4. Strategic Narrative

What is your approach towards integration of health and social care from:

When answering the sections below please highlight any learning or changes you have undertook from the previous planning 2017/19.

A. Person-centred outcomes such as:

- *Promoting choice and independence.*
- *Providing dignity in care.*

Promoting choice and independence

The Hillingdon approach to promoting choice and independence includes:

- *An asset-based starting point:* This is a focus on the attributes that residents already have that can be employed to deliver better outcomes for them. It is also focused on what already exists within the community, e.g. within the voluntary and community sector, that can support choice, independence and more fulfilling lives. The experience from the various iterations of the BCF plan thus far, as well as other integration work being undertaken in Hillingdon, is that this requires a significant culture shift across health and care partners that will take time to fully embed.

- *Self-help through access to information and advice*: As part of the implementation of its obligations under the Care Act, the Council has developed an online directory of services called Connect2Support (C2S). This system is being upgraded to improve the public interface and functionality options available to residents. An action for 2019/20 is for partners to move to a single directory of services that avoids the issues faced by there being multiple directories, e.g. confidence in the accuracy of the content and C2S is being considered for this purpose. The intention is to link the C2S directory to the Health Help Now app.

- *Promotion of Personal Health Budgets (PHBs) as Direct Payments and integrated budgets*: Since 2014 the Council has long had has managed the process for people taking their PHB as a Direct Payment, which Hillingdon identifies as a proxy measure for how engaged a person is in managing their health condition. At 31st March 2019 there were 20 people in receipt of a PHB as a Direct Payment and the intention is that by the end of 2019/20 this will have increased to 40. The intention is to also

encourage the number of people in receipt of integrated budgets. The availability of providers to support people wishing to employ their own personal assistants via a Direct Payment and accessible through a dynamic purchasing system (DPS) provides necessary infrastructure to support residents to pursue more personalised options to address their health and care needs.

- *Empowering the resident voice*: The provision of advocacy ensures that people who may have difficulty expressing themselves are able to give a view and make informed decisions. The Council has in place an integrated advocacy contract with a provider to deliver statutory advocacy services such as:

  - *Independent Mental Capacity Advocacy (IMCA)*;
  - *Independent Mental Health Advocacy (IMHA)*;
  - *Care Act Advocacy* .

  There are pan-London arrangements in place to support people who wish to make complaints against NHS bodies.

- *Supporting people in their own homes*: A key focus of partners is to support the independence of residents in their own homes in a community setting. This is addressed in more detail in section B.

- *Developing alternatives to institutional care*: During 2019/20 Park View Court, the second of two new extra care sheltered housing schemes, will open to provide 60 self-contained flats to Hillingdon's older residents. This concludes a supported living programme that will see an additional 148 flats for older residents in premises that have been developed to Stirling University's gold standard for dementia design. Hillingdon's supported living programme has also seen additional schemes for people with learning disabilities and people with mental health needs come on stream over the last three years. A partnership priority for 2019/20 is to prevent escalation of need that results in people having to step-up to more supported and more restrictive settings. Section B expands on this.

Providing dignity in care.

The approach to delivering dignity in care includes:

- *Joint assessments*: Avoiding the need for residents to tell their story multiple times has been a recurrent theme in all of Hillingdon's plans. Joint assessments contribute to reducing the need for multiple assessments. There was agreement as part of the 2017/19 plan that GPs would be the lead professional for high risk populations. How this is being taken forward within the context of the development of primary care networks is expanded on section B.

- A single assessment form has been developed for use by all partners supporting the discharge process from Hillingdon Hospital and this will be adapted to reflect the learning from the practical experience of using it.

- *Integrated case management for people with learning disabilities*: For some years the Council has provided a case management service on behalf of the CCG for people with learning disabilities who qualify for CHC funding as well as those receiving a health contribution under section 117 after care arrangements. The integrated case management service includes brokerage for securing placements and other services required to meet assessed needs. The intention is to create a seamless service for people with learning disabilities. Including this provision within the 2019/20 forms part of a general review of the model of integration and the intention is to secure agreement on what this might look like in order to maximise the independence of people with learning disabilities and manage need more effectively. The intention is that the results of the review will be implemented in 2020/21.

- *Data sharing*: Joint work between partners to prototype the Care Information Exchange funded through the Imperial College Partnership Fund in order to deliver interoperability between IT systems was unsuccessful. Hillingdon CCG has received £183K to support set up costs of the Health and Social Care Network (HSCN), which replaces the N3 connection. This will provide the underlying network arrangements to help better integrate health and social care services. A key milestone in 2019/20 will be the implementation of a single integrated care record that will initially be accessible by NHS partners. The scope for establishing direct linkages between the GP patient management system called EMIS and the Council's social care database, Protocol, will also be pursued.

