implementation of NWL Child Sexual Abuse (CSA) hub.
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 LeDeR. • Monitor providers regarding NHS England LeDeR Programme and embedding any lessons learnt.

6. Key Achievements in 2019/20

Keeping People Well

- ✓ More support for carers in primary care with a Carer Lead identified in each GP practice, including a supporting information pack to increase awareness of carers' and their needs.
- ✓ GP Practices established Mental Health Registers and recall systems to facilitate Annual Physical Health Check appointments for people with Severe Mental Health needs.
- ✓ Developed a primary care mental health service that is enabling more people to recover and stay well in the community.
- ✓ Work with the LBH and schools to expand access to strategies to manage anxiety and depression for CYP to improve their overall health and wellbeing.
- ✓ Supported the establishment of Primary Care Networks (PCNs) that will support GP Practices to work together in groups to provide some services to residents in more efficient ways by pooling time and resources together.
- ✓ Established Neighbourhood Teams to deliver integrated and personalised care via multidisciplinary teams that have Primary Care and GP Practices at the centre of their approach so residents can access care closer to home through their GP Practice.
- ✓ The design and delivery of a prototype Improving Access to Psychological Therapies (IAPT) and multimorbidity clinic has commenced in one of the Neighbourhood Areas to test the concept. If successful, the service will be expanded over the next year to benefit more people.
- ✓ Increased capacity in the Community Heart Failure team, run by hospital consultants in collaboration with GPs, to help more people to have their check-up appointments in Community Clinics nearer to their homes rather than in hospital.
- ✓ Established a Cancer Survivorship Group working with cancer clinicians, sector partners and Macmillan to give people access to psychological support and help them have the information to understand and manage their health after cancer treatment.
- ✓ Rolled out the Faecal Immunochemical Test (FIT) to detect bowel cancer in low risk symptomatic groups of patients in primary care. Recent NICE guidance in this and other areas is helping to bring these types of tests out into primary care so that a diagnosis can be made faster.
- ✓ Conducted outreach work with Asian and Somalian groups to promote cervical cancer screening awareness.
- ✓ Four PCNs have been successful in obtaining funding from Transforming Cancer Services Team (TCST) for London to participate in the National Cancer Diagnostic Audit (NCDA) to help practices improve pathways in primary care to diagnose patients earlier with cancer.
- ✓ Working with leads and pooling resources with Cancer Research UK, RMP Partners and NHS National Bowel Cancer Screening Programme at St Mark's Hospital at LNWHT to increase uptake of bowel cancer screening in primary care and to train staff.
- ✓ Joined up working with the THHFT Paediatric Asthma team to identify schools to host childhood Asthma workshops for children and parents.
- ✓ Developed a new Hillingdon Aggie the Alien self-care video – see direct link to the video on YouTube: **https://youtu.be/M_i-b7jKoK4**

- ✓ We have successfully recruited and trained 11 MyHealth facilitator Health professionals to deliver the MyHealth workshops, and achieved the accreditation of the Diabetes MyHealth Programme to help support people to self-care and self-manage their condition at home. Last year we helped 100 people to manage their health and avoid future A&E visits. This year we are helping over 2000 people with the MyHealth programme to manage their diabetes, childhood asthma, heart health, basic first aid for parents with young children, and seasonal wellness in the heat of summer and cold of winter. We are also looking to expand our programme to include respiratory/COPD support, dermatology, weight issues, and cancer wellness.

MyHealth Hillingdon is a free patient education and self-management programme. Helping patients to take greater control of their own health. Patient feedback:

*"The facilitator was caring and genuinely interested on my thoughts and what I wanted to learn, I'm looking forward to putting what I learnt into action and attending the advanced session." (**Borderline Diabetes Patient).***

*"I was surprised how much my daughter knew about her Asthma and how little I knew. The session has given me information so we can both keep on top of it."**(Parent of child with Asthma).***

Right Care, Right Time

- ✓ Extended Primary Care Access Hubs so that there are more primary care appointments available for patients who urgently need to see their GP and avoid a visit to A&E when their condition is not life threatening – expansion to deliver an increased number of appointments based on a baseline of 14min/per 1000 residents to 30min/per 1000 residents.
- ✓ Promoted the use of shared care records in the Coordinate My Care platform and have one of the best and highest rates of use in London.
- ✓ Re-commissioned the Michael Sobell Hospice specialist palliative care service with providers that are accountable to local oversight offices to deliver Hillingdon standard care to Hillingdon residents after the service difficulties experienced last year.
- ✓ Established a community children's community phlebotomy service so that children don't need to go into hospital for routine tests.
- ✓ Developed a new Integrated CYP's Therapy model co-developed with the London Borough of Hillingdon with input from families who use these services to support CYP with mild to moderate needs in relation to communication and mobility skills.
- ✓ Worked with local providers to develop a single point of access for musculoskeletal services, including physiotherapy in the community and primary care GP practices. Previously there were a number of services doing slightly different things and the refreshed model provides more joined up care out of and into hospital when needed. This includes First Contact Practitioners in primary care and self-referral into physiotherapy services.

- ✓ Worked with our ophthalmology team to develop a new and innovative model of care that will link hospital and community care through an enhanced skill mix of practitioners with selected optometrist practices on local high streets.
- ✓ Specialist Neurology Nurses in the community have been appointed so that people with Parkinson's and Epilepsy can have help closer to home to manage their condition rather than needing to go into hospital. It is further hoped that by managing the condition closer to home, this will mean slowed deterioration and reduced episodes, which will mean a better quality of life and fewer visits to A&E.
- ✓ Clinical Decision Support software is being introduced to help GPs and consultants choose the best test or imaging (eg ultrasound and MRI) to confirm a potential diagnosis, and to know best when a person should be referred for these tests. These tests can be helpful, but they should be done only when necessary.

At times of Crisis

- ✓ We have supported High Intensity Users (people who use our Urgent and Emergency Care services very significantly above the average visit to A&E, or call to our ambulance services) to know that they will be cared for with regular check-ins from staff to ease their concerns about their health. Our current services are highly equipped and qualified to help all patients, regardless of their level of need, be it for one call to our 111 line, an urgent GP appointment, or a visit to hospital. We consider it best practice that our patients have access to primary care and community support to prevent visits to A&E, except when an accident or an emergency occurs. Our programme of assistance around High Intensity Users calls on our current services to identify and support these patients into a normal package of care over a period of time.
- ✓ Introduced an Autism Register list to help proactively care for adults, CYP with autism to manage their condition with support, and prevent distressing hospital admissions.
- ✓ We continue to develop the Learning Disability Register list for CYP to align with our programme for the Adults Learning Disability Register.
- ✓ We have invested in additional community and primary care capacity to improve urgent access to clinician advice and help closer to home e.g. patients are able to call their GP or 111 out of hours and to get an urgent primary care appointment the same or next day. Patients are also able to rapidly access community support and care
- ✓ We have invested in integrated discharge processes to help patients get home on time after an emergency visit to hospital that results in an admission. We have worked to bring together our hospital, community, primary and social care teams to form one working collaborative. They then response so that those few patients who need extra support getting home have a swift response and can enjoy leaving hospital on time, rather than have an extended and unnecessary hospital stay after they have been treated.
- ✓ We have worked to improve our engagement and support to Care Homes to prevent unnecessary trips to A&E for our frail elderly population. We have also invested in a GP visiting service to care homes to deliver proactive care planning and prescriptions.

