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Health and Wellbeing Board

Date: **TUESDAY, 4 DECEMBER 2018**

Time: **2.30 PM**

Venue: **COMMITTEE ROOM 6 - CIVIC CENTRE, HIGH STREET, UXBRIDGE**

Meeting Details: Members of the Public and Press are welcome to attend this meeting

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To Members of the Board:

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Councillor David Simmonds CBE (Vice-Chairman)
Councillor Jonathan Bianco
Councillor Keith Burrows
Councillor Richard Lewis
Councillor Douglas Mills
Councillor Raymond Puddifoot MBE
Dr Ian Goodman, Chair - Hillingdon CCG
Lynn Hill, Chair - Healthwatch Hillingdon

Statutory Members (Non-Voting)
Statutory Director of Adult Social Services
Statutory Director of Children's Services
Statutory Director of Public Health

Co-Opted Members
The Hillingdon Hospitals NHS Foundation Trust
Central & North West London NHS Foundation Trust
Royal Brompton & Harefield NHS Foundation Trust
Hillingdon Clinical Commissioning Group
Hillingdon Clinical Commissioning Group
LBH - Director of Housing, Environment, Education, Performance, Health & Wellbeing

Published: Friday, 30 November 2018

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Putting our residents first

Lloyd White
Head of Democratic Services
London Borough of Hillingdon,
Phase II, Civic Centre, High Street, Uxbridge, UB8 1UW

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Agenda

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HILLINGDON HEALTH AND CARE PARTNERS – DELIVERING HILLINGDON'S INTEGRATED CARE SYSTEM

Board Member	Councillor Philip Corthorne
Organisation	Hillingdon CCG and Hillingdon Health and Care Partners (HHCP)
Officer Contact(s)	Joe Nguyen, Hillingdon CCG Keith Spencer, Hillingdon Health and Care Partners
Papers with report	Appendix 1 – Integrated Care System Update

1. HEADLINES

Summary	• Our co-research activities with patients, residents and front-line staff (professionals) across health and care have identified 3 key themes of 1) Connected, 2) Collaborative and 3) Open to define and drive our Integrated Care System work locally in Hillingdon. • We have developed an overarching 'Hillingdon Whole System Plan' that defines what an integrated health and care system would look like, including a 5-year system financial approach for Hillingdon CCG and Hillingdon Health and Care Partners (which includes Hillingdon 4 All, Hillingdon Primary Care Confederation, Central North West London Foundation Trust and The Hillingdon Hospital Foundation Trust). • Current development is focused on 18+ but will widen to whole population (including Children's and Young People and Transitions) in April 2019. • Our current focus is on five key priorities that will improve urgent care performance in the system – and potentially deliver up £10m to the system for re-investment and closing our collective deficit across our partnership. In April 2019, we will further develop integrated plans for Self Care, Prevention & Early Intervention, Children & Young People including Transitions, Mental Health and Learning Disabilities – working alongside London Borough of Hillingdon to provide improved person-centred care and support. • Designing and 'prototyping' new 'Neighbourhood' and locality based model of integrated care – led by residents, patients, carers and primary care – building on multi-disciplinary working with community, mental health, secondary care and social care – this builds on our current work with our Care Connection Teams, Community Mental Health Teams and Children's & Young People Locality models. This will help us prioritise our health and care resources to the local needs of those neighbourhoods – led by the residents and primary care in those areas. • Strengthened our current HHCP governance structure to help

	all partnership organisation sign-up and move more rapidly from ideas to benefits realisation. • Seeing to move to a single Integrated Care Contract incrementally over the next 3 years to reduce administration burden and provide clarity on outcomes for population cohorts and prioritisation of resources across health and care partners to deliver better outcomes for neighbourhoods, families and individual residents.
Contribution to our strategies	This contributes to the Health and Wellbeing Strategy, Hillingdon CCG Operating Plan and individual organisational strategies for Hillingdon Health and Care Partners (HHCP).
Financial Cost	There is currently no additional financial cost and burden to the London Borough of Hillingdon, Hillingdon CCG and Hillingdon Health and Care Partners – this forms part of our annual operating plans.
Relevant Ward(s)	All

2. RECOMMENDATION

That the Health and Wellbeing Board review and feedback on the Hillingdon Health and Care approach, emerging model of care and work plan for 2018/19.

