Appendix 5

HILLINGDON
LONDON

Health Impact Assessment Update: 2019/20 Better Care Fund Plan

STEP A) Description of what is to be assessed and its relevance to health

What is being assessed? Please tick ✓

Review of a service ☐ Staff restructure ☐ Decommissioning a service ☐

Changing a policy ☐ Tendering for a new service ☐ A strategy or plan ✓

The Better Care Fund (BCF) Plan is a mechanism for providing better outcomes for residents and patients through integration between health and social care and closer working between the Council and local NHS organisations. This assessment updates that undertaken for the 2017/19 BCF plan, which was itself an update of the assessment undertaken for the original 2016/17 plan.

The focus of the 2019/20 BCF plan is broader than covered by the 2017/19 plan and includes:

- All of Hillingdon's residents aged 85 and over
- Frail older people aged 75 and over with one or more long-term conditions
- Older people who are at risk of dementia
- Older people who are at risk of falling for a first time;
- Older people who are socially isolated;
- Children and young people with special educational needs (SEN);
- Adults with learning disabilities and/or autism; and
- Carers of all ages.

The HIA that was undertaken for the 2017/19 plan still applies to the new plan and this assessment focuses on the changes for 2019/20. There are eight schemes within the 2019/20 BCF plan and these 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 and/or autism.

Appendix 1 provides a summary of each of the schemes, but key developments under the proposed plan for 2019/20 include:

Scheme 1

- Establish a single online information system as the directory of services across Health and Care Partners in Hillingdon.
- Establish the eight Neighbourhood Teams aligned to the Primary Care Networks across the borough.

Scheme 2

- Ensure the identification of a Carer's Champion in all GP practices.
- Review and develop the Carer Assessment Tools to simplify the assessment process.
- Ensure Carer identification markers are included in the development of information sharing platforms.

Scheme 3

- Clarify the end of life model of care for people who wish to die at home.

Scheme 4

- Establish a point of coordination within Hillingdon Hospital for hospital discharges.
- Establish a point of coordination for access to community resources to build up suitable packages of care and support.
- Review all specialist pathways to include Frailty, End of Life and Palliative Care to ensure these are aligned to the integrated discharge model.
- Develop and implement the standards for the triaging process, including the automation of data reporting.

Scheme 5

- Secure agreement on long-term integrated brokerage arrangements.
- Undertake a competitive tender for new model of integrated homecare provision.
- Implement Enhanced Support for Care Homes and Extra Care Service.

- Open Park View Court and manage implementation of fill strategy in partnership with GP practices.

Scheme 6

- Develop training for care homes in how to manage people with challenging behaviours.

- Enable people living with dementia to continue to live independently in our community and feel supported and knowledgeable about where to access advice and help when required.

Scheme 7

- Implement the integrated therapies pathway model.

Scheme 8

- Deliver a model of care and support for people with learning disabilities and/or autism who are in a supported living setting that maximises their independence and supports their health and wellbeing.

- Implement the action plan from reviews completed between health and social care under the Learning Disabilities Mortality Review Programme.

What is the lead organisation for the service to be assessed? EG Hillingdon CCG or London Borough of Hillingdon

The plan is jointly led by HCCG and Hillingdon Council (LBH)

Who is accountable for the service? E.g. Head of Service or Corporate Director

Managing Director, HCCG
Corporate Director of Adults and Children and Young People's Services, LBH

Date assessment completed and approved by accountable person

Date assessment completed:
Date assessment approved:

Names and job titles of people carrying out the assessment

Gary Collier - Health and Social Care Integration Manager, LBH/HCCG

A.1) What are the main aims and intended benefits of what you are assessing?

By 2023/24 we expect to have in place a model of care and supporting enablers:

- Where residents have easy access to information and advice about services,

including care and support services;

- That has a focus on improving health outcomes for residents with one or more health conditions or care needs, a personalisation of service provision and a collaborative approach between providers;

- Where there is systematic early identification of susceptibility to disease or exacerbation in the population, alongside integrated management of conditions and a consistent approach to care provision;

- Where better coordination of services are configured around Hillingdon's residents, including a much stronger focus on case management and prevention, integration of health and social care and on the wider role played by the third sector;

- Where residents and carers are actively involved in the planning of their care and recognised as expert partners in care;

- Enablement of self-care and preventative services and promotion of independence for as long as possible;

- Where people are only admitted to Hillingdon Hospital when they are acutely ill;

- Where a hospital admission is necessary and unavoidable their lengths of stay are reduced;

- That enables people to be treated at or close to their home wherever possible;

- A reduction in the number of people living in residential care;

- The most effective use of health and care resources is made to achieve best value for the Hillingdon £ by allowing for a flexible use of collective resources and reduction in transaction costs; and

- Enablers such as IT interoperability, development of a sustainable workforce and a vibrant market offering residents/patients quality choices.