Integrated Care Partnership

- ✓ We have implemented a Neighbourhood Team model that brings hospital clinics in the community, community care, social care and primary care services, including PCNs, together to focus a set of services around GP Practices. This means that our residents can expect to have their care managed and supported well before a visit to hospital is needed. This is our particular focus this year in addressing LTCs and older people's growing frailty and susceptibility to things such as falls resulting in a break or fracture, and common colds/flus during the winter.
- ✓ We have made progress toward implementing an Integrated Care Partnership with a number of key services working together on pathways of care (for example musculoskeletal and physiotherapy services as previously described, and end of life palliative care) with nominal shared budgets.
- ✓ We have rolled out the Commissioning Primary Care Outcomes Based contract in line with Integrated Care Partnership. This is intended to support practices to focus on the key population needs and to address some of our variation in health outcomes through a programme of targeted information and support. We have also rolled out the Diabetes Outcomes Based contract.
- ✓ We have launched the Primary Care Dashboard that contains a plethora of health and care information from a number of different, and previously separated reported sources, in the one place. Our practices have fed back that they have found it very useful to see the information in one place.
- ✓ We have procured a new `One Template' for coding of illness and conditions in computer records in line with national guidance to support in standardisation of coding in practices.

Enablers

- ✓ We have successfully supported 100% use of the nationally rolled out eRS system (Electronic referral service) improved the use of GP2GP across GP Practices so that patient medical records can be transferred between practices in a timely way when patients move.
- ✓ We are reducing the use of paper and becoming more digitised and environmentally friendly.
- ✓ We have invested significantly in our IT data network to future proof the flow of digital information across its service as the number of records and detail of information we hold increases. The migration to a full fibre network across all sites is planned to be completed by summer end 2019.
- ✓ We have successfully recruited new staff in primary care: GP trainers (7), Nursing student placements (58), Independent Prescribing Pharmacists Students (9), Pharmacists (6) & Transitioned nurses (19) amongst others, to increase Primary Care capacity and the number of appointments available for residents.
- ✓ We have delivered over 50 training courses, forums, masterclasses this year with 1,500 attendees across all practices and staffing groups including the wider HHCP primary are teams practices. Education and training keeps our workforces' skills strong!!
- ✓ We have engaged independent Pharmacist Prescribers to manage the repeat prescribing systems and requests so patients get their medicines more quickly and reduce duplication.
- ✓ We have implemented the Medicines Optimisation in Care Homes programme so our elderly residents get their medication on time.
- ✓ We are piloting respiratory/COPD Virtual Clinics in GP practices.

7. 2020-2022 Strategic Intentions

T1. Transforming Care for Older People

Key Strategic Health Outcomes and Actions	Strategic Intentions 2021/22
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 care homes, enabling them to live independently and in the family home for longer • Embedding use of LBH Connect to Support service • Further reduce delayed transfers of care • Reduced frequency of unplanned events, reduction in Non-Elective Admissions & ZLOS Admissions • Community point of co-ordination 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 patients • 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** • Ensure access to advice, support and advocacy services so that informed choices can be made for older people, their carers and families • Enhancement of support to care homes and extra care housing with SaLT and dietician capacity taking into account any new resource allocated via PCNs • Increased capability and efficiency within the Neighbourhood Teams for provision of preventative, social prescribing and case management interventions • Continue to build on the offer to carers, consolidating GP Champions with GP practices and linking in with neighbourhood assets developed via H4All • Develop and implement collaborative care, support planning and shared care records in line with LTC management • Further integrate and utilise predictive tools, such as those as part of WSIC, to identify and proactively manage health risks • Proactively identify people at risk of falling and increase capacity in falls prevention services **Right Care, Right Time** • Embedding of integrated physical and mental health service provision at a neighbourhood and Network level, including access to IAPT and dementia diagnosis and follow up post diagnosis for patients and their families and carers • To increase the number of shared cared records through the Coordinate My Care platform to help proactively manage developments in our older residents' frailty journey **Care at times of Crisis** • Build on the Single Point of Coordination integrated functions between hospital, community and primary care • Support the implementation of Same Day Emergency Care pathway for when older individuals require a visit to Accident and Emergency • Embed the 2 Hour 2 Day standards described in the local Intermediate Tier programme of work and NHS Long Term Plan

T2. New Primary Care Model of Care

Key Strategic Health Outcomes and Actions

By 2021/22 we will be delivering the following outcomes:

- Delivering services and increasing number of patients managed outside of hospital setting in the context of the broader ICS
- Reduction in the mortality gap
- Reduction in unplanned care events for vulnerable people, and those with a mental health condition or LD
- Greater access to integrated primary care 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 LTCs
- Supporting investment in Primary Care at scale for new models of care in place for all populations with integrated teams throughout the system, including social care, the voluntary sector and easy access to secondary care expertise.
- Implementation of Neighbourhood Primary Care Models of Care, which includes the establishment of Primary Care Networks (PCNs) in 2019 and their ongoing development to deliver population-based health outcomes
- Premises development for out of hospital and GP Services in Hubs in Hillingdon in 2021 in the north/south and middle of Hillingdon.
- Extended GP out of hours working implemented to support integration of urgent and primary care services so patients can access urgent GP advice and treatment without a need to visit hospital. Patients will be able to access GP out of hours through calling their local surgery or 111
- Support 111 direct booking into GP out of hours and hubs so patients can access urgent appointments without a need to visit hospital
- Expand access to and use of online digital technology information and advice for patients to make care more efficient and more effective for service users
- Explore opportunities for routine, low-complexity diagnostics in the community and primary care
- Implementation of a Neighbourhoods model, aligned with the PCNs and the Neighbourhood Teams, that will support whole-population health and care prevention and management through a place-based / local neighbourhood model that will deliver individual care closer to home as well as enable some services to be delivered across a wider population with collaboration between multiple GP practices and community services
- Expand on personalised care & support creating a harmonised approach via holistic interventions in PCNs
- Increase practice capacity by improving the use of self-care and online consultations
- Build on partnerships working with voluntary sector, social prescribing link workers, public, patients and carers

Key local aims to achieve by 2021/22:

- Strengthened primary care provider landscape able to deliver new primary care models of care and primary care services at scale through HPCC
- 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

T2. New Primary Care Model of Care (Cont'd)