3. SUPPORTING INFORMATION

Integrated Care System Update

1. The appendix provides the Health and Wellbeing Board with additional information on:
    a. Highlight report update;
    b. High-level population health data – sourced from the CCG Whole Systems Integrated Care database;
    c. Emerging model of care – co-designed with resident and patient feedback and by operational professionals and clinical input; and
    d. Key benefits – which will be further developed in granularity as part of our business case development work.

Financial Implications

There are financial implications which will be further published with the development of our business case for the 5 priority areas. The emerging strategic financial approach for the partnership is focused on value-based commissioning and delivery – which focuses on optimising resources, processes and digital opportunities to deliver better outcomes for patients, families and carers through integration of resources and reducing non-value-added activity. We are able to do this by consolidating the resources across all partners to redesign our care and delivery model that is lean and effective.

4. RESIDENT BENEFIT & CONSULTATION

The benefit or impact upon Hillingdon residents, service users and communities?

Our proposed approach to developing our Integrated Care system is focused on residents, families, neighbourhoods and front-line staff and professionals.

Consultation carried out or required

There has been consultation on the approach as part of the Hillingdon CCG Public and Patient Engagement committee and also co-developed with over 200 health and care professionals across the Hillingdon Health and Care partnerships. We have also initiated our co-production and co-research activities by undertaking 30 ethnographic interviews with residents and front-line professionals across health and social care services and support. The summarised themes are set out in the following table and informs our design principles and methodology:

Theme	Residents	Professionals
1. Connected	• A system that sees **multiple dimension** of need (physical, psychological, emotional, social) - concurrently, through multi-skilled individuals or teams • **Fewer** handovers, journeys and appointments • Professionals are connected and **'know my story'** • **Streamlining transitions:** from hospital to community; from children's to adult services	• **System interoperability** (shared care records and plans) • **Space, time and resource** to connect professionals and organisations • Quick access to **experts and expertise** • Knowledge about **local community options** • Simplified and smarter IT systems that **reduce workload rather than add to it**
2. Collaborative	• Treating people as **sources of value and support**; more listening, respect and compassion • Fostering **partnerships** and reciprocal relationships • Patients and carers seen as **partners,** affording them greater control and means to be effective • Investing in building **volunteer capacity** and activating community assets and resources	• Better collaboration with **commissioners** and **service users** to make improvements • Encouraging the **involvement of staff from all levels** in service improvement and redesign • **Inverting hierarchies** and celebrating **team-work** • **Collaborative relationships** between GPs and acute; and in neighbourhoods - with voluntary sector organisations and across professionals in NHS and LA
3. Open	• Better and **quick access to advice**, support and information across medical, social and wellbeing • **Transparency** and access to	• A **learning system** • **Less rigid** and **more adaptable** to local needs and assets • Encourages colleagues from across the system to **learn**

	records and data • **Diversity of available options** aligned to needs and preferences of population, rather than single option with long waiting list (or available 'while you wait') • Early intervention for **MH and behavioural issues** in schools and community organisations	**together,** shadow and innovate together • Fosters '**can do' culture -** permission to improve and offer care and compassion to patients

5. BACKGROUND PAPERS

NIL.

Hillingdon Health and Care Partners (HHCP)

Integrated Care System Update

23rd November 2018

Hillingdon Health and Care Partners

NHS 70 YEARS OF THE NHS 1948 - 2018
Hillingdon Clinical Commissioning Group

What our residents and professionals have told us that they want from an Integrated Care system:

Theme	Residents	Professionals
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**Based on initial co-research work between August and October 2018 – to be further developed as part of ICS co-production approach.*

How are we addressing these requirements? **Where are we now?**

1. Developing an overarching 'Hillingdon Whole System Plan' that defines what an integrated care system would look like including a 5-year system financial plan – *focusing on Children's and Young People (CYP), Mental Health & Learning Disabilities, Urgent Care and Planned Care*
2. Widened the focus of the HHCP integrated service model to the **18+ age cohort** in order to improve urgent care performance across the system
3. Currently focused on **five key priorities** that will improve urgent care performance and as a corollary potentially deliver savings of up to £10m to the system
4. Developing a new **Neighbourhood based model of integrated care** that embeds multi-disciplinary working based on an integrated workforce spanning primary, secondary, mental health, community care, social care and the voluntary sector
5. Strengthened the current **HHCP Governance Structure** to enable HHCP to move more rapidly from ideas to benefits realisation
6. Developed a **draft integrated business case** based on the 5 HHCP key priorities (due for approval in December 2018) including a robust Implementation plan with clear timelines and accountabilities that is implemented at pace
7. Seeking to move to **a single Integrated Care Contract** incrementally over the next 3 years