The key outcomes of the plan are:

a. A maximum of 2,435 emergency admissions (also known as non-elective) to hospital attributed to the 65 and over population with ambulatory care sensitive conditions, i.e. cases where effective community care and case management can help prevent the need for hospital admission, such as chronic hepatitis B; asthmas; congestive heart failure; diabetes; chronic obstructive pulmonary disease; hypertension; epilepsy; and dementia;

b. A maximum of 170 permanent admissions of people aged 65 + and over to care homes;

c. 90% of older people (65 + and over) discharge from hospital into the Reablement Service in quarter 3 of 2019/20 who are still at home 91 days after discharge;
d. The number of delayed transfers of care to be no more than 13.6 daily delays (4,964 delayed days for 2019/20);

e. In respect of CYP:

- **Prevention & Early Intervention** - *"A CYP, their families and carers are able to access wellbeing support before it becomes an issue.*"
- **Identification** - *"A CYP's needs are identified as early as practically possible."*
- **Triage** - *"A CYP is signposted to the necessary intervention shortly after referral."*
- **Assessment & Individual Care Planning** - *"A CYP's needs are assessed and clear recommendations are made around the provision they require."*
- **Review & Transition** - *"Therapy delivery provides targeted intervention that enables CYP to make good progress."*

f. In respect of people with learning disabilities and/or autism:

- People with a learning disability and/or autism are able to lead happy and fulfilling lives as independently as possible in the least restrictive environment feasible;
- People with a learning disability and/or autism have a positive experience of care and support.

A.2) Who are the service users or staff affected by what you are assessing?

The service users, residents and patients affected by the BCF Plan are:
- Hillingdon's 65 and over population;
- Adults with learning disabilities and/or autism;
- Children and young people with special education needs; and
- Carers of all ages.

A.3) Who are the stakeholders in this assessment and what is their interest in it?

Stakeholders	Interest
Residents and patients	People directly affected by the plan.
Carers	People directly affected by the plan.
Hillingdon Health and Care Partners	Involved in delivery of the schemes.
Third sector (voluntary and community)	Involved in delivery of the schemes.

A.4) Which health-related issues are relevant to the assessment? ✓ in the box.

Employment or financial well-being	✓	Self-care	✓
Access to healthcare (primary, secondary, specialised)	✓	Social inclusion	✓
Environmental exposures (e.g. noise, air quality, green space)		Mental wellness	✓
Lifestyle (e.g. diet, physical activity, smoking, alcohol)	✓	Health inequalities	✓
Infectious disease	✓	Community Safety (e.g. crime, road safety, defensible space)	
Scope of health care services	✓	Other – please state	

STEP B) Consideration of information; data, research, consultation, engagement

B.1) Consideration of information and data - what have you got and what is it telling you?

Overview

NHS Right Care data shows Hillingdon has higher non-elective (NEL) admission rates in several areas when compared with the England and peer group average. For example, the rate of unplanned hospital admissions for adults with chronic ambulatory care sensitive conditions is above the England average and 46% higher than the Best 5 CCG's nationally. In addition, the rate of emergency admissions for Hillingdon people aged 75+ with a stay of <24 hours is 53% higher than the England average and 62% higher than the best 5 CCGs in the country. The proportion of Hillingdon people aged 65+ in hospital for more than 10 days is 7% higher than the England average and we know that if a person over the age of 80 spends 10 days or more in hospital, then it leads to the equivalent of 10 years ageing in their muscles and makes subsequent independent living difficult. If we look to understand what is driving this locally, we know that:

- 2% of the Hillingdon population (6,417 people) account for 50% all emergency admissions to hospital;
- Within this cohort at least 21% of these admissions ambulatory care sensitive conditions, i.e. cases where effective community care and case management can help prevent the need for hospital admission, such as chronic hepatitis B; asthmas; congestive heart failure; diabetes; chronic obstructive pulmonary disease; hypertension; epilepsy; and dementia.