Strategic Intentions 2021/22
Keeping People Well • Primary Care Networks (PCNs) to take a lead role in addressing the prevention of ill-health through support for smoking cessation and addressing obesity and high alcohol intake • To provide holistic management for patients through the roll out of multi-morbidity clinics to support patients with long term conditions to manage their condition, including heart disease, respiratory and diabetes • Incorporate Self Care and Prevention programme principles in all models of care as appropriate to informing and enabling patients to proactively engage in improving and managing their health • To roll-out social prescribing LINK workers in PCNs **Right Care, Right Time** • Develop a delivery plan to support PCNs to develop relationships with community provider partners • Identifying and addressing gaps in the GP Five Year Forward View as regards the provision of proactive, accessible and coordinated care to improve health outcomes • To enhance and maximise the use of new dashboard-type approaches to evidence based clinical care in order to reduce unwarranted clinical outcomes via the PCNs. Our current platform is the Whole Systems Integrated Care (WSIC) dashboard • PCNs Networks are established with the growing capability to assess and manage the Health and Social Care needs of the whole population, as well as scoping, developing and implementing opportunities to collaboratively manage their populations' health needs • Alignment of GP led PCNs to GP led Neighbourhood Teams, which will be cornerstone of the new ICP model with multidisciplinary/speciality working across a range of staffing and skill sets, including links into social and third sector support. These staff will include a core team of GPs, community nurses, community pharmacists, social care staff and integrated health and social care support-workers together with a wider team of mental health professionals, allied health professionals, Care Connection Teams, pharmacists, acute consultants, independent and third sector staff • Local organisational development programme in place to support the development of the 8 Neighbourhoods • To work with Hillingdon Primary Care Confederation (HPCC) to develop a sustainable workforce to support PCNs and Neighbourhoods • Premises development of two further GP Hubs in the North and Central to support local population by offering a number of integrated care services • To review how we use our estates across the Integrated Care Partnership organisations in order to use our footprint to its best use as part of the Neighbours working model • To further improve access to early diagnostics for patients and staff in primary care and the community. We have begun to offer Irritable Bowel Syndrome (IBS) tests in primary care and are scoping routine tele-dermatology imaging in primary care, among other opportunities • To create a single outcomes based contract for Multimorbidity conditions management/Improving Access to Psychological Therapies to join up physical and wellbeing health services • To continue to expand access to routine primary care access for patients 7 days a week through use of our three locality extended access hubs across Hillingdon • To update referral pathways in collaboration with GP practices and secondary care consultants in line with national clinical and local best practice guidance • To support practices in releasing capacity via the Increasing Clinical Capacity Contract (ICCPC) contract • Digitally enabling PCNs with infrastructure and clinical systems **Care at times of Crisis** • The implement Single Point of Coordination functionality in the Neighbourhoods 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 • Pre bookable primary care appointments accessible via the extended access hubs operating 7 days a week • Supporting GPs to refer individuals directly to urgent community and hospital pathways where their condition or need cannot be addressed in primary care

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

Key Strategic Health Outcomes and Actions	Strategic Intentions to 2021/22
By 2021/22 we will be delivering the following outcomes: • Helping a greater number of people to be able to die in their preferred place of death, which is usually in the comfort of their home/usual place of residence • We will have embedded coordinated palliative services support for people at End of Life and their families/carers on a 24/7 basis and across all care settings • We will have begun to identify more and more people who are at the end of life in order to better plan for their care and treatment preferences at a time when compassionate care to manage worsening symptoms is likely to be preferred over invasive treatment **Key strategic actions to achieve these include:** • Implementation of our End of Life Strategy and new integrated service model • Increased access and use of the Coordinate My Care record Enhanced social support for those at end of life to continue our record as the locality with the best and highest use of the records platform **Key local aims to achieve by 2021/22:** • Reducing the number of admissions for people in the last 30 days of their life • Improving access to information and anticipatory care plans in the Coordinate My Care platform for clinicians and professionals • 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 support 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 • To create shared care records with patients with palliative needs that express patient wishes, preferred care and treatment, and enable services to coordinate around patient needs. **Right Care, Right Time** • Improved in-reach to care homes to help health and care staff to identify and support non-acute palliative needs • For care planning to include preferred care at end of life through shared care records, including pre-planned and prescribed medications access and availability. • To support clinicians to identify patients with end of life and palliative care needs and to have difficult but necessary conversations with patients and loved ones about their best care. • To continue to test and embed the 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 **Care at times of Crisis** • Ensure access to hospice and continuing care beds reflects local need • To coordinate service response at times of crisis to ensure patients receive the right care at the right time. This may mean a visit to hospital, or urgent care provided at home • To reduce unnecessary unplanned time spent in hospital at end of life when care could be better delivered in the comfort of home through improved care and capacity in the community, as well as in-hospital identification and a managed discharge pathway so that people who do need a visit to hospital can be swiftly supported back to the comfort of their home after being stabilised

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

Key Strategic Health Outcomes and Actions	Strategic Intentions 2021/22
By 2021/22 we will be delivering the following outcomes: • Reducing prevalence growth for core LTCs and significant progress made in closing key prevalence gaps in respiratory, diabetes and cardiology • 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 • 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 multi-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 2021/22:** • 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** • Increased uptake and capacity of Structured Education programmes and applying the learning to better manage their condition as informed patients e.g. via the MyHealth programme • Diabetes remission prototyping to provide learning to inform implementation of remission at wider scale across Primary Care Networks (PCNs) • Provision of person-centred care through multimorbidity clinics • Earlier diagnosis of COPD, asthma and hypertension through analysis of primary care data from the CVDPREVENT audit tool • Improve uptake of pulmonary rehabilitation and smoking cessation services • Ensure patients medications are optimised (Right medicine, Right Time) **Right Care, Right Time** • People with LTCs are supported within Neighbourhoods to link their GP with primary care at scale services through the PCNs as well as community care services • People with diabetes participation in remission prototyping programme • IAPT and multimorbidity prototyping learning incorporated within the mobilisation of multimorbidity clinics for fast implementation • Robust care planning with patients to have shared health goals • To continue to enhance mental health integration within the LTC programme • Optimisation and management of patients prior to referral to acute services **Care at times of Crisis** • Assessing and addressing the reasons for Diabetes Type 1 patients attending A&E to help prevent health exacerbations through a more managed approach • The Integrated Respiratory service will provide a telephone advice service for patients with exacerbations of COPD • Rapid Access Clinics will be available for acute exacerbation patients when they need consultant advice and support • The Respiratory Specialist Team will work closely with generalist Rapid Response and Hospital At Home teams to ensure patients have a multidisciplinary response

T5. Transforming Care for People with Cancer

Key Strategic Health Outcomes and Actions	Strategic Intentions 2021/22
By 2021/22 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 Direct Access and Straight-to-Test (STT) community diagnostics **Key strategic actions to achieve these include:** • To work with RMP West London Cancer Alliance to deliver evidence-based care • 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 Direct Access (DA) and STT • Rollout outstanding actions from Cancer Improvement Plan • Evaluation of cancer screening outreach programmes **Key local aims to achieve by 2021/22:** • 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 • To deliver personalised care for patients to meet their psychological and health and wellbeing needs and improve their quality of life	**Keeping People Well** • Improve cancer screening rates for vulnerable patients e.g. learning disabilities and in communities with lower rates of uptake, working with partners • Continue work with partners to promote bowel cancer screening and early detection of bowel cancer through use of FIT in primary care, focusing on high risk groups • Implement recommendations from RMP low dose CT lung screening programme • Increase the number and quality of primary care Cancer Care Reviews in primary care for patients who have had cancer and are now managed in primary care • Roll-out `C the Signs' Tool to help GPs identify and manage patients at risk of cancer at the earliest and most curable stage of the disease • Support practices to participate in the National Cancer Diagnostic Audit to facilitate early diagnosis of cancer • To work with THHFT to implement Macmillan `Right by You' programme to ensure patients who have cancer as a LTC receive personalised care **Right Care, Right Time** • Prototype Cancer MyHealth programme, working collaboratively with Harlington Hospice, to deliver personalised care support for patients in Neighbourhoods • Work with THHFT and RMP partners to implement Straight-to-Test pathway for colorectal, prostate, oesophageal and the national lung optimal pathway • Work with our local hospital to facilitate the implementation of 28 day Faster Diagnostic Standard and meet the 62 day Treatment Standard • Evaluate and expand Prostate Cancer Stratified Follow-up Pathway to enable patients who are stable to be managed in primary care • Fully implement and enhance stratified follow-up pathways for colorectal, lung and breast cancer **Care at times of Crisis** • Reduce unplanned emergency admissions and identification in an unplanned care setting for those with cancer through symptoms management and early identification of patients via learning derived from local data, NCDA and NHSE RightCare analysis