- In order to support hospital discharge the Council has provided restricted access to its care management database, Protocol, and will consider the scope for giving access to appropriate staff within the Neighbourhood Teams.

- *Managing the local market*: A combination of integrated commissioning, monitoring against the delivery of quality standards and jointly managing provider risk will all contribute to achieving dignity in care for our residents. For example, the Council has in place a care governance process that monitors the level of risk presented by care and support providers, which is informed by data such as LAS attendances and conveyances. A provider risk panel that includes CCG representation considers quality issues posed by providers and identifies remedies, including levels of support for providers, which can be delivered by the in-house Quality Assurance Team or clinical input through Hillingdon Health and Care Partners.

1,114

B. Neighbourhood/HWB Level

i] Your approach to integrated services at HWB and neighbourhood (where applicable) level, including:

- *Joint commissioning arrangements*
- *Alignment with primary care services (including PCNs)*
- *Alignment of services and the approach to partnerships with the VCS*

Joint Commissioning Arrangements

The care and support providers required to ensure that residents are able to live as independently as possible in their own homes tend to operate on a borough or locality level rather than across an ICS. In Hillingdon the BCF has provided an opportunity to take a more integrated approach to market development and 2019/20 will see this developed further, in some cases for implementation in 2020/21.

This can be seen in the integrated brokerage and homecare pilots undertaken during 2017/18 and 2018/19 where the Council led on behalf of the CCG. This has provided the foundation for development work during 2019/20 the result of which will be implemented in 2020/21, subject to approval through governance processes. If agreed a vertically integrated brokerage service will be implemented covering access to homecare and long and short-term nursing home placements for children and adults irrespective of whether the funder is the NHS or the Council. A further development in 2019/20 that will see implementation in 2020/21 following a procurement process later in this year is an integrated homecare service. This will comprise of three contracts covering three zones that broadly aligned to the three borough localities. In addition, a dynamic purchasing system (DPS) will also be established to address any capacity issues that may arise with contracted providers. All contracts will be held by the Council and there will be a central point of contact for providers, thus alleviating confusion and complexity for them.

The Council is working with the GP Confederation to explore the scope for broadening the staff skill mix reflected in the service specifications with the aim of relieving primary care of some tasks that can be delivered in the community, e.g. add in examples. The intention is to also build additional capacity into the contract for a more specialised service in the central zone that will allow for more flexible deployment to prevent A & E attendances and hospital admissions that are avoidable, e.g. where the London Ambulance Service identifies that a person requires someone to be with them overnight after a fall or a health exacerbation that does not require treatment in hospital.

During 2019/20 it is intended to run a pilot where the Council will procure nursing care home placements on behalf of the CCG in order to see if this results in better value for money for the CCG.

Hillingdon's 2019/20 plan also includes the implementation of an integrated therapies service for children and young people (CYP) that will be led by the Council. This service brings three contacts for Integrated Speech and Language Therapy, Physiotherapy and Occupational Therapy Service into one for a pilot that enables a test of concept to be undertaken to deliver an early intervention and prevention model that should improve the quality of life of CYP and help reduce resource pressures once they have progressed to adulthood. This represents a considerable step-change in Hillingdon's integration journey and level of ambition. It is also paves the way for the inclusion of integration of services for CYP more broadly to be reflected in a future iteration of the BCF plan.

Alignment with primary care services (including PCNs)

Eight multi-disciplinary Neighbourhood Teams have been formed that will be coterminous with the new Hillingdon Primary Care Networks required under the LTP. Relevant CNWL community staff and H4All Wellbeing Service staff will be aligned to the new teams, which will be led by a clinical director. Social Care Teams have been restructured into localities that broadly align with the catchment areas of the Neighbourhood Teams. Named Social Care contacts have been provided to the Neighbourhood Teams to foster relationship development. The effectiveness of this approach will be kept under review over the next two years as the NTs become established and consideration given to alternative structures should this prove necessary to deliver better outcomes for residents and patients.

The emerging model of homecare previously referred to that will be implemented in 2020/21 will see partnerships develop with contracted providers in the different homecare zones and the relevant Neighbourhood Teams. It is intended that a specialist provider based in the central part of the borough will have capacity to be deployed flexibly by the networks to prevent admission to hospital. This is part of the building a package of care around the resident previously mentioned.

Alignment of services and the approach to partnerships with the VCS - This is addressed in section C.

740

ii] Your approach to integration with wider services, including housing:

- Disabled Facilities Grant: Please describe your approach to using the DFG to support the housing needs of people with disabilities or care needs. This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the Regulatory Reform Order, 2002.

