INTEGRATED CARE PARTNERSHIP UPDATE

Board Member	Councillor Philip Corthorne Dr Ian Goodman
Organisation	London Borough of Hillingdon (LBH) Hillingdon CCG / Hillingdon Health and Care Partners (HHCP)
Officer Contact(s)	Keith Spencer, Hillingdon Health and Care Partners (HHCP) Joe Nguyen, Hillingdon CCG
Papers with report	Not applicable

1. HEADLINES

Summary	This reports provides the Board with the latest update on the Integrated Care Partnership (ICP) achievements, progress and proposed developments for the 2019/20 programme of work.
Contribution to our strategies	This contributes to the Health & Wellbeing Strategy, Hillingdon CCG Operating Plan and individual organisational strategies for Hillingdon Health and Care Partners (HHCP). The Integrated Care Partnership is also our local vehicle to deliver on the commitments of the NHS Long Term Plan.
Financial Cost	There are no costs arising from this report.
Relevant Ward(s)	All

2. RECOMMENDATIONS

That the Health and Wellbeing Board:

1) **reviews and provides feedback on the progress update on Hillingdon ICP development.**
2) **reviews and provides feedback on the proposed 2019/20 priorities – in particular on the joint working and development between LBH and HHCP across areas such as Intermediate Tier working.**
3) **notes the proposed the direction of travel for Hillingdon ICP development in the context of NWL CCGs case for change and Long Term Plan.**

3. SUPPORTING INFORMATION

Context

The NHS 10 Year Plan, published earlier this year, put into print the much needed recognition that health, social care providers and commissioners having been waiting to see, this included:

- A commitment to boost ‘out-of-hospital’ care, ending communication issues and system

gaps between primary and community health care providers
- Support to redesign emergency hospital services that reduces pressure on staff
- A move towards personalised healthcare that gives patients and their carers more control to manage or live with their health condition(s) so they stay healthy, at home and part of their communities
- Mainstreaming access to digital services and information relevant to primary and out-patient care services.

In readiness to deliver these system changes health and care organisations; CNWL, The Hillingdon Hospital, The Hillingdon Primary Care Confederation, Hillingdon for All (a consortium of voluntary sector providers) and The Hillingdon Clinical Commissioning Group have formed an alliance known as The Hillingdon Health and Care Partners (HHCP). This alliance will enable frontline staff from across the different organisations to work together to provide joined up care.

What is an Integrated Care Partnership (ICP)?

ICPs are alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved. Some ICPs are taking on quasi commissioning functions that previously have lodged in CCGs with some aspects being delegated (but not fully). The ICP forms the local and borough component of the NWL CCGs case for change for developing a single-CCG footprint.

This had started with our integrated care journey kicking-off in 2014/15 including the development of our local BCF programme and HHCP. We are now able through new policy (i.e., Long Term Plan) to further accelerate our ICP maturity. The ICP development is an important step for us locally to be able to bring together our health and care resources locally and be able to optimise the value and outcomes for our residents. This provides a way for us to co-produce a health and care offer locally that will attract and excite professionals and staff to work in Hillingdon. This also provides an opportunity to work in a collaborative way and be able to tailor our resources to tailor our support for residents, families and the neighbourhoods they live in.

In Hillingdon, there is an opportunity for us to further mobilise ICP governance to jointly manage acute, mental health, community, continuing health care, medications management and mental health care provision. Jointly, we could be delegated additional functions around joint commissioning, clinical pathway redesign, public and patient engagement and safeguarding. We would operate under an outcomes-based contract – delivering a population-health model that works within a capitated budget to target resources where they are most needed. This would be underpinned by shared transformation, programme delivery, digital, estates and other back-office functions across current and future partner organisations.

What are the benefits for our residents?

- Empower our residents and patients to keep themselves well and take charge of their own health.
- Provides access, where required, to high quality, sophisticated care at the right time.
- Quicker access to specialist or inpatient care, where required, but:
    - where an admission is unavoidable, patients will return home quickly; and

    - with a personalised care package that continues to support their needs either from home or in the community.
- An improved “End of Life” care that better supports people to die in their preferred place.
- Identifies and intensively supports high risk patients to better manage their health and wellbeing in the community.

What are our key achievements in 2018/19?