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

Key Strategic Health Outcomes and Actions	Strategic Intentions 2021/22
By 2021/22 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 through Annual Health Checks. • Reduction in unplanned care for people with a known mental health condition and/or learning disability/autism • Improved rates of adults with a learning disability or mental health need living in stable and appropriate accommodation • Improved Access to Psychological Therapies and maintaining the recovery rate • Reduction in risk of harm to vulnerable CYP, and adults **Key strategic actions to achieve these include:** • Expand integrated care delivery models to include adults, CYP with MH needs • Full operational delivery of the strategy for adults and children with autism • Re modelled CYP mental health and emotional wellbeing pathway and further integration with mainstream children's support services • Improve the LD and Autism pathway for Hillingdon residents, especially those with Complex Behavioural Needs • Invest in a new joint management model with our local council to develop and deliver a new integrated service and specification under Section 75 for people with a learning disability and/or complex needs • Align mental health and physical health services within a multidisciplinary approach (IAPT and Primary Care Mental Health (PCMH) **Key local aims to achieve by 2021/22:** • 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 plans for Mental Health & Future in Mind • 100% of people with a Learning Disability and 60% of people with a serious mental illness receiving a full health check and appropriate ongoing care	**Keeping People Well** • Facilitate implementation of the `Ask Listen Do' Framework to support patients/carers with learning disabilities, autism or both to provide feedback and make a complaint more easily to services • We will work towards Stopping the Over Medication of People with a learning disability autism or both and Supporting Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP) programmes to stop the over-medication of people with a learning disability, autism or both • Increase the number of available assessments to support adults with ASD (non-LD) to be diagnosed in a timely way to reduce backlog by 20/21 • Embed annual physical health checks for people with a learning disability and/or autism and for people with severe mental ill-health **Right Care, Right Time** • Increase awareness of Personal Health Budgets for adults and children • Increase access to mental health services for CYP with mental health disorders due to increase in prevalence rate from 102% to 119% to meet government MHDS target for Hillingdon by 20/21 • Support enhancement of health checks and planning for those with LD in primary care as part of annual physical health review for people with severe mental illness and help GPs meet key aims to deliver outcomes based physical health through shared care arrangements • Increase access to specialist perinatal wellbeing support allowing more women to receive evidence based treatment closer to home when they need it • Reduce waiting times to 2 to 4 weeks for access to emotional well-being and physical health support for patients, including CYP **Care at times of Crisis** • Commission safe haven crisis services, including crisis cafés with a clinical component, and 24/7 CYP's crisis services access • Improve identification and support to those with emotionally unstable personality disorder and serious mental ill health to access 24/7 crisis care • Targeted support to prevent and reduce suicides with a multiagency approach • High intensity support available in primary care to step people down to appropriate crisis management services through a multidisciplinary approach

T7. Integrated Care for Children & Young People

Key Strategic Health Outcomes and Actions	Strategic Intentions 2021/22
By 2021/22 we will be delivering the following outcomes: • Early identification of issues and prompt intervention through integrated CYP services. • Coordination of care and support for CYP across health, social care and education services. • Reduction in unplanned hospital admissions for CYP with LTC i.e. asthma and diabetes. • Earlier identification and intervention for CYP requiring SaLT, and OT. • Improved 0-4 year olds dental health to England average for dental caries. • There will be a comprehensive offer for 0-25 year olds that reaches across mental health services for CYP and adults. The KOOTH on line counselling service will be extended from 18- 25 year olds in 2019/20 as part of this development • Reduce CAMHS waiting times for CYP to 2-4weeks via new early intervention mental health services and complete pilot and evaluation of the new early intervention model in a designated neighbourhood area with the view of scaling the model across Hillingdon. • Achieve 2020/21 target of 95% of CYP with eating Disorders accessing treatment within 1 week for urgent cases and 4 weeks for Routine cases. • Stopping over medication of people with a learning disability autism or both and Supporting Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP) programmes to stop the overmedication of CYP with a learning disability, autism or both. Improve support for parents and children with ASD/LD and develop an annual health check for CYP with Autism / LD **Key strategic actions to achieve these include:** • Upskilling of primary care though joint working and sharing of skills, knowledge and expertise with hospital staff. • Delivery of wellbeing training programme for schools and implementation of the CAMHS national Link Training Programme in 2020. • Establishment of multi- agency steering group to implement the STOMP/ STAMP programmes • Introduce Single point of Coordination for CYP	**Keeping People Well** • Fast access to joint GP / Paediatrician assessment via Paediatric Integrated clinics • Signpost families to book appointment for childhood immunisations, that are not up-to-date, when children are seen at the Paediatric Integrated Community Clinics • Improved dental health via supervised teeth brushing programme. • Updated and refreshed CYP mental health model of care and specification aligned to the Early Intervention Service • Ensure a robust system is in place for health checks for children with LD and autism with local GP`s in line with the NHS 10 year Plan • Improve the time taken for children to receive emotional well-being and mental health /physical support in schools and community settings **Right Care, Right Time** • Development of early access and prevention services to deliver an integrated early intervention team to reduce waiting times and enhance specialist services with extended pathways (step up/step down) in collaboration with other local providers and voluntary sector to provide an equitable service in the community including schools and GP hubs • CAMHS LD service specification revised and updated by 20/21 to improve access and outcomes to services and make sure all local healthcare providers are making reasonable adjustments to support people with a LD or autism • Extend children and adults mental health services from 0-18 to 18 -25 to enable a supportive transition period for those moving into adult services and address the gap • Implement an all age Autism dynamic Risk Register to support proactive care that will help those with autism avoid an unexpected trip to hospital • Continue to develop the all age LD Register to align with the LD Adults Register to support proactive and planned care • Multi-professional clinics held in the community to review infants and children prescribed special milk formulas for suspected cow's milk intolerance

T7. Integrated Care for Children & Young People (Cont'd)