We are **focusing on 5 priority areas for 18/19**…building on the partnership work to date:

1. **Extending active case management to the 15% of the adult population most at risk of a non-elective episode and admission to long term care** by implementing the following key interventions:
   - **I. Extension of Care Connection Teams 's to a broader age group cohort (18+)**
   - **II. Implementing a High Intensity User Service** to better manage the top 50 'Frequent ED Attenders'
   - **III. Revised End of Life Care Pathway** to reduce the number of people spending the last year of their life in an acute hospital bed
   - **IV. Revised Falls Service and Frailty Pathway** to reduce the number of non-elective episodes
   - **V. Better Support to Care Homes** (to prevent Non-Elective presentations)
2. **Transforming the MSK Pathway** to reduce the number unnecessary secondary care interventions
3. **Optimizing the Hospital Interface** (Front Door) through Effective Same Day Emergency Care for ambulatory care sensitive conditions.
4. **Optimising Intermediate Care**, Rapid Response/GP Visiting including Discharge arrangements
5. **Developing integrated multi-disciplinary 'Locality Neighbourhood' Team** working built from and led by general practice as the basic delivery unit of integrated care

What is the data telling us about our population?

- **There are 230,000 people in the 18+ Hillingdon Population**
- **Approximately 34,000 (15%) 18+ have a life limiting illness (LLTI)**
- **Approx 5,500 are identified as high-risk of emergency admission**
- **6,417 people (3% of Adult population) account for 50% of all Hillingdon emergency hospital admissions (equates to £26m)**
- **Approx 1350 Hillingdon residents died of predictable causes liable to require palliative care in the last year of their life; 54% of whom died in a hospital bed (compared to England average of 47%)**

Based on the data currently available, we plan to address the needs (stratify) of the local population based on the following assumptions:

➢	**Tier 1:**	Mostly healthy people with low needs (195,500)
➢	**Tier 2:**	People with 1 or more well-managed long term conditions (29,000)
➢	**Tier 3:**	People with 1 or more complex or unstable long term conditions (4,133)
➢	**Tier 4:**	People with Advanced or incurable illness (1,350)

Moving towards a **needs based and active case management** model…

Focus of the Integrated Business Case

TIER 1: Mostly Healthy (Low Needs)

These people are in relatively good health; there are no serious on-going health or social care concerns. They would benefit from support to 'stay well'.

195,500 People (85% of over 18s)

TIER 2: 1 or more well-managed LTCs (Substantial)

These people are stable - coping with one or more long-term conditions and would benefit from support to plan care and manage their condition.

29,000 People (13% of over 18)

TIER 3: 1 or more complex or unstable LTCs (Critical Needs)

These people have complex needs and require significant multi-disciplinary support. In addition to unstable LTCs, they may have mental health or social care needs.

TIER 4: Advanced & incurable illness (People at the end of their life)

These people have advanced, progressive, incurable illness. The key aim of support is to help them to live as well as possible until they die and support them to die at home

High-risk 5,500 People (3% of over 18)