Building on this early non elective success of 2017/18 with the +65 population, the scope of work of the ICP was extended to cover all adults in order to further improve urgent care performance and further flat line non elective growth (in scope services circa £100m). Our key achievements included:

- Co-production and approval of an Integrated Business Case (IBC) by all sovereign provider boards and the CCG governing body in March 2019. This set out a range of key priorities for the further development of an ICP in the Hillingdon system including:
    - New integrated care model of care on 8 primary care-led Neighbourhoods – aligned to primary care networks with joined up physical and mental health care and aligned social care.
    - A transformed Intermediate Tier design with an emphasis on same day emergency care.
    - The population segmentation and active case management of the 5,500 Hillingdon adults most at risk of a non-elective episode and who drive 50% of all non-elective activity. Key Interventions have a specific focus on:
        - High Intensity Users
        - Care Homes
        - Falls and Frailty
        - End of life care
        - Ambulatory Care Sensitive Conditions.
- This business case is currently being implemented and is on target for full mobilisation in July 2019. In summary:
    - 8 Neighbourhoods have been formed and will be coterminous with the new Hillingdon Primary Care Networks required under the NHS Long Term Plan. Relevant CNWL community staff and H4 All Third sector staff will be aligned to New Neighbourhoods which will be clinically led by a Clinical Director (of both the Primary Care Network and Neighbourhood).
    - Leadership Teams for the 8 Neighbourhoods are currently being identified and will be in place from 1 July 2019.
    - Care Connection Teams are in the process of being expanded and will be re-aligned to map to the new Neighbourhoods. They are currently in the process of expanding their caseloads from the 3,500 to 5,500 adults most at risk of a hospital non-elective episode.
    - The High Intensity User service for the 50 most frequent users of the Hillingdon Hospital emergency department is now operational.
    - A new multi-disciplinary service to support care homes across Hillingdon will commence in July 2019.
    - The impact of these changes will be to effectively flat line all hospital non-elective activity and deliver cumulative net savings over 5 years to partners of £29.8m by 2023/24 based on National tariff. This equates to average annualised saving of £8m.
- Providers and commissioners have agreed a risk and gain arrangement for in scope services based on a 50:50 split between commissioner and providers. Providers have their own backing agreement in place to further sub divide their 50% share between all partners.

- Partners have agreed a cost-based approach to future transformation and the system deficit reduction.
- Non elective hospital admissions and ED attendances for the Hillingdon registered adult population (18+) have reduced by 1% at year-end 2018/19 compared to the previous year.

Key priorities for 2019/20

The North West London Collaboration of CCG's has recently produced draft guidance setting out the development trajectory for ICP's over the next 2-3 years. In the light of this, our ICP has agreed a set of key priorities for 2019/20 onwards to enable the Hillingdon system to achieve formal ICP status as soon as practicable. These include:

- Extending the ICP target Operating model to include all children's and adults community health services, planned care, primary care at scale, and children's and adults mental health bringing the value of in scope services to circa £170m.
- Working closely with the London Borough of Hillingdon to re-design the Intermediate Tier. The Intermediate Tier provides a range of time limited health and social care services that promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. It provides the essential community rapid response to crisis, rehabilitation, reablement and short-term home care packages which together act as the critical bridge between hospital, neighbourhood and home avoiding unnecessary emergency admission to hospital and supporting sustainable early discharge. Our proposal is to work with the Council to develop a more integrated health and social care response covering the intermediate tier which will be responsible for allocating resources more dynamically to create bespoke care packages for individuals based on a single point of access.
- Working with the Council to further develop the Neighbourhood model to feature resident, community and elected members in the designated geographies – further enhancing our community well and being offer to residents with further alignment to the Council offer (e.g., Youth Centres).
- Implementing an enhanced alliance agreement to incorporate the agreed risk and gain share and enable the appointment of a shared integrated management team with delegated authority.
- Implementing a single capitated contract for in scope services to the ICP under a lead provider model.
- Implementing an integrated management structure across all providers for in scope services to better join up care and reduce management overheads.
- Addressing the system financial recovery plan priorities by realising the benefits expected from the IBC relating to non-elective care. Planning and undertaking the digitally enabled transformation of Planned Care to realise activity and financial benefits of up to 30% over the next 2 years.
- Reducing overheads and infrastructure costs by working towards shared support services commencing initially in 2019 with transformation/PMO, business intelligence and digital, estates.
- Moving towards a single ICP control total and block/capitated contracts for all in scope services from 2020/21.