Key Strategic Health Outcomes and Actions	Strategic Intentions 2021/22
• Re modelled CYP's Mental Health end emotional wellbeing pathway and further integration with mainstream Children's support services • Develop a local mechanism to reduce the over medication of CYP with a learning disability / autism spectrum disorder line with national guidance **Key local aims to achieve by 2021/22:** • Roll out new model of Integrated Therapies enabling CYP with mild to moderate needs to access support before issues escalate. • Practice nurse Role modelling initiative to upskill in Asthma care for CYP rolled out to 15 practices. • Defined pathway in place for infants with suspected cow's milk intolerance. • Achieve 2020/21 target of 95% of CYP with eating disorders accessing treatment within 1 week for urgent cases and 4 weeks for routine cases • 35% of CYP in our population that are indicated to have a mental health illness, as estimated from national prevalence rates, will be receiving treatment and support to manage their concerns • Revised ASD pathway and service specification with CAMHS specialist services will be included alongside work with CYP's mental health services to test and implement the most effective ways to reduce waiting times for specialist services.	**Care at times of Crisis** • Improve transition planning to better integrate the support provided to young people who need to transfer into adult services. Proposed improvements include: case management, key workers and service navigators • Introduce health passports for Looked After Children (LAC) leaving care in order to support self-care and transition to adult services • To commission a local review of crisis services toward a redesign of these services as part of our approach to expanding urgent 24/7 capacity and primary care and community services urgent access for CYP so they can get help when they need it. The review will ensure the delivery of 24/7 mental health crisis provision for CYP which combines crisis assessment, brief response and intensive home treatment functions by 2023/24

T8. Integration across the Urgent & Emergency Care System

Key Strategic Health Outcomes and Actions	Strategic Intentions to 2021/22
By 2021/22 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 • NHS 111 direct booking of appointments in GP Practices, as well as referral on to community pharmacy to support urgent care and patient self-management • 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 2021/22:** • 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** • 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** • Helping High Intensity Users to understand that they have wraparound care to address their ongoing health concerns **Care at times of Crisis** • Integrating early first response services to respond rapidly to patients in their home environment when they become unwell • To undertake a review of the MIU at Mount Vernon Service to ensure it delivers in line with 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 • Continue to embed and scale same day emergency and ambulatory care 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 • To commission an integrated community based urgent health care offer including NHS 111 and Clinical Assessment Service (CAS) enhancement, community primary care hubs, and pharmacy connection schemes • Full implementation of Urgent Treatment Centre (UTC) model In line with national quality standards • Opportunity to improve same day emergency care and ambulatory emergency care to support rapid stabilisation of patients • Continue to build on good work to support LAS to identify and refer patients to the right care where patients require urgent support but not emergency lifesaving intervention; including UTC, urgent primary care GP appointment, pharmacy, end of life advice and help, and rapid community response

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

Key Strategic Health Outcomes and Actions	Strategic Intentions 2021/22
By 2021/22 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 • Supporting reduced air pollution levels in Hillingdon with partners **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 2021/22:** • 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	• To enhance the offer of the MyHealth programme workshops to patients and work with the Primary Care Integrated care systems to offer bespoke packages of self-care workshops to their patient populations. • To increase the appointments offered in the MyHealth programme to 10,000 in 2021/22 Including an increase in self-referrals • Continued monitoring of patients Patient Activation Measure (PAM) score through the MDT's (Multi Disciplinary Team) and aligning patients to the right level of self-care / prevention / support in accordance with their levels • For cancer patients raising awareness of blood levels and neutropenia to avoid sepsis and potential delays in treatment as a result. Alongside this work to collaborate with Macmillan and Harlington Hospice to co-produce a holistic package of care that is tailored to the patients cancer journey and their activation level • To work with QISMET to gain accreditation if all workshops within the MyHealth Programme. Work to start in 2019/20 with annual funding allocated to accredit courses that emerge as part of the continued expansion • To reduce levels of obesity and smoking via access to digital and online support to enable 24/7 wrap around care • Delivery of timely information and materials that link back to the patients record and condition to support 24/7 self-management outside of treatment and workshops • Improved screening process and uptake to tests that pre-empt the patients likelihood of getting Health problems in the future i.e. cancer, dementia, breathing or heart problems etc. prevention courses / materials linked to these services **Right Care, Right Time** • Improved awareness of health services in Hillingdon, including how and when to access services for the condition of concern • Better access to information in a range of languages and easy read for people with learning disabilities

T10. Transformation in Local Services

Key Strategic Health Outcomes and Actions	Strategic Intentions to 2021/22
By 2021/22 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 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 2021/22:** • 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 • 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	**Keeping People Well** • Continue to commission best practice pathways to ensure health outcomes are optimised, and deterioration in health is avoided, reducing the future demand on care. e.g. reduce presentation for people with a flare up of persistent pain • Integrating planned care pathways with MyHealth programmes to enhance prevention • Review and develop the role of diagnostics within primary care including testing of Clinical Decision Software (CDS) software for feedback to GPs on the results of tests. • A greater focus on work to tackle the wider determinants of health, intended to identify and manage risk. Taking a population-approach to prevention to ensure more sustainable planned care provision in future years **Right Care, Right Time** • Support long term plan 'hot' and 'cold' site model development at THHFT as appropriate to local conditions • Support and promote new approaches to planned care, including digital and e-clinics, as well as consultant led out-reach models that enable ongoing care in a non-acute setting to manage patients needing ongoing oversight of a consultant • Work with the voluntary sector to fully embed the Patient Activation Measures for musculoskeletal services and other priority areas to support stratified pathways of care and improve health and wellbeing outcomes • Continuing to commission shared care pathways to enable people with LTC to be seen closer to home in primary care, avoiding longer waits for specialist hospital services • Demand and capacity planning and optimised utilisation of available capacity to support RTT recovery and ensure care is provided at the right time • A greater focus on 'general surgery', in line with the NWL review of general surgery pathways, and colorectal procedures and treatments • Develop co-working with ICP partners on personalised elective care as part of 'rethinking medicine', and as part of the THHFT Outpatient Transformation Programme

T10. Transformation in Local Services (Cont'd)

Key Strategic Health Outcomes and Actions	Strategic Intentions to 2021/22
By 2021/22 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 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 2021/22:** • 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 • 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	• Support future planned care provision on a sustainable basis by implementing a unified referral access process for general practice and other referrers, ensuring referrals receive clinical triage and decision-making that supports the reduction of unnecessary appointments in specialist services • Implementing digital initiatives to provide more care via a digital network of care and support improving access, and reducing unnecessary admissions • Focus on outpatient transformation and best practice pathways to reduce unwarranted variation and maximise productivity and efficiency • Work with provider hospitals, to roll-out of interactive face-to-face training for staff, in shared decision making programmes that will develop professional skills and behaviours around personalised care and support planning, across the ICP • Embed effective mechanisms to enable people to exercise choice and control in elective care **Care at times of Crisis** • Enhancing access to MSK pathways through introduction of the FCP service in PCNs in 2020/2021 • Working with the NW London MSK clinical network to enhance access to care for people with persistent pain when setbacks or flare-ups occur and improve care provided in general practice for this complex cohort • Continuing to work with providers to identify opportunities to deescalate care from urgent care settings, redirecting suitable patients to planned care pathways • Providing more care via PCNs to improve access for people who require a quicker response to health needs, thereby stratifying care and reducing escalation to urgent care pathways • Planned care pathways will be designed to ensure that the drivers for urgent care attendances are understood via clinical audit and that alternate arrangements are made to avoid unnecessary hospital admissions