Disabled Facilities Grants

Hillingdon is a unitary authority and therefore incorporates housing responsibilities contained within the Housing Grants, Construction and Regeneration Act, 1996, i.e. disabled facilities grants, within its sphere of responsibility. DFGs will continue to be utilised to support older and disabled residents to remain in their own homes. In 2018/19 251 people were assisted with DFGs and of these 59% (147) were people aged 60 and over. 24% (59) of older people receiving DFGs were owner occupiers, 74% (187) were social housing tenants and 3% (8) were private tenants.

In 2018/19 DFG flexibilities were used to establish the Hospital Discharge Grant to fund house and/or garden clearances, deep cleans and a range of other home-based activities where difficulties in arranging help can delay the return home of people no longer needing to be in hospital for treatment. Since the start of the pilot in November 2018 this has supported the discharge from hospital of 26 people. An initial £250k has been allocated for the pilot in 2019/20 and an evaluation in the summer of 2019/20 will determine whether the grant will become part of the Council's permanent offer to support hospital discharge.

Relevant housing officers have been involved in the development of the 2019/20 plan. At an elected member level, it should be noted that the chairman of Hillingdon's HWB is also the Cabinet Member for Social Care, Housing, Health and Wellbeing.

Other Council services

The Council provides a range of services that contribute to supporting the health and wellbeing of residents:

- *Assistive technology* - The Council has established staffing capacity to actively promote assistive technology such as telecare, which is available free of charge to people aged 75 and above. A priority during 2019/20 will be to raise awareness within primary care of the opportunities presented by the range of equipment available to support people in their own homes. The Council's telecare offer also includes access to a responder service for people who may not have any relatives or friends that can assist in the event of a call going through to the Council's TeleCareLine Service.

- *Housing Services* - Good housing is recognised as critical to being able to address the health and wellbeing of residents. As a unitary authority the Council also has within its remit the homelessness and housing allocations obligations under the 1996 Housing Act and works with partners to identify appropriate housing solutions.

- *Libraries and green spaces* - The Council's 17 libraries provide opportunities for residents to access information and be sign-posted to relevant advice providers. They also provide venues for voluntary and community groups to meet that will help prevent social isolation. The borough has over 40 parks and green spaces, one of the highest in London, which provides opportunities for residents to be physically active in a de-stressing environment.

- *Sports and leisure facilities* - Hillingdon has five sports and leisure centres provided by the Council and concessions are provided to older and disabled residents and also people who are Adult or Young Carers as defined under the Care Act, 2014 and Children and Families Act, 2014.

Effective use of the Council's Estate

- *Extra care sheltered housing* - Two consulting rooms have been included in the two new extra care schemes that are available to Care Connection Teams to deliver clinics both to tenants within the schemes and the local community. They are also available to third sector partners to deliver information and advice clinics. Facilities within all schemes provide scope for third sector partners to deliver activities to support tenants and local residents.

597

C. System alignment, for example, this may include (but is not limited to):

- How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans

- A brief description of joint governance arrangements

Overview

Hillingdon's overall vision for integrated care and support within the geographical boundary of the borough is set out within our STP submission and reflected in the 2017/19 plan. This continues into 2019/20 and can be seen in **Annex 1**.

The BCF is key to the delivery of some aspects of the North West London (NWL) Sustainability and Transformation Partnerships (STP) plan that are dependent on integration between health and social care or closer working between the NHS and the Council. The Hillingdon place-based aspects of the STP, including the relevant delivery areas, are reflected in the 2018-2021 Joint Health

and Wellbeing Strategy and the schemes within the 2017/19 plan were devised to contribute to the implementation of the relevant STP delivery areas. The beneficiaries of the 2019/20 plan have been expanded beyond older people and Carers of all ages to include children and young people with special educational needs (SEND) and people with learning disabilities and/or autism. This will therefore increase the number of STP delivery areas to which the BCF will be making a contribution.

In accordance with the direction set out in the NHS Long-term Plan (LTP) that all STPs should develop into Integrated Care Systems (ICSs) with a single CCG by April 2021, discussions are in progress across NWL to determine the implications at a system, place and network level. Key functions that have been identified as sitting solely at a system or NWL level include:

- Business intelligence
- Digital strategy
- Clinical standards
- Medicines management
- Continuing Health Care Framework
- Health personalisation framework
- NHS Finance

The BCF has an important role in supporting the delivery of key changes set out in the NHS LTP, e.g. reducing pressure on emergency hospital services and focusing on population health and this is reflected in the CCG's 2020-2022 commissioning intentions that incorporate its initial LTP implementation plan.

Hillingdon has a wide range of system transformation programmes in progress that are linked to the delivery of the Five-year Forward View (5YFV) to which the BCF will contribute and these include:

- Urgent and emergency care
- Primary care
- Personalisation
- Mental health
- Long-term conditions
- Children and young people

The eight schemes within the 2019/20 BCF plan are:

- *Scheme 1*: Early intervention and prevention.
- *Scheme 2*: An integrated approach to supporting Carers.
- *Scheme 3*: Better care at end of life.