Hillingdon's Population

Hillingdon's Joint Strategic Needs Assessment (JSNA) shows that based on the Greater London Authority (GLA) estimates the population of the borough in 2019 is 312,567. Table 1 below shows the projected growth by age group for the period 2019 to 2030.

Table 1: Population Growth by Age Group 2019 - 2030									
Year	0-19	20-64	65 +	80+	All Ages	% of Total Population			
						0-19	20-64	65+	80+
2019	83,560	187,386	41,634	12,100	**312,580**	26.7	59.9	13.3	3.8
2024	88,246	192,897	47,516	13,300	**328,273**	26.8	58.7	14.4	4.0
2030	87,750	193,300	53,650	16,300	**334,800**	26.2	57.7	16.0	4.8

Ethnicity

According to the Greater London Authority in 2018, in Hillingdon 41.7% of the population are White British, 8.3% are White Other and 50% are from Black & Minority Ethnic groups. Ruislip and Northwood is least ethnically diverse part of the borough with just over 30% identifying themselves as coming from non-White households, compared to 51% in Hayes and Harlington.

The GLA Ethnic Group Population Projections data suggests that in the period to 2030 Hillingdon's population will become increasingly diverse, e.g. 51.6% of the population is projected to be non-White by 2024 and 54% by 2030. It is noteworthy that the older the population group in Hillingdon is the less diverse it is. For example, 23% of the 65 and over population is projected to be from non-White groups compared to 15.6% of the 80 and over population group. These groups are projected to become more diverse over time so that by 2030 33.8% of the 65 and over age group and 23.6% of the 80 and over age group will be from non-White groups. The older people population from Black and Minority Ethnic Groups (BAME) is concentrated in the south of the borough.

Older People: Deprivation

Income Deprivation Affecting Older People Index (IDAOPI) 2015 identified that the percentage of older people in Hillingdon experiencing deprivation was in line with the general level of deprivation in the borough and at 15.7% was relatively low in comparison with the average for England of 16.2%. However, IDAOPI data applied to GP practices shows that older people experiencing the greatest levels of deprivation are concentrated in practices in the south of the borough.

Older People: Dementia

Public Health England shows that in 2018 Hillingdon had a dementia diagnosis rate of 66.7%, which compares to 70.5% for London and for England. The Projecting Older People Population Information System (POPPI) estimates suggest that the number of older people living with dementia in 2019 is 2,970. This is projected to increase to 3,404 by 2025 and 3,939 by 2030. For the 85 and over population POPPI estimates suggest that the number living with dementia is 1,334 in 2019 and

that this will rise to 1,562 by 2025 and 1,808 by 2030.

Older People: Social Isolation

An older person living on their own is a risk indicator of social isolation. POPPI projections suggest that in 2019 there are 13,399 people aged 65 and above living on their own, 7,973 of whom are aged 75 and over. This is projected to increase to 15,359 (9,345 aged 75 and over) in 2025 and 17,433 (10,401 aged 75 and over) by 2030.

The study *Preventing Suicide in England - a cross-governmental outcomes strategy to save lives* (DH 2012) shows that living alone and becoming socially isolated and experiencing bereavement are contributory factors that can lead to suicide. Available figures show that the number of suicides amongst the 65 + age group in Hillingdon is small, e.g. 5 in 2010, 4 in 2011 and 3 in 2012, but they predominantly occur amongst men.

Older People: Long-term Conditions

Table 2 shows estimates of the prevalence of older people living with long-term conditions.

Table 2: Prevalence of Long-term Conditions within Older People Population

Borough Estimate	Stroke	Cardio Vascular Disease	Chronic Heart Disease	Hypertension	Diabetes	Mental Health Conditions
2016	3,067	12,299	6,532	26,616	7,098	4,502
2021	3,312	13,271	7,047	28,688	7,662	4,816

POPPI projections suggest that the number of people aged 65 and over with a body mass index of 30 + was 10,094 in 2019 and that this will increase by 23% to 13,950 by 2030. The numbers of older people living with types 1 & 2 diabetes are projected to increase by nearly 23.5% from 5,180 in 2019 to 6,770 in 2030.

Health Survey for England 2008 Volume 1 Physical activity and fitness shows that approximately 50% of Hillingdon's population aged 65 - 74 year olds spend 6 or more hours sedentary time per day during the week and over 50% at weekends. For the over 75s it is 62% for both week days and at weekends. Sedentary lifestyles are known to contribute to the onset of diabetes.