E1. Developing the Digital Environment

Key Strategic Health Outcomes and Actions	Strategic Intentions 2021/22
By 2021/22 we will be delivering the following outcomes: • Become paper free at the point of care across all services (subject to availability of sufficient capital funding from NHS England to automate 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 EOL care planning and digitally enabled self-care • Share and realise plans for use of real time data in decision making • Promote 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 • Clear information available to aid planning of services through BI and analytical systems fed by each provider • High utilisation of Shared Care Record across settings by provider clinicians, and promotion to patients by providers • Promote the use and sharing of information with the London Health and Care Information Exchange (CIE) to enable digital transfer of care between health care settings • IT systems take into account the ease of accessibility for users and those with a physical/learning disability **Key local aims to achieve by 2021/22** • 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: • Support automation of systems through NHSE capital funding projects toward becoming paper free in our primary, community and acute care services • Support services to embed digital technologies that enable transfer of care between healthcare settings, including ready access through user-interfaces to shared care records • Enable home-based technology • Improve access to shared care records to support integrated care • Help our partners and GPs to align their digital operating structures and processes so that these integrated, or align, to support share digital care and support plans between multi-disciplinary and multi-speciality teams within health and care organisations • Provide thought-leadership, planning and realisation for the implementation of real time data in decision making • Identify new assistive technologies and enable their use and integration into digital systems • Support development of Pan-London shared care records, whilst also deploying an interim solution to support emerging PCNs and ICIP/ICS to enable dataset read-ability between social services and healthcare settings and so enable more integrated care for patients • Implement system to enable extended viewing of datasets between SystemOne and EMIS software in community, mental health and primary care settings • Deploy an online consultation (triage & video consultation) offer in each practice working towards removing the need of up to a third of face to face visits • Provide patients with digital self-care and management tools such as apps, to empower them in managing their health conditions and associated wellbeing • Increase the use of digital tools to transform how outpatient service are offered, including more options for virtual appointments • Make better use of data and Digital technology, first by providing convenient access to services and health information for patients by standardising on the NHS app as the digital front door to provide access to digital tools and patient records, and to clinicians to support population health planning through intelligence and live analytics

E2. Creating the Workforce for the Future

Key Strategic Health Outcomes and Actions	Strategic Intentions 2021/22
By 2021/22 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 THHFT, 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 • 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) • 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 • 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 **Key local aims to achieve by 2021/22:** • 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: • Create quality and consistent ways of working in general practice for The Confederation membership and support practice teams to find the space and time to work better together • To transition local Vocational Training Scheme (VTS) GPs and nurses into primary care • Ensure all programmes continue to increase figures, skills and joined up working • We will share the workforce data with PCNs to support at scale collaboration to enable a more standardised offer that is easier to deliver at scale • Resource local practice managers groups for peer support in IT, HR and general business sustainability • We will package primary care roles in a standardised way, with recruitment material (on the Capital Nurse Portal) and wider portfolio offers that describe competencies, training packages and career pathway for staff • Offer supported, and sometimes targeted, recruitment of new staff into general practice including through apprenticeship programmes (ST3s, GPNs) • Target management skills at Practice Managers to lead the changes; upskilling nurses and HCAs to manage more of the patient caseload; upskilling 'medical assistants' and 'signposters' to deal better with the paperwork and non-clinical patient support • Establish inter-professional, multi-organisational and multi-HEI packages of student placements and apprenticeships for joint learning, including training hubs and peer support for multi-disciplinary forums, training and education within The Confederation membership • Create a targeted, multi-professional and multi-organisational pipeline of new staff for recruitment e.g. IPP pharmacists, physician associates and utilisation of regional apprenticeship programmes if and when required • Establish the Transition Academy to coordinate these activities and engender quality and consistency of staffing and general practice offer • The portfolio offers to include not just cross-practice, PCN and Confed roles, but also those that enable rotations of work with other HHCP partners where desirable

E3. Delivering Our Strategic Estates Priorities

Key Strategic Health Outcomes and Actions	Strategic Intentions 2021/22
By 2020/21 we will be delivering the following outcomes: • Working with local authority and health partners to deliver a Local Estate Strategy for Hillingdon • Support The Hillingdon Hospital acute estates approach **Key strategic actions to achieve these include:** • Better utilisation of existing estate taking into consideration triple integration of primary, community and mental health services delivered around Primary Care Networks (PCNs) • Reduce / eliminate any void space that exists within NHS Property Services and health providers estate • Dispose and reinvest into new fit for purpose premises • Continue to support the hub programme delivery within North Hillingdon, Uxbridge & West Drayton and Hayes and Harlington localities **Key local aims to achieve by 20/21:** • An estate portfolio that meets the needs of our residents for accessing services and clinics that has regard to geography and transportation	We will: • Deliver a local service primary care Hub in North Hillingdon by 2022/23 • Deliver a local service primary care Hub in the Uxbridge and West Drayton area by 2022/23 • Provide additional primary care capacity in the Yiewsley Area by end of 2020, including delivering support to the Estates Technology Transformation Fund (ETTF) improvements to Yiewsley Health Centre • Undertake a capacity study within the Hayes and Harlington locality based on projected future growth and need to deliver a new health primary care focussed facility This work will consider existing estate including HESA Primary Care Centre and future opportunities with the Old Vinyl Factory and Nestle sites • Deliver a new health primary care facility on a redeveloped Woodside development in 2020/21 • Invest in primary care infrastructure by supporting business cases made by practices for Improvement Grant applications and Estates Technology Transformation Fund applications • Implement a primary care estates solution to Heathrow villages in 2020/21 to provide additional local services • Support The Hillingdon Hospital strategic estates approach and the Long Term Plan hot/cold site opportunities, following the lead of partners • Enable a Hillingdon-wide strategic estates programme to support best use of estates and unused space with our ICP organisations, HHCP, and NW London ICS

E4. Delivering Our Statutory Targets Reliably

Key Strategic Health Outcomes and Actions	Strategic Intentions 2021/22
By 2021/22 we will be delivering the following outcomes: • Continued, consistent and sustained achievement of our mandatory and statutory targets for: 18 weeks RTT for elective care, cancer waits, A&E waits, and ambulance handover times • Incorporate and performance manage any changes emanating from the NHS Review of Access Standards **Key strategic actions to achieve these include:** • Continued focus on improvement in A&E Performance to reduce demand and implementation of resilience plans • To transform planned care elective services in line with ambitions in the NHS Long Term plan • Robust demand and capacity study undertaken around RTT, Cancer and Diagnostic Targets • Work with providers to achieve by 2020 the new 28 day faster diagnostic standard for cancer • Development of diagnostic capacity to meet demands and targets for Cancer pathways **Key local aims to achieve by 2021/22** • 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, LD and community services • Reduction in waiting lists and 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 to deliver an 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 promote patient choice and engage patients in decisions regarding their care pathways and experiences, actively listening and applying learning

E5. Medicines Management

Key Strategic Health Outcomes and Actions	Strategic Intentions 2021/22
By 2021/22 we will be delivering the following outcomes: • More effective medicines expenditure per capita including reduced wastage, taking into account growth in costs • Improved outcomes for people utilising medicines • Supporting patients self-manage their own care through greater awareness of the Over The Counter scheme • Clarify **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 • Continue initiatives to ensure Antimicrobial Stewardship by prescribers in general practice and across the interface, including the implementation and delivery of the government's new 5-year action plan on Antimicrobial Resistance • Continued support for prescribers regarding any national, local and NHSE prescribing guidance e.g. Items of low clinical value • Supporting new pathway development for prevention initiatives and to reduce health inequalities • On-going implementation of national, local and NHS E prescribing guidance • Continued support for new pathway development for prevention initiatives and to reduce health inequalities. • Further develop Integrated Care Partnership (ICP) pharmacy development – including workforce development and medicines management. **Key local aims to achieve by 2021/22** • Supporting in reducing unplanned admissions related to medicines • Increased use of skilled workforce e.g. specialised clinical pharmacists in GP practice setting • Pharmacy connection schemes will be implemented as per national guidance as a result of the national pilot schemes ending in March 2020	We will: • Continue the Interface Pharmacy pilot project – phase 2 implemented • Improve in and out of hours end of life medication pharmacy provision • Undertake domiciliary reviews by ICP pharmacy workforce • Strengthen pharmacy workforce integration between partner organisations • Deliver support and mentoring for Clinical Pharmacists in General Practice • Reduce incidence of harm through implementation of the PINCER project • Provide support for the STOMP/STAMP overprescribing for the learning disabilities programme • Support the Enhance Health in Care Homes programme with Medicines Optimisation in Care Homes Pharmacist (MOCH) • To reconcile medication of care home residents discharged from other settings to increase safety in prescribing • Deliver training and educating to care home staff to increase their understanding of medications needs of residents • When appropriate, promote reduction of drugs that are likely to cause kidney injury, antipsychotics in the elderly, anticholinergics, and harmful combinations of drugs, with a focus on care homes • Support practice staff with the self-care agenda • Continue to engage with CNWL and primary care to develop shared care protocols and guidance for prescribing mental health and learning disabilities medication • Deliver medicines management support for COPD Virtual Clinics in practices, Independent Pharmacist Prescribers in the Heart Failure, and the Multi-morbidity programme • Support reduction in antidepressant prescribing in adults and increased referrals to IAPT • Improved discharge and reduced readmission through established Interface systems and procedures • Strengthen integrated pharmacy teams as part of the Integrated Care Partnership

E6. Redefining the Provider Market – Our Integrated Care Partnership

Key Strategic Health Outcomes and Actions	Strategic Intentions 2021/22
By 2021/22 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 THHFT master planning exercise Key local aims to achieve by 21/22: • 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: • Operationalise and embed the current ICP programmes to implement population health and person-centred care models for the over 18 population by: ○ Extending active case management to the 15% of the adult population most at risk of a non-elective episode ○ Transforming the MSK pathway to enable more people to receive care closer to their home ○ A transformed Intermediate Tier with an emphasis on better same day emergency care ○ The implementation of a new clinical model for integrated care based on 8 Primary Care led Neighbourhood Teams aligned to the new Primary Care Networks with joined up physical and mental health care and aligned social care • Develop and Implement an agreed model of Integrated Care covering the whole population focusing initially on 2 key priorities; the redesign and implementation of new service models for Urgent and Emergency Care including Mental Health (building from the current partner approved HHCP IBC) and Planned Care. This will be enabled by the continued and accelerated development of 8 Primary Care led Integrated Neighbourhoods aligned with Primary Care Networks as the basic delivery vehicle for population health in Hillingdon. During **2020/21**, we will also focus on the essential development work necessary to meet national requirements regarding CYP

E6 Redefining the Provider Market – Our Integrated Care Partnership (Cont'd)

Key Strategic Health Outcomes and Actions	Strategic Intentions 2021/22
By 2021/22 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 THHFT master planning exercise Key local aims to achieve by 21/22: • 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	• Supporting the development of a SOC, OBC and FBC for a new local hospital in Hillingdon • Maintaining sustainable local organisations through partners working collaboratively • Develop a System Operational Plan (SOP) that addresses local priorities and the system deficit focussing initially on Urgent and Emergency Care and Planned Care • Implement a new governance framework and approach to Integrated Management across our ICP that supports the new models of care and the implementation of system priorities • Progressively implement a shadow 'ICP type' contract let in the first instance through a revised Alliance arrangement moving towards a Lead Provider model by April 2021 • Live within our means by moving towards a single budget for the Hillingdon system through the implementation of an agreed 'placed based' control total or another suitable alternative mechanism that will ensure the sustainability and viability of HHCP partner organisations going forward • To work closely with NWL ICS to align NWL programmes in HHCP work programme to ensure joined up working and outcomes

8. NW London Clinical Commissioning Group

8a. NWL wide-work

Across NW London, over 30 NHS organisations and local authorities are working together to improve health and social care through the joint Sustainability and Transformation Plan (STP) which will form the ICS. This plan is focusing on five areas to make the biggest and quickest positive impact on our residents' health. These areas are: **improving health and wellbeing, better care for people with long-term conditions, better care for older people, improving mental health services and safe and high quality and sustainable hospital services.**

NHS and council colleagues are joining-up efforts to prevent illness, to improve care for people with diabetes and those with mental health needs. Teams are working hard to provide services in more convenient locations in local communities, and to give older people a better experience of using care services through integrated and coordinated care. Other staff are also helping to recruit and retain the professional staff we need, to use our resources more effectively and modernise our IT systems. These improvements will sometimes change how patients currently use services and some will make it easier for them to receive care more quickly and conveniently. Other changes are needed so our staff can work better together.

8b. Planned Procedure with a Threshold (PPwT) and Individual Funding Request (IFR)

The NHS is required to improve the health and care of local populations within a limited and increasingly challenging financial budget. There are some treatments that are therefore not normally available on the NHS and there are some treatments are only funded if certain clinical thresholds to warrant treatment are met. These are called **Planned Procedure with a Threshold (PPwT).** This means we have to:

- Review the clinical reasons in exceptional individual cases;
- Examine the evidence for the safety and effectiveness of any treatment; and
- Assess and evaluate the current services and treatments we provide in order to continue to give patients the greatest health gains from the resources available.

As part of ensuring the most effective use of resources, standardisation of clinical practice and equity in access for patients, the PPwT portfolio of policies are commissioned across the eight CCGs in NW London. During 2019/20 PPwT policies have been reviewed and updated. The **NW London CCG Policy Development Group (PDG**) will be reviewing a number of local treatments with limited clinical value with a view to develop policies with access criteria for implementation in year 2020/21. In addition, NHS England, both National and London Region, have identified a series of policies that will also provide commissioning guidance for local CCGs to consider through local governance arrangements. These may supersede existing PPwT thresholds or add new policies to the current PPwT portfolio. The access for treatment will continue to be through a clinical authorisation route (PPwT form), or if the procedure or drug is not routinely funded, through the completion of an **Individual Funding Request (IFR) form.**
For more information on PPwT and IFR please refer to the web link: https://www.hounslowccg.nhs.uk/what-we-do/individual-funding-requests-and-ppwt.aspx

9. List of Abbreviations Used

Term	Meaning	Term	Meaning	Term	Meaning
A&E	Accident & Emergency	ED	Emergency Department	LA	Local Authority
AF	Atrial Fibrillation	EoL	End of Life	LAS	London Ambulance Service
BCF	Better Care Fund	ENT	Ear, Nose & Throat	LD	Learning Disability
BHH	Brent, Harrow, Hillingdon CCGs	FCP	First Contact Practitioner	LIS/LES	Local Incentive Scheme Locally Enhanced Service
CAMHS	Children & Adolescent Mental Health Services	FCT	Faecal Calprotectin Testing	LBH	London Borough of Hillingdon
CCG	Clinical Commissioning Group	FIT	Faecal Immunochemical Test	LIS/LES	Local Incentive Scheme Locally Enhanced Service
CHC	Continuing Health Care	FT	Foundation Trust	LNWH	London North West Hospitals NHS Foundation Trust
CHD	Coronary Heart Disease	FUP	Follow Up (Appointment)	LoS	Length of Stay
CIE	Care Information Exchange	FY	Financial Year	LTC	Long Term Conditions
CMC	Coordinate My Care	FYFV	Five Year Forward View	MDT	Multi-Disciplinary Team
CNWL	Central & North West London NHS Foundation Trust	GP	General Practitioner	MCA	Mental Capacity ACt
COPD	Chronic Obstructive Pulmonary Disease	GPN	General Practice Nurse	MH	Mental Health
COTE	Care of the Elderly	H4All	Hillingdon 4 All	MIU	Minor Injuries Unit
CQC	Care Quality Commission	HCCG	Hillingdon Clinical Commissioning Group	MMT	Medicines Management Team
CQG	Clinical Quality Group	HENWEL	Higher Education North West London	MSK	Musculo-Skeletal
CQRG	Care Quality Reference Group	HHCP	Hillingdon Health Care Partners	MS	Multiple Sclerosis
CRHTT	Crisis Response Home Treatment Team	HWB/HWBB	Health & Wellbeing Board	NEL	Non-Elective
CSE	Child Sexual Exploitation	IAPT	Improving Access to Psychological Therapies	NEPTS	Non-Emergency Patient Transport Service
CSPR	Child Safeguarding Practice Reviews	IBC	Integrated Business Case	NHSE	NHS England
CT	Computed Tomography	IBD	Irritable Bowel Disease	NICE	National Institute Clinical Excellence
CYP	Children & Young People	IBS	Irritable Bowel Syndrome	NWL	North West London
CVD	Cardio-Vascular Disease	IM&T	Information Management & Technology	OOA	Out of Area
DA	Direct Access	IPP	Independent Pharmacist Prescriber	OOH	Out of Hours or Out of Hospital
DES	Directed Enhanced Service	ICP	Integrated Care Partnership	PAD	Peripheral Artery Disease
DH/DoH	Department of Health	ICS	Integrated Care System	PCC	Primary Care Contract
DHR	Domestic Homicide Review	IT	Information Technology	PCN/s	{Primary Care Network/s
DNA/s	Did Not Attend/s	IUC	Integrated Urgent Care	PHB	Personal Health Budgets
DOLS	Deprivation of Liberty Standards	IV	Intravenous	PPE	Public & Patient Engagement
DTOC	Delayed Transfer of Care	JSNA	Joint Strategic Needs Assessment	PTS	Patient Transport Service

Term	Meaning	Term	Meaning	Term	Meaning
Pt/Pts	Patient/s	ZLOS	Zero Length of Stay		
PYLL	Potential Years Life Lost				
PH	Public Health				
QIPP	Quality, Innovation, Productivity & Prevention				
QOF	Quality & Outcomes Framework				
RBH FT	Royal Brompton & Harefield Hospitals NHS Foundation Trust				
RTT	Referral To Treatment				
SaLT	Speech & Language Therapy				
SAR	Safeguarding Adult Reviews				
SCR	Shared Care Record or Summary Care Record				
SI	Strategic Intentions				
SPA	Single Point of Access				
SSoC	Shifting Settings of Care				
ST3	(GP Registrar Year)				
STT	Straight-To-Test				
TB	Tuberculosis				
TCST	Transforming Cancer Services Team				
THH FT	The Hillingdon Hospital NHS Foundation Trust				
TIA	Transient Ischaemic Attack				
UEC	Urgent & Emergency Care				
UCC	Urgent Treatment Centre				
VTE	Venus Thromboembolism				
WTE	Whole Time Equivalent				

10. 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. Care UK
9. Central & North West London NHS Foundation Trust
10. Central North West London Mental Health Trust
11. Direct Healthcare Services
12. East & North Hertfordshire NHS Trust]
13. Egton MIG Healthcare Gateway
14. First Databank Europe Ltd
15. Frimley Park Hospital
16. Great Ormond Street Hospital for Children NHS Foundation Trust
17. Greenbrook Healthcare
18. Guy's & St Thomas' NHS Foundation Trust
19. Harlington Hospice
20. Hayes Cottage
21. Healthshare Ltd
22. Hertfordshire Partnership University NHS Trust
23. H4All
24. Hillingdon MIND
25. Imperial College Healthcare NHS Trust
26. Kingston Hospital NHS Trust
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. Moorfields Eye Hospital NHS Foundation Trust
35. North Middlesex University Hospital NHS Trust
36. NUPAS (formerly Fraterdrive Ltd)
37. Omnes Healthcare General Practice 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 Confederation, Hillingdon CIC (The Confederation)
47. The Hillingdon Hospitals NHS Foundation Trust
48. The Royal Marsden NHS Foundation Trust
49. The Whittington Hospital NHS Trust
50. Royal Trinity Hospice
51. University College London Hospitals NHs Foundation Trust
52. West Hertfordshire Hospitals NHS Trust
53. West London Mental Health NHS Trust

11. Hillingdon CCG Primary Care Networks

Name of Primary Care Network	GP Practices
HH Collaborative	HESA Medical Centre, Hayes Medical Centre, Glendale House Surgery, Kingsway Surgery, North Hyde Practice, Kincora Doctor's Surgery, The Cedarbrook Practice, Townfield Doctor's Surgery & The Warren Practice
Synergy	The Belmont Medical Centre, Central Uxbridge Surgery & The Medical Centre Brunel University
Celandine Health	King Edwards & Swakeleys Medical Centre, St Martins Medical Centre, Southcote Clinic, Wood Lane Medical Centre, Lady Gate Lane Medical Centre & Wallasey Medical Centre
Colne Union	Yiewsley Family Practice, The High Street Practice, Otterfield Medical Centre, The Medical Centre West Drayton
North Connect	Eastbury Surgery, Harefield Heath Centre, Carepoint, Mountwood Surgery, Acre Surgery & Acrefield Surgery
MetroCare	Cedars Medical Centre, Devonshire Lodge Practice, Oxford Drive Medical Centre, The Abbotsbury Practice, The Medical Centre Queen's Walk and Walnut Way Surgery
APPLICATION PENDING	Acorn Medical Centre, Parkview Surgery, Hillingdon Health Centre, Oaklands Medical Centre, Shakespeare Health Centre, Willow Tree Surgery, Pine Medical Centre, Yeading Court Surgery & Heathrow Medical Centre

** Two GP practices in Hillingdon are not part of a PCN; West London Medical Centre and Church Road Surgery.

NHS
Hillingdon
Clinical Commissioning Group