- *Scheme 4*: Integrated hospital discharge and the intermediate tier.
- *Scheme 5*: Improving care market management and development.
- *Scheme 6*: Living well with dementia.
- *Scheme 7*: Integrated therapies for children and young people.
- *Scheme 8*: Integrated care and support for people with learning disabilities.

Alignment of services and the approach to partnerships with the VCS

The main vehicle for the delivery of integrated care in Hillingdon is the Integrated Care Partnership (ICP), known as Hillingdon Health and Care Partners (HHCP) and comprising of the GP Confederation, the Central and North West London NHS Foundation Trust (CNWL), The Hillingdon Hospitals NHS Foundation Trust (THH) and the H4All third sector consortium. The latter comprises of Age UK Hillingdon, the Disablement Association Hillingdon (DASH), Harlington Hospice, Hillingdon Carers and Hillingdon Mind. The involvement of H4All within the ICP demonstrates recognition of the vital role of the third sector in supporting residents and preventing or delaying escalation of need. The following are examples of the extent to which the H4All consortium is integral to delivering system change in Hillingdon:

- *End of life workstream:* The chief executive of Harlington Hospice is the Senior Responsible Officer (SRO) for the delivery of this project, which is an HHCP priority for 2019/20.

- *Wellbeing Service:* This an early intervention and prevention service delivered by H4All that takes referrals of people at risk of escalating need mainly (but not solely) from primary care. Through the application of the nationally recognised Patient Activation Measure (PAM) tool they are able to determine the extent to which a person is motivated to manage their long term condition and then measure the impact of their intervention. 2019/20 will see the focus of this service move beyond the 65 and over population to a broader adult population. It will also see the service firmly embedded in Neighbourhood Teams as they become established.

- *Prevention of Admission and Readmission:* Age UK is an integral part of Hillingdon's admission prevention and early supported discharge approach. With a combination of paid staff and volunteers this Age UK is based in A & E to support people home who do not need to be admitted. Support for up to six weeks is also available to enable older people admitted to hospital who have lower levels of need not requiring intervention or involvement of statutory partners to return home at the earliest opportunity.

Priorities for reducing health inequalities and promoting equality under the Equality Act, 2010.

The 2019/20 BCF plan seeks to address the health inequalities faced by Hillingdon's most vulnerable older people, e.g. people living with long-term conditions, including frailty and dementia. The resourcing of the Neighbourhood Teams is intended reflect the concentration of deprivation in the south of the borough, which is manifested in the variation in life expectancy of 6.8 years for men and 5.2 years for women living in the least deprived part of the borough, i.e. Eastcote and East Ruislip, compared to those in the most deprived, i.e. Botwell. Expanding the remit of the plan in 2019/20 to include children and young people with special education needs and adults with learning disabilities is also assist in addressing health inequalities faced by these vulnerable groups.

The 2017/19 plan health impact assessment has been updated to support the decision by HCCG's Governing Body and the HWB to approve the plan. This shows that the payment as Direct Payments of Personal Health Budgets (PHBs) for people meeting Continuing Health Care (CHC) thresholds and also for people meeting the National Adult Social Care Eligibility Criteria provides opportunities for more personalised approaches to addressing need that would reflect cultural and religious diversity. Early identification of people at risk of deterioration and active case management by the Neighbourhood Teams will help to maximise independence through determination of the most appropriate intervention, which may be social prescription to address risk factors such as social isolation.

The 2017/19 plan equality impact assessment has also been updated to support the decision of HCCG's Governing Body and the HWB to approve the draft plan. The impact of the eight schemes was neutral on three of the protected characteristics and these were gender identity, pregnancy and maternity and marriage and civil partnership. The assessment showed that the impact of the plan was positive for all other characteristics. It should be noted that Hillingdon includes Carers as a protected characteristic and therefore considers their needs in any impact assessment.

Governance

The delivery of the BCF plan is overseen by a Core Officer Group comprising of senior officers from the Council and the CCG, including the statutory director of adult and children's social care services and the CCG's managing director. This meets on a monthly basis. Performance reports are sent on a quarterly basis to both the HWB and HCCG's Governing Body to which the Core Officer Group is accountable. The 2019/29 delivery plan is appended as **Annex 2** and implementation of this will be reflected in the performance reports.

The Core Officer Group also reports into the Hillingdon Health and Care Transformation Board, which has executive representation from partner organisations, including the chairman of the HWB. **Annex 3** illustrates where the governance for the BCF sits within the broader health and care system management arrangements in Hillingdon.

1,275