Long-term Conditions

It is estimated that 2% of the most complex patients (all ages), e.g. people living with two or more long-term conditions, comprise 16.2% of CCG spend. 57% of these complex patients are people aged 65 and over; 35% are aged 75 and over and 14% aged 85 and over. In 2018/19 the local health spend on people aged 65 and over living with multiple health conditions was £9.1m.

Within the next 6 years to 2025, there is a projected increase of 14% in the number of people aged 65 and over with a limiting long-term illness whose day to day activities are limited a lot from 9,749 to 11,273. In terms of comparisons with our near

neighbours the increase is the same as that projected for Ealing and Harrow but marginally below that for Brent and Hounslow. It also corresponds with the projected increase for the London region. There is a projected increase of 24% in the period between 2019 and 2030 to 12,777. This rate of increase is broadly in line with our near neighbours and the rate of increase for the London region.

Frailty

Frailty is a clinically recognised state of increased vulnerability which results from ageing associated with a decline in the body's physical and psychological reserves. Older people with frailty are at risk of unpredictable deterioration in their health resulting from minor stressor events. A 2015 Institute for Fiscal Studies report suggests a prevalence rate of 6.5% for the population aged 60 to 69 and 65% for the population aged 90 and over.

Falls and Fractures

The consequences of falls have a significant impact on both NHS and social care services. Falling can precipitate loss of confidence, the need for regular social care support at home, or even admission to a care home. Fractures of the hip require major surgery and inpatient care in acute and often rehabilitation settings, on-going recuperation and support at home from NHS community health and social care teams. In addition, hip fractures are the event that prompts entry to a care home in up to 10% of cases. Indeed, fractures of any kind frequently require a care package for older people to support them at home.

In the UK, 35% of over-65s experience one or more falls each year. About 45% of people aged over 80 who live in the community fall each year. Between 10% and 25% of such fallers will sustain a serious injury.

In 2018/19 there were 921 falls-related admissions to Hillingdon Hospital of people aged 65 and over at a cost of £3.4m, which compares to 868 admissions at a cost of £3.1m in 2017/18.

Life Expectancy

Public Health England's 2018 Local Authority Health Profile for Hillingdon shows that life expectancy for both men and women is higher than the England average. However, it is 6.8 years lower for men and 5.2 years lower for women in the most deprived ward in Hillingdon compared to the least deprived, i.e. Botwell ward compared to Eastcote and East Ruislip.

People with Learning Disabilities

Table 3 below shows the Projecting Adult Needs and Service Information (PANSI) and POPPI estimates for the numbers of people in Hillingdon with a moderate to severe learning disability who are therefore likely to be accessing or in need of services.

Table 3: Estimates and Projections for People with Moderate to Severe Learning Disabilities 2019 - 2030			
	2019	**2025**	**2030**
18 - 64	1,095	1,139	1,175
65 +	116	133	152
TOTAL	**1,211**	**1,272**	**1,327**

People with Learning Disabilities and Dementia

The Royal Society of Psychiatrists' 2009 study *Dementia and People with Learning Disabilities: Guidance on the assessment, diagnosis, treatment and support of people learning disabilities who develop dementia* shows that there is an increased susceptibility amongst this population group to develop dementia once they reach the age of 50. The following figures suggest that the risk is up to four times greater than the general population:

- 1 in 10 of those aged 50 to 64
- 1 in 7 of those aged 65 to 74
- 1 in 4 of those aged 75 to 84
- Nearly three-quarters of those aged 85 or over.

Research undertaken in partnership with the Alzheimers' Society estimates that 1 in 10 people with a learning disability will go on to develop dementia between the ages of 50 and 65 and approximately 50% of those aged 85 and over. For people living with Down's syndrome 1 in 50 are estimated to develop dementia in their 30s and 50% of those aged 60 and over will develop it.

People with Autistic Spectrum Disorders

Table 4 below shows the PANSI estimates for the numbers of people aged 18 to 64 with autistic spectrum disorders.

Table 4: Estimates and Projections for People with Autistic Spectrum Disorders and Challenging Behaviours 2019 - 2030						
	Autistic Spectrum Disorders			**Challenging Behaviours**		
	2019	**2025**	**2030**	**2019**	**2025**	**2030**
18 - 64	1,973	2,054	2,123	88	91	93

Children and Young People with Special Educational Needs

The 2018 Schools Census showed that there were 7,318 children and young people requiring special educational need (SEN) support or with an Education and Health Care Plan (EHCP) in Hillingdon. Of the total volume 1,822 have an EHCP and 5,496 require SEN support. Table 5 below shows the breakdown between state funded primary, secondary and special schools.

Table 5: Summary Breakdown of Need Across Hillingdon's Schools							
School Type	**Total Pupils**	**Pupils with EHCPs**	**%**	**Pupils with SEN Support**	**%**	**Total SEN & EHCP**	**% of all pupils with SEN**
Primary school	30,690	557	1.8	3,577	11.7	4,134	13.5
Secondary school	20,431	318	1.6	1,911	9.4	2,229	10.9
Special schools	955	947	99.2	8	0.8	955	100
Overall Total	**52,076**	**1,822**		**5,496**		**7,318**	**14.1**

Table 5 shows an increase in the 0 - 19 age group to 2024. As the numbers of people aged 0-19 continue to grow so will the SEN population.

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. Additional census information showed that approximately 10% of Carers were aged under 25, which emphasises the continuing importance of supporting Carers of all ages. POPPI data suggests that in 2019 there are 5,612 older people providing unpaid care and nearly 36% (2,017) are providing 50 hours a week or more. The number of older carers is projected to increase to 6,438 in 2025 and 7,342 in 2030. As at 31st March 2019 there were 1,112 Young Carers, i.e. Carers aged between 5 and 24, registered with the Hillingdon Carers' Partnership who were actively providing care to a relative.

PANSI estimates suggest that in 2019 there are 426 adults with learning disabilities living with parents and this is expected to rise to 435 in 2025 and 451 in 2030. As at 31st July 2019 there were 226 people with learning disabilities in receipt of Social Care services with live-in Carers and of these 8% (19) were people aged 75 and over. This illustrates both the importance of supporting older Carers and the need to plan for a time when they will be unable to continue their caring role because of the effects of old age.

Consultation

B.2) Did you carry out any consultation or engagement as part of this assessment?

Please tick ✓ NO ☐ YES ✓

If Yes, what did you do or are planning to do? What were the outcomes?

The timescale for delivering the HIA did not permit consultation with a wide group of patients, residents and other stakeholders. However, the following stakeholders were invited to comment on the draft assessment:

- Kevin Byrne - *Head of Health Integration and Voluntary Sector Partnerships, LBH*
- Sally Chandler - *CEO, Hillingdon Carers on behalf of H4All.*
- Carol McLoughlin - *Senior Commissioning Manager for Children and Young People, HCCG*
- *Turkay Mahmood - Interim Chief Executive, Healthwatch Hillingdon*
- Keith Spencer - *Director of Integration and Delivery, HHCP*
- Jane Walsh - *Commissioner Older People's Services, HCCG*

B.3) Provide any other information to consider as part of the assessment

MTFF/QIPP context

The Council is required to find £8m of savings in 2019/20 rising to nearly £14m in 2020/21.

HCCG's two year financial plan for 2019/21 identified a requirement to generate efficiencies of £15m in 2019/20 and an equivalent sum in 2020/21.

National Policy Context

The Better Care Fund has been introduced as part of national policy as a tool to implement the general duty under the 2014 Care Act to integrate services between health and social care. The intention behind integration is to achieve efficiencies through better coordination and provide patients and residents with an improved experience of care and support.

A further objective is that there are timely and appropriate interventions by the statutory agencies working with primary care and the third sector to prevent non-elective attendances at A & E that are avoidable as well as avoidable hospital admissions. Integration through the BCF is also intended to be used as a mechanism for preventing escalation in the needs of residents that result in a loss of independence and the need for more expensive forms of intervention by health and social care.

Hillingdon's plan has been drafted in accordance with the requirements of the *Better Care Fund Policy Framework 2019/20* (DHSC/MHCLG April 2019) and the *Better Care Fund Planning Requirements for 2019/20* (DHSC/MHCLG/NHSE July 2019).

Local Policy Context

The Better Care Fund plan is key to the delivery of the aspects of Hillingdon's statutory Joint Health and Wellbeing Strategy that are dependent on integration between health and social care or closer working between the NHS and the Council for delivery. The Health and Wellbeing Strategy reflects the Hillingdon specific aspects of the North West London Sustainability and Transformation Plan (STP).

The BCF enables HCCG and the Council, as well as other statutory partners, to meet integration requirements contained within the 2012 Health and Social Care Act.

C) Assessment

What did you find in B1? Who is affected? Is there, or likely to be, an impact on certain groups?

C.1) Describe any **NEGATIVE** impacts (actual or potential):

Health-related issues	Impact on this issue and actions you need to take
Employment or financial wellbeing	The 2019 assessment review confirmed that there are no negative impacts on this health-related issue arising from the proposed 2019/20 plan. The potential negative impact on staff as a result of the development of further integration options (structural as well as functional) that apply under proposals contained within scheme 4: *Integrated hospital discharge and the intermediate tier* and the proposals for the vertical integration of brokerage will be mitigated through the application of good employment practice procedures. The seven day working requirements reflected within High Impact Change Model could also result in staff coming under pressure, real or perceived, to work extended hours to ensure that services are available. This issue was identified in assessments for previous plans and will continue to be mitigated, once again, through the application of good employment practice procedures.
Access to healthcare	Assessments of earlier iterations of the BCF plan considered whether the BCF Plan would lead to resources being diverted from other user groups. There has been no evidence of this arising from the implementation of previous plans. In 2019/20, as in previous years, much of the investment going into the pooled budget is committed to existing contracts and this militates against this eventuality. Additional demands on health services could arise from the pro-active early identification work proposed to be undertaken as part of *scheme 1: Early intervention and prevention*. The compensation for this is the potential for avoiding or delaying increased costs as a result of a more anticipatory model of care.

	Scheme 5: Improving care market management and development - The mobilisation of the Enhanced Support for Care Homes and Extra Care Service is expected to reduce demand on the Hospital. The plan continues to be aligned with the key integration enablers such as care and support planning being delivered by the GP Confederation, shifting to planning for anticipated needs with GPs as lead professional. This will result in more services being delivered from local GP practices and may create access issues for some people who might otherwise have gone to Hillingdon Hospital. However, the compensation is the probable increased access and convenience that there will be for others as a result of health services being delivered closer to home. There is concern about additional demand on GP practices from the new extra care schemes arising from staff requesting GP visits inappropriately. This will be mitigated by a combination of the Council reinforcing the message to staff and tenants that the latter should attend surgeries unless too ill to do so and also GPs providing timely escalation should issues arise. A clear escalation route will be provided to GPs.
Self-care	A point made during assessments for two previous plans that people with capacity had the right to make 'bad' decisions was considered to be equally valid for the 2019/20 plan as was the continuing objective to ensure that people had access to information and support to enable them to make informed decisions.
Social inclusion **Mental wellness** **Lifestyle** **Infectious disease**	No negative impacts were identified from the eight schemes within the 2019/20 plan on these health-related issues. The importance of H4All Wellbeing Service and third sector consortium partners managing flow through services, including managing dependency and associated service capacity, was identified in the 2017 assessment and is still relevant in 2019/20. This will be kept under review through the Integrated Care Partnership (ICP) contract monitoring process and also as part of the specific action within the BCF delivery plan to review the model of third sector provision.
Health inequalities	The expansion of the remit of the CCTs to a broader population group will assist in addressing health inequalities, as will the expansion of the plan to include

	children and young people and people with learning disabilities and/or autism. The resourcing of the Neighbourhood Teams is intended reflect the concentration of deprivation in the south of the borough, which is manifested in the differentiation in life expectancy in wards in the north of the borough compared to some in the south.
Scope of healthcare services	The proactive approach to identification of need required under *schemes 1 and 2: An integrated approach to supporting Carers,* may lead to the identification of health needs for which the appropriate services may not currently be in place and which may therefore have additional resource implications. During the period of the 2017/19 plan the H4All Wellbeing Service and Hillingdon Carers' Partnership have pursued innovative ways of addressing additional needs when they have been identified with the support of other H4All consortium members and through attracting external funding. The individual benefits of the schemes versus additional resource requirements will continue to be kept under review as part of the BCF monitoring process.

C.2) Describe any **POSITIVE** impacts

The assessing team felt that the comments raised as part of the 2015/16 plan assessment were still valid. Additions have been made to those comments where the team felt that this was appropriate in view of the content of the 2016/17 proposed plan.

Health-related issues	**Impact on this issue and actions you need to take**
Employment or financial well-being.	*Scheme 1* