Joint Health and Wellbeing Strategy

Draft outline

HILLINGDON
LONDON

www.hillingdon.gov.uk

Contents

1. Introduction

The aim of Hillingdon's Joint Health and Wellbeing Strategy is to improve the health and wellbeing of all our residents and to reduce disparities in health and care across our communities.

All health and care partners in the borough share this vision and commit to working together to integrate health and care to improve services, to promote wellbeing, prevent ill health wherever possible and to support people when they do become unwell.

This, our Joint Health and Wellbeing Strategy 2022-2025, contains our plans for achieving this vision. Our integrated approach will address these priorities through:

- being driven by evidence and data
- strengthening community capacity and resilience
- building effective integrated teams
- moving resource to where it will have most impact
- using joined up information and aligning governance
- effective management of our quality and performance.

The delivery of this strategy between 2022 and 2025 will also be shaped by the Health and Care Bill currently proceeding through Parliament and the anticipated government's proposals for adult social care.

2. Background

Hillingdon is the second largest of London's 32 boroughs covering an area of 42 square miles over half of which is a mosaic of countryside including canals, rivers, parks and woodland, interspersed with historic towns and villages. The borough is well served by a network of tube and rail links, especially into central London. The far south of Hillingdon is dominated by Heathrow Airport and the transportation infrastructure and hospitality services which support it. The Hayes area together with Yiewsley and West Drayton are more urban in nature. Uxbridge provides a metropolitan shopping centre and Tube line terminus and is home to Brunel University.

Our overall population is diverse and growing and people are living longer. It includes more affluent areas (within the top 20% nationally) as well as areas of deprivation (within the lowest 20% nationally).

Hillingdon enjoys many characteristics that makes taking a joint approach to meeting the health and wellbeing needs of our population less of a challenge than for some other areas. We have a single local authority, one acute hospital trust with two sites in the borough, a GP confederation that includes 43 of the borough's 45 practices, a single community health and community mental health provider and an established consortium of the five larger third sector organisations in the borough.

These local advantages, and our record of joint working, enabled Hillingdon to respond quickly to the demands of the COVID-19 pandemic. Together we delivered many changes, including providing more services over the phone or online, setting up joint health and care teams to provide care for people in the community to avoid emergency admissions, increasing capacity in key services such as rapid response, discharge to assess, reablement and home care to speed up the discharge of people from hospital back to their own home. Through joint work we have also helped the local care market to be more stable throughout the COVID-19 emergency.

Across our health and care system we have supported families and communities to access services they need. Our Community Hub worked closely with established foodbanks to meet emergency needs and has helped over 2,000 with food support. During the pandemic we made direct contact with over 18,000 residents who were deemed clinically extremely vulnerable to ensure that they had access to support needed. Through our partnership with the voluntary sector, we have referred residents so that they received emotional and practical support such as befriending and shopping. We have also engaged directly with over 150 local faith and community groups to promote the take up of COVID-19 vaccinations and to listen to views across our population.

3. Health and care challenges in Hillingdon

Hillingdon's Joint Strategic Needs Assessment (JSNA) identifies the key health and wellbeing needs of people in Hillingdon. It is regularly updated with the latest available information to help us respond to the changing needs of our population. For more information see www.hillingdon.gov.uk/jsna.

On average, people in Hillingdon live longer and healthier lives compared to the rest of England. Data shows that:

Life expectancy and life chances

- Overall life expectancy in Hillingdon compares well with the national average.
- The number of years men can expect to live a healthy life, free from disability or poor health also compares well, but the figure is lower for women.
- The degree of variation in life expectancy across different areas within the borough is low for both men and women.
- Inequality in life expectancy for men and women in Hillingdon compares favourably nationally and regionally.

The evidence on life chances is also generally good:

- The proportion of children under 16 living in low income families is lower than the regional and national averages.
- Educational attainment is influenced by both the quality of education children received and family socio-economic circumstances. The average attainment score for pupils in Hillingdon at Key Stage 4 is higher than the national average and broadly the same as in London.
- Levels of employment affect life chances, and the proportion of working age people in employment in Hillingdon during 2019/20 was only slightly below the London and England average.

We know however that there are many existing health challenges which need to be addressed. We know that in Hillingdon, compared to the national average:

- The mortality rate from all cardiovascular diseases is higher.
- The percentage of cancer diagnosed at early stage is lower.
- Physical activity among adults is lower.
- Smoking prevalence in adults is higher, including adults in routine and manual occupations.
- The incidence of tuberculosis is higher.
- The increase in overweight and obese children between ages 4 and 5 and 10 and 11 is higher.
- The dental health of children is worse.
- Admission to hospital for alcohol-related conditions is higher, including for women over 65.
- Our rate for hospital admissions due to asthma were worse than the England average.

We also know that we need to ensure more support is available from services to support people to take control of their own health and to address the problems caused by long-term conditions including poor cardiovascular health, dementia, diabetes, learning disabilities, mental health, and 'Post Covid'.

The evidence also shows that Hillingdon has several persistent health challenges, which we will wish to address, particularly:

- inequalities in life expectancy and life chances
- obesity

- child dental health
- cancer prevention, detection and survival
- long-term conditions, cardiovascular health, dementia, learning disabilities, mental health, and 'Post Covid'.

Key indicators for Hillingdon's population are:

Inequalities

- Life expectancy in Hillingdon is estimated at 80.8 years for males and 83.8 years for females (data from 2015 to 17). There are inequalities within the borough at ward level - based on 2013-17 data, the gap in male life expectancy between Eastcote and East Ruislip and Townfield wards is 7.2 years and the gap in female life expectancy between Eastcote and East Ruislip and Botwell is 3.7 years.

An ageing population

- Over the next five years to 2025, the population in Hillingdon will increase by 7% with the over 65 population growing by 11%. As people age, the likelihood of them developing long-term conditions, and requiring hospital and other long-term care intervention increases.

Carers

- The 2011 census showed that there were over 25,000 carers in Hillingdon providing unpaid support. The census also showed that 18% of unpaid carers were aged 65 and over and that approximately 10% of carers were aged under 25, which emphasises the continuing importance of supporting carers of all ages. An impact of the COVID-19 pandemic is likely to be an increase in the number of carers in Hillingdon and it is expected that data from the 2021 census will support this.

Long term conditions (LTCs)

- 34,000 people in Hillingdon are known to have one or more long-term conditions. 51% of people in Hillingdon over the age of 65 state that their day-to-day activities are limited (either a little or a lot) by LTCs. This figure rises to 82% for those aged 85+.
- An estimated 9,854 people aged 65 and over had conditions which limited their activities a lot in 2020. A further 10,392 within this age group had long-term conditions that limited their daily activities a little in 2020 and it is expected that these needs will increase as the population group ages.
- Local Hillingdon data analysis shows that 50% of all adult social care activity, 50% of all emergency admissions to Hillingdon Hospital, 51% of all first hospital outpatient appointments and 70% of all outpatient follow up appointments are utilised by just 5,500 people (3% of the adult Hillingdon population). These are local people with one or more unstable long-term conditions.

Cardiovascular health

- Deaths from cardiovascular diseases are slightly above the national and regional averages. The rate for men aged under 75 is significantly higher but is lower for women.
- However, the mortality rate from cardiovascular disease for people age over 65 is high.
- Hospital admissions for alcohol-related cardiovascular disease are high, for both men and women.

Alcohol

- Admission to hospital where alcohol was the main or a contributing factor is slightly below the national average in Hillingdon but is above the London average.

Smoking

- The prevalence of smoking is below the national and London averages, but the numbers of people setting a date to quit smoking and numbers who quit successfully after four weeks is below average.

Mental health

- In 2020 an estimated 36,282 people were predicted to have a common mental health problem such as depression, anxiety, or OCD. 3,597 people over 65 were estimated to suffer from depression, and 1,147 from severe depression.
- The Quality Outcomes Framework records 2,640 patients diagnosed with mental health disorders (schizophrenia, bipolar disorder and other psychoses) on GP registers in Hillingdon in 2019/20, which is 0.81% of the GP register population. This is lower than the London average and lower than the average for England.

Dementia

- An estimated 3,033 people aged 65 or over in 2020 are likely to have dementia.
- GP registers record a lower figure. The Quality Outcomes Framework recorded 1,996 patients diagnosed with dementia on GP registers in Hillingdon in 2019/20, 0.63% of the GP register population. This is above the London average for GP observed prevalence of dementia but lower than the national average.

Learning disabilities

- Estimates indicate that there were 4,714 adults aged 18 to 64, plus 874 aged 65 or over, with learning disabilities living in Hillingdon in 2020.

Autism

- Estimates suggest that in 2020 there were 1,953 people aged between 18 and 64 living with autistic spectrum disorder (ASD) conditions and a further 396 aged 65 and above.

Cancer prevention, detection, and survival

- Figures for 2017 suggest that around 50% of cancers are diagnosed at an early stage in Hillingdon.
- Premature deaths from cancer are below the national average but are higher than the London average.
- Cancer screening coverage for breast and bowel cancers is below the national average but is similar to the rest of London.

Obesity

- 65% of adults in Hillingdon are classified as overweight or obese.
- Physical activity among adults remains low, with 31% of adults classed as physically inactive.

- Obesity among school-age children at both Reception and Year 6 is too high. Around one in five children at Reception Year are classified as overweight or obese. By Year 6 the proportion has increased to one in three.

Child dental health

- Nearly a third of children aged five in Hillingdon are reported to have visible tooth decay, which is higher than less than a quarter nationally.

Tuberculosis

- The three-year incidence of tuberculosis remains higher than average, at 23.4 per 100,000

Post Covid

- We know that the lasting effects of COVID-19 are still being felt. A disproportionate impact of COVID-19 infections and mortality rates have been seen amongst certain groups such as BAME communities and those from more deprived backgrounds. We will ensure that there is local support for suffers of the longer-term effects of COVID-19.

4. Partnership achievements: Our story so far

We have a history of strong partnership working in Hillingdon both between the different organisations within the NHS and between these bodies and the Council. Since 2015 this has been enhanced by the Government's Better Care Fund (BCF) initiative and then, from early 2020, impacted by the COVID-19 pandemic response.

Our main achievements resulting from partnership working include:

- **Creation of an Integrated Care Partnership (ICP)** – Known as Hillingdon Health and Care Partners (HHCP), Hillingdon's ICP was one of the first to be created in the country. Its purpose was to bring organisations together to improve efficiency and effectiveness through a reduction in duplication and better use of resources in order to produce better outcomes for residents and manage demand. HHCP comprises of the GP Confederation, the Central and North West London NHS Foundation Trust (CNWL), The Hillingdon Hospitals NHS Foundation Trust (THH) and the third sector consortium known as H4All. The latter includes Age UK Hillingdon, Carers Trust Hillingdon, the Disablement Association Hillingdon, Harlington Hospice and Hillingdon Mind. An alliance agreement between these organisations determines how decisions are made.
- **Creation of Primary Care Networks and Neighbourhood Teams** – Six Neighbourhood Teams were set up in September 2020. These are coterminous with the six Hillingdon Primary Care Networks. The PCN/Neighbourhoods were the basic building block of our collective response to COVID-19. Achievements included:
  - Co-ordination and delivery of COVID-19 Vaccination Programme.
  - Implemented zoned COVID-19 positive (Hot) and COVID-19 negative (Cold) facilities for managing patients face to face.
  - Closer working with the third sector including the volunteer hub to support third sector partners and volunteers in the borough.
  - Developed an integrated shielded and vulnerable person management function with all partners – in order that patients have one personalised care plan and one key worker across health, social care and volunteers.
  - Implemented an integrated COVID-19 response hub including: a domiciliary visiting service, remote home-based monitoring of people with respiratory conditions (including using oximeters) and testing all patients in hard to reach community settings who need to be tested in a familiar setting (LD, supported living, children).
- **Active case management** – A single Care Connection Team for each PCN/Neighbourhood (six in total) was put in place from September 2020 to manage the people most at risk of a planned outpatient intervention or an emergency admission. The teams identify people from GP practice populations who typically have one or more complex or unstable long-term conditions usually with underlying mental health challenges and social care needs and who are more likely to live in poorer neighbourhoods. A package of care is put together by the team to maintain them at home for as long as possible.
- **Establishing the High Intensity User Service** - By directing support to the top fifty most frequent attenders at Hillingdon Hospital this service has managed to reduce attendances and emergency admissions amongst this group by 38% and 51% respectively.
- **Establishing the Care Home Support Service** - This multi-disciplinary service comprising of GPs, nurses and therapists, provides daily calls to care homes for older people and weekly calls to people with learning disabilities and/or mental health needs. Working closely with the council's Quality Assurance team, the intention is to provide clinical advice and support to care homes to avoid unnecessary demand on the London Ambulance Service (LAS) and avoidable

attendances at A & E. The new service has reduced ambulance call outs from care homes by 5% and emergency admissions by 13%. This service also supports the council's four extra care sheltered housing schemes and is now based in one of them, Grassy Meadow Court.

- **Supporting the care market** - Close working between the council, HHCP and the North West London Clinical Commissioning Group (NWLCCG) has resulted in targeted infection prevention and control information, advice and training being delivered to care home and homecare providers that has assisted in maintaining key services during the pandemic.
- **Reformed "intermediate tier" services** – These services support timely discharge from hospital and the prevention of admission and the last 12 months has seen the following changes introduced:
  - Establishment of a discharge hub to improve patient flow from the Hillingdon Hospital including integration of our community and discharge teams (HHCP and the council).
  - Establishment of an Integrated Urgent Response Hub to manage the needs of people requiring an urgent two-hour response in the community to avoid unnecessary attendances at A & E and emergency admissions.
  - Enhanced bridging care capacity delivered by an independent sector provider has meant that we have been able keep more people out of hospital in a crisis.
  - The repurposing of flats within an extra care scheme for use as intermediate care has supported early discharge from hospital and prevented admission.
- **Transformed Outpatient Services** – The implementation of digital advice and guidance to GP surgeries from specialist hospital consultants at Hillingdon Hospital and the use of video as opposed to face-to-face appointments where clinically appropriate has reduced unnecessary outpatient referrals to the hospital by 29%.
- **Integrated therapies for children and young people (CYP)** – Contractual arrangements for the provision of therapies to CYP with special education needs and disabilities (SEND) were brought together into a pilot single service focussed on triage and early intervention.

5. Our priorities for 2022 to 2025

Our joint plan is intended to enable us to deliver on the following six priorities between 2022 and 2025:

- **Priority 1:** Support for children, young people and their families to have the best start and to live healthier lives.
- **Priority 2:** Tackling unfair and avoidable inequalities in health and in access to and experiences of services.
- **Priority 3:** Helping people to prevent the onset of long-term health conditions such as dementia and heart disease.
- **Priority 4:** Supporting people to live well, independently and for longer in older age and through their end of life.
- **Priority 5:** Improving mental health services through prevention and self-management.
- **Priority 6:** Improving the way we work within and across organisations to offer better health and social care.

6. Delivering our priorities: What we will do

Appendix 1 sets out the delivery plan actions required to deliver our priorities and sets out the metrics that will enable us to monitor and measure that a difference is being made to the lives of our residents and to the sustainability of Hillingdon's health and care system.

Delivering our priorities

Priority 1: Support for children, young people and their families to have the best start and to live healthier lives

We know that the first year of life can have a huge impact on the health and wellbeing of an individual and that family and environmental factors will impact on the overall health of a child.

We have redesigned our offer of early help and prevention for families, and teams will adopt a multi-agency, locality approach to support children at the earliest possible stage by working closely with partners across Hillingdon in services for young people.

A new Stronger Families service launched in August 2021 that will engage families earlier and provide long-lasting solutions to ensure a safe, stable and nurturing environment in which children, young people and parents can thrive. The introduction of a unique Stronger Families 'hub' will offer a wide range of information, advice and support 24 hours a day, seven days a week.

Key actions will also seek to reduce the levels of obesity in our young children. We wish to see the increase in levels of overweight and obesity recorded at Reception, through the National Child Measurement Programme of currently over one in five, and at Year 6 (currently over one in three) reduced. Our Child Healthy Weight Plan seeks to work across partners, especially schools, to improve diet and nutrition and to increase levels of physical activity. We will promote greater uptake of breastfeeding. We will work to see the levels of tooth decay reduced. We will also work to reduce smoking in families.

We will consolidate the integration of therapy services for children and young people (CYP) to redirect resources into early intervention and address unmet need through the reduction of duplication, the rationalisation of bureaucratic processes and embedding integrated triage and intervention teams.

Priority 2: Tackling unfair and avoidable inequalities in health and in access to and experiences of services

We will take a stronger evidenced based approach to identifying inequalities in Hillingdon and engage directly with our communities to understand how we can support their health and wellbeing. We will undertake, through collaboration with Brunel University, a new approach to our Joint Strategic Needs Assessment so that it not only provides an accurate picture of health in the borough but supports thinking as to how we can meet future needs and reduce health inequalities. This work will provide our evidence base to guide decisions for our public health programme and to tackle inequalities.

We will expand the scope of our model of care to support people with learning disabilities and/or autism at a neighbourhood level.

We will help to improve the life chances of people with learning disabilities and/or autism through increased integration between health and social care.

Informal carers are crucial to the sustainability of Hillingdon's health and care system and many people undertaking a caring role do not recognise themselves as carers. As a partnership we will increase the opportunities for people undertaking an unpaid caring role to be identified and

ensure access to the support that will enable them to continue caring for as long as they are willing and able to do so.

Priority 3: Helping people to prevent the onset of long-term health conditions such as dementia and heart disease

Cardiovascular disease and cancers are two of the main causes of death in Hillingdon, particularly in the 65 and over population. Actions to address the causes or contributors to these conditions, such as obesity, smoking and reducing alcohol consumption will assist in enabling our population to live longer and healthier lives. Increasing early detection will also facilitate early treatment and increase survival rates.

Vascular dementia is a type of cardiovascular disease and the actions taken to prevent other forms such as heart disease and stroke, would also apply. The promotion of a balanced healthy diet, keeping weight within recommended levels, keeping hydrated, stopping smoking, avoiding drinking too much alcohol and keeping cholesterol and blood pressure under control are all actions that will assist in stopping, or at least delaying, the onset of Alzheimer's disease, which is the main form of dementia. Increasing rates of detection also ensures access to early treatment and appropriate support networks.

Priority 4: Supporting people to live well, independently and for longer in older age and through their end of life

The focus of this priority is the 65 and over population. During the lifetime of the strategy, partners will further embed neighbourhood working to identify people most at risk of losing their independence and ensure timely access to services that will prevent avoidable attendance and/or admission to hospital. This will include addressing risk factors such as susceptibility to falls and loneliness deriving from social isolation.

We will further develop services to prevent a hospital admission where possible and expedite discharge where it is not or where an admission is appropriate to address medical need.

Taking into consideration the projected expansion in the older population during the lifetime of this strategy and beyond, we will plan for future retirement accommodation provision to address the future expected range of need.

For people who are on the end of life pathway, dying in hospital may not be their preferred choice. We will improve end of life services to ensure that people who wish to die in their own home rather than hospital are able to do so.

We will continue to support older people to live well through social activity programmes and support to voluntary and community groups.

Priority 5: Improving mental health services through prevention and self-management

Our aim is to ensure that people with mental health needs including learning disabilities and/or autism are able to live longer healthier lives.

We will expand the scope of the new model of care to support people living with mental health challenges and/or people with learning disabilities and/or autism at a neighbourhood level.

We will work across partners to offer support early to prevent crisis but also to ensure that should crisis occur we have the right response in place to provide timely and appropriate support. We will offer a range of crisis alternatives to support both early intervention and those going through crisis. We will widen the offer of community support availability with the development of mental health and remodelled community mental health teams including primary care, additional roles reimbursement scheme.

We will work with partners to prevent suicide in Hillingdon and to offer support to those who are bereaved.

Priority 6: Improving the ways we work within and across organisations to offer better health and social care

This priority concerns the key enablers upon which delivery of the other five priorities are dependent. The enablers are:

- **Care market management and development:** 92% of the council's spend on care and support services for adults is with independent sector providers. NHS spend on care home and homecare provision is much lower than the council's, but the same providers tend to be used. The sustainability of the independent sector care market is of critical importance to residents remaining independent in their own homes and to managing demand on more expensive services, which includes in-patient hospital services.

  Examples of what we will do include:

  - We will embed adult social care provider engagement arrangements to identify and address provider issues, including access to guidance and sharing good practice. Provider fora and weekly newsletters are examples of how this will be done.
  - We will review our integrated approach to adult social care provider risk management arrangements to ensure timely and appropriate interventions where required.
  - We will secure agreement on long-term brokerage arrangements to simplify systems for providers and improve understanding of market capacity.
  - We will coordinate a local response to COVID-19 outbreaks in care homes and supported living schemes.
  - We will establish and implement lead commissioning arrangements to address local health and care system care home placement requirements.
- **Digital and business intelligence led improvements:** This is about better use of data to improve understanding of need, capacity and pressure points and increasing efficiency and effectiveness through the use of digital assistive technologies, such as telecare in people's homes and remote monitoring equipment in care homes.

  Examples of what we will do include:

  - We will maximise opportunities for sharing relevant activity data to ensure that there is understanding across the health and care system of capacity and pressure points and required interventions.
  - We will promote the roll out of the nationally recognised advanced planning tool Coordinate My Care (CMC) in care homes.
  - We will embed remote consultation technology in care homes to facilitate access to timely advice from health and social care professionals.
  - We will establish a remote vital signs, e.g., blood sugar level, blood pressure, respiratory rate, temperature, etc., monitoring pilot in care homes to facilitate early intervention by the relevant health professionals.
  - We will promote the use of telecare technology to support the independence of residents.
- **Workforce development:** The availability of a suitably trained workforce is crucial to the delivery of the services required to support the independence and wellbeing of residents both within the independent sector provided care market and within HHCP. This enabler considers how early warning systems will provide alerts to possible capacity issue within the independent sector as well as the development of workforce development plans within and across HHCP.

Examples of what we will do include:

- We will complete and implement a HHCP integrated community workforce plan.
- We will monitor staff vacancy and retention levels among adult social care providers and identify possible interventions to provide support where there are issues.

- **Delivering our strategic estate priorities:** This enabler ensures that most effective use is made of existing NHS or council owned assets to meet the current and future health and wellbeing needs of residents.

  An example of what we will do is:

  - We will review council and NHS owned assets and explore the scope for meeting current and future population and health and care system needs.

Our model of care

The delivery of the above priorities is underpinned by the ways in which we work, or our "model of care" based on neighbourhood working. The cornerstone of the model is the implementation of a fully integrated health and care system through the six Neighbourhood Teams.

Hillingdon's model sets out to:

1. Boost 'out-of-hospital' care and remove the distinction between primary (GP based) and community health services.
2. Redesign and reduce pressure on emergency hospital services.
3. Give people more choice and control over their own care, regardless of whether this is health or local authority funded. This includes through more personalised options, such as Personal Health Budgets.
4. Make digitally enabled primary and outpatient care mainstream.
5. Enabling people to live as independently as possible in the least restrictive, least supported care setting appropriate to meet their needs and wishes.

Key components of the model of care include:

- **Integrated Primary Care Networks (PCNs)/Neighbourhood teams** – Neighbourhood teams are working with Primary Care Networks to meet the needs of people in their neighbourhood through active case management.
- **Expanding Active Case Management** – Neighbourhoods actively manage the top 15% cases within their population based on the level of need and the support required. Some of the key neighbourhood interventions include:
  - The extension of Care Connection Teams (CCTs).
  - Continuation of the support service for frequent attenders at A & E.
  - Enhanced support to care homes through the Care Home Support Service.
  - Development of support for people with mental health needs.
  - A revised approach to delivering end of life services.
- **A reformed Intermediate Tier** - The Intermediate Tier includes a range of short-term services, i.e., up to six weeks, intended to support independence by promoting faster recovery from illness, preventing unnecessary emergency hospital admissions and attendances and premature admission to long-term residential care. Examples include rapid response, rehabilitation and reablement and short-term homecare to enable home-based assessments to take place, thereby reducing unnecessary stays in hospital.
- **Transformed Outpatient (Planned) Care** – Transforming outpatient care to reduce the number of unnecessary hospital interventions by investing in primary and community care

alternatives, maximising the opportunities presented by the rapid digitisation of health during the COVID-19 pandemic and through the active case management by PCN/Neighbourhoods of the 5,500 patients most at risk of a hospital outpatient intervention.

- **Hillingdon Hospital redevelopment** – Subject to all necessary approvals being obtained, a new hospital will be opening on the existing THH site within the lifetime of this strategy. The new build will reflect modern practices, including the use of technology and form an essential part of Hillingdon's health and care system.
- **Integrated commissioning arrangements** - Lead commissioning arrangements between the council and NHS partners are agreed where this will lead to better outcomes for residents and the health and care system. The commissioning of homecare services, a hospital discharge bridging care service known as D2A, nursing care home placements, community equipment and integrated therapies for children and young people are examples of where lead arrangements have been agreed.

7. Delivering our priorities: Monitoring delivery

Six workstreams have been created to deliver the priorities. The workstreams and the priorities featured within their scope are shown below.

- Workstream 1: Neighbourhood Based Proactive Care — Priorities 2,3,5 and 6.
- Workstream 2: Urgent and Emergency Care — Priorities 2,3, 5 and 6.
- Workstream 3: End of Life Care — Priorities 3, 4 and 6.
- Workstream 4: Planned Care — Priority 3 and 6.
- Workstream 5: Care and support for Children and Young People — Priority 1 and 6.
- Workstream 6: Care and support for People with Mental Health challenges (including addictions) and/or People with Learning Disabilities and/or Autism — Priorities 2, 5 and 6.

Each workstream is led by a transformation board with a senior responsible officer (SRO) who holds an executive level position within HHCP or the council. The transformation boards have responsibility for project managing the implementation of the delivery plan actions shown in Appendix 1. The boards also have responsibility for monitoring performance against the metrics shown in Appendix 1. Monthly performance reports are considered by the HHCP Delivery Board and quarterly progress updates by the Health and Wellbeing Board. The latter is jointly chaired by the council's Cabinet Member for Health and Social Care and HHCP's Managing Director.

The cross-cutting nature of priority 6 means that the implementation of related delivery plan actions shown in Appendix 1 impacts on all of the workstreams. Accountability for this aspect of the delivery plan sits with the Integrated Care Executive, which includes as its members the Corporate Director for Social Care and Health from the council, the Hillingdon Joint Borough Directors from NWL CCG and the Managing Director for HHCP.

Appendix 1: Key Outcome Metrics: Joint Health and Wellbeing Strategy

Priority 1: Support for children, young people and their families to have the best start and to live healthier lives.

Delivery Plan Actions	Place Based (Outcome) Metrics	Service (Lead) Metrics
• Transform the support offered across partners to families and children to promote healthy weight and reduce obesity	• Percentage of term babies with low birth weight (under 2.5kg) • Levels of overweight and obesity in CYP at Reception and Year 6 • Hospital admissions for tooth decay in under 5s • Percentage of physically active CYP	• Improve take up and continuance of breastfeeding (to stage 3 of Unicef healthy baby standard) • Reduce the increase in levels of overweight or obese children under the NCMP at Reception and Year 6 • Improve level of tooth decay in under 5s to the national average
• Develop a strong universal offer to ensure that CYP enjoy good physical, mental and emotional health	• School readiness at end of Reception • Children in absolute and relative low-income families • Age-standardised avoidable, treatable and preventable mortality rates in children and young people (aged 0 to 19 years) by sex • Children in need due to family stress or dysfunction or absent parenting: rate per 10,000 children aged under 18 • Children in need due to abuse or neglect: rate per 10,000 children aged under 18 years • D&A and substance misuse under 18	• Achieve national targets for waiting times for Eating Disorder services • Meet national targets for CYP immunisation and vaccinations uptake rates (95% herd immunity) • 35% of CYP with diagnosed MH condition seen by NHS funded community mental health services • Percentage of patients treated within 18 weeks of referral to CAMH services
• Implement the long-term new integrated therapies pathway model for CYP	• Percentage of children with a disability or long-term limiting illness	• 85% of referrals (reviewed by the MDT Panel) with referral decision communicated to the referrer within two weeks

• Work with schools and families to improve participation, inclusion and attendance to drive up levels of attainment	• Pupil absence • Levels of school attainment including children not in school • Indicator on positive activity?	• Support families sooner through new family hubs • Numbers of children out of school • Numbers of looked after children (LAC)
• Support CYP and families experiencing SEN, LD and autism to ensure needs are met and the child's development is supported	• Number of CYP with EHCP in employment, education or training	• Numbers of EHC Plans • Timeliness of EHC Plans

Priority 2: Tackling unfair and avoidable inequalities in health and in access to and experiences of services (learning disability issues covered in priority 5)

• Undertake a Public Health review of disparities and inequalities in Hillingdon and recommend actions	Note: Metrics on this action will be agreed following completion of the next iteration of our JSNA with a strong focus on inequalities. • Life expectancy at birth by neighbourhood	• Levels of disparity in health and care services • Levels of disparity across wider determinants of health • Levels of disparity at neighbourhood level
• Ensure that all patients have fair and equal access to services, starting at the local level in Primary Care Networks and proactive approaches to wellbeing	• The rate of unplanned hospitalisations by neighbourhood per 100,000 weighted for population and need • The rate of unplanned hospitalisations per 100,000 by neighbourhood by ethnic group • The rate of referrals per 100,000 moving to MH recovery by ethnic group (IAPT) by neighbourhood	• Develop neighbourhood plans to tackle local inequalities • 95% of YP will have a documented care plan in place on handover to adult services/leaving care (taken from new Hillingdon Transitions service specification)
• Reduce barriers to employment for adults with SEN, LD or autism and support people to access opportunities	• Levels of employment, education or training in adults with SEN, LD or autism	• Percentage of people with learning disabilities known to services in a) Part-time education; b) Training; c) Voluntary employment; d) Paid employment
• Reduce homelessness	• Number of homeless people	
• Tackle violent crime by reducing and preventing domestic abuse, supporting victims and reducing and preventing knife crime	• Levels of knife crime • Youth violence incidents • Levels of first-time offenders/reoffenders • Domestic abuse reported	• Youth justice strategic partnership action plan and dashboard

• Ensure mechanisms are in place to identify and support carers to enable them to continue in their caring role	• Carers' quality of life outcomes	• Deliver against carers strategy targets • Percentage of carers on the Carers' Register • Support for young carers

Priority 3: Helping people to prevent the onset of long-term health conditions such as dementia and heart disease and to successfully manage the impact of LTCs on their daily life

• Improve levels of prevention, detection and survival for: - cancers - cardiovascular disease - dementia - COVID-19 and Long Covid - alcohol and substance misuse	• Under 75 mortality rate from cardiovascular disease by neighbourhood	• Number of emergency admissions to hospital bed by neighbourhood • Number of ED attendances by neighbourhood.
	• Cancer prevalence per 100,000 population by neighbourhood	• Percentage of suspected cancer patients seen within two weeks by a specialist by neighbourhood
	• Dementia diagnosis rate by neighbourhood	
	• Percentage of people in Hillingdon stating that their day-to-day activities are limited (either a little or a lot) by LTCs • Screening rates • Obesity rates • Physical activity • Smoking cessation levels • Drug and alcohol misuse levels • Patient education/self help	• Elective care: Percentage of patients treated within 18 and 52 weeks of referral by neighbourhood • Elective care: Number of new and follow up attendances by neighbourhood compared to target

Priority 4: Supporting people to live well, independently and for longer in older age and through their end of life

• Embed PCNs and neighbourhood approaches to population health management (HIU, CEV list, care homes etc) BCF W1	• The rate of unplanned hospital admissions for adults with chronic ambulatory care sensitive conditions by neighbourhood	• Percentage of people in receipt of short-term services who achieved their agreed outcomes and require no further ongoing support

• Develop urgent and emergency care and end of life support (BCF W2)	• The rate of emergency admissions for Hillingdon people aged 65+ with a stay of <24 hours by neighbourhood • Percentage of deaths occurring in a hospital bed by neighbourhood v regional and national averages	• Proportion of people on an end of life pathway on CMC who achieved their preferred place of death per neighbourhood
• Determine capacity requirements for intermediate tier provision, i.e., D2A and step-down/ step-up, to support hospital discharge and admission prevention and implement	• Number of permanent admissions aged 65+ to care homes • Percentage of people aged 65 and over discharged to reablement still at home 91 days later • Percentage of reablement users discharged requiring no ongoing long-term service	• The proportion of Hillingdon residents aged 65+ in hospital for more than 10 days by neighbourhood
• Work with the voluntary and community sector to support people to live well, remain independent and to reduce loneliness	• Falls prevention • Care homes • Re-admission rates to hospital by neighbourhood	

Priority 5: Improving mental health, learning disability and autism services through prevention and self-management (learning disability issues covered in priority 2)

• Support people to remain in the community by reconfiguring community mental health services to provide MH expertise in primary care	• Gap in the employment rate for adults known to MH services v overall adult population • Life expectancy for people living with mental illness (and by neighbourhood)	• Reduce delayed transfers of care • Reduce acute length of stay. • Increased support to self-manage • Increased MH support in the community • ARRS roles recruited to • Further ARRS KPIs determined • Reduction in high intensity users
• Implement roles in primary care arising from the Additional Roles Reimbursement Scheme (ARRS)		
• Complete transition of Community Framework Transformation to a hub model		

• Ensure universal and mental health services make reasonable adjustments for people with autism • Implement crisis and short-term intensive support teams for people with autism	• Implement the requirements of the Autism Strategy published in July 2021	• Reduction in adult assessment waiting times • Increased support for people newly diagnosed with ASD • Dynamic Support Register in place • Reduction in hospital admissions to make medication changes • Reduction in avoidable deaths
• Develop a collaborative approach to improve services for people who misuse drugs and alcohol and are mentally ill	• Streamline the MH pathway • Adults in contact with secondary MH services living in stable and appropriate accommodation	• Reduction in re-admissions rate • Reduced acute MH length of stay • Increased support to people to self-manage
• Remodel the MH pathway and provide a range of crisis alternatives that offer earlier intervention and support	• Adults in contact with secondary MH services living in stable and appropriate accommodation	• Reduction in acute crisis presentations • Increased access to community-based alternatives

Priority 6: Improving the ways we work within and across organisations to offer better health and social care

Care market management and development • Embed adult social care provider engagement arrangements • Secure agreement on long-term integrated brokerage arrangements • Review adult social care provider risk management arrangements • Establish and implement lead commissioning arrangements to address local health and care system care home placement requirements • Coordinate response to COVID-19 outbreaks within care homes and supported living services	• Percentage of adult social care providers registered by CQC as 'good' and above • Number of emergency admissions from care homes	• Uptake of COVID-19 vaccines in the community.

Digital and business intelligence led improvements • Maximise scope for sharing activity data to ensure system wide understanding of capacity and pressure points and opportunities for early intervention • Promote roll out of advanced planning tool Coordinate My Care (CMC) in care homes • Embed remote consultation technology in care homes to facilitate access to timely advice from health and social care professionals • Establish a remote vital signs monitoring pilot in care homes to facilitate early intervention by relevant health professional • Promote use of telecare technology to support independence of residents • Maximise opportunities for sharing relevant activity data to ensure system wide understanding of capacity and pressure points	• Systematic sharing of system capacity data in place • Number of care homes approved to use CMC • Number of care homes utilising remote consultation technology • Provider reported outcomes from pilot • Numbers using telecare equipment per 100,000 75 and over population	
Workforce development: • Complete and implement the HHCP integrated community workforce plan • Monitor vacancy and retention levels among adult social care providers and identifies possible interventions to provide support where there are issues	• HHCP community workforce plan in place • Adult social care vacancy and retention rates below or equal to averages for benchmarking group of councils	
Delivering our strategic estate priorities: • Review council and NHS partner owned assets and determine scope for meeting current and future population and system needs	• Number of properties repurposed	

Produced by Hillingdon Council

September 2021
13939