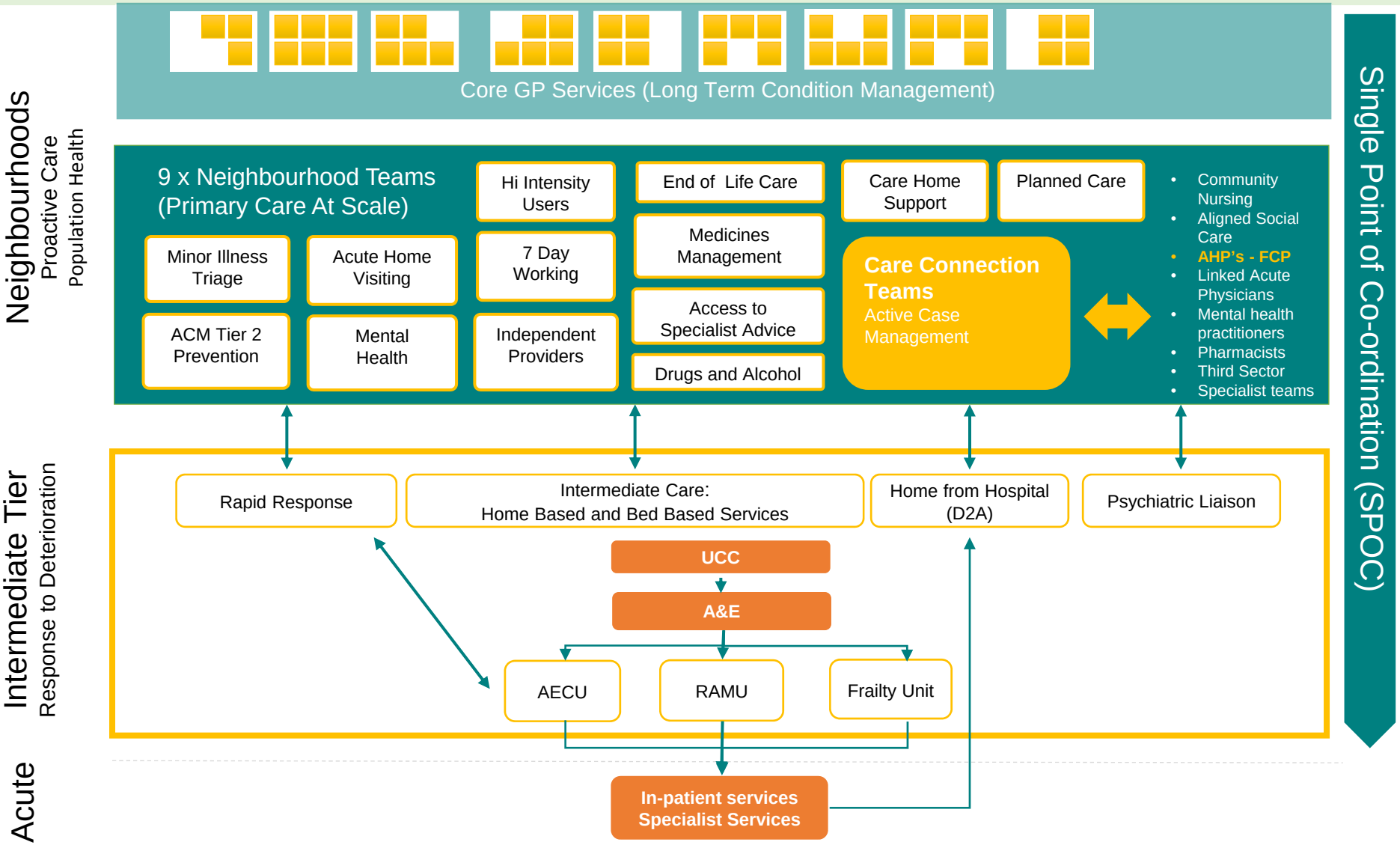
4,150 People (2% of over 18)

1,350 People (1% of over 18)

The Hillingdon model of care and 5 HHCP priorities is underpinned by active case management.

Active Case Management (ACM) is an integral part of the Integrated Neighbourhood Team and wider health care system. The aim of ACM is to identify (stratify) and then care for patients with complex needs at high risk of hospital admission, through intensive co-ordination, at a complex health and social care multi-disciplinary team level.

The emerging model of care



Toward a new model of care…the **key benefits:**

Benefits for residents and patients will be:

- People will only have to tell their story once
- Reduced hand-offs between services by creating neighbourhood teams who work together with primary care and the third-sector to deliver care and support to meet patients' and carers needs.
- Patients with have a named case manager who will organise and co-ordinate their care.
- Breaking-down demarcation lines between professionals and multi-skilling of staff to improve care.
- Services will be available over extended hours
- More care will be provided closer to home
- There will fewer confusing transfers between organisations and services
- Increased breadth of provision in local GP practices

Benefits for wider health and care system will be:

- Keeping people independent at home for longer
- Ensuring safe and sustainable General Practice and out of hospital services
- Reducing avoidable hospital admissions for those most at risk
- Substantially reducing avoidable visits to accident and emergency departments
- Reducing avoidable admissions to care and residential homes
- Reducing the average length of time people stay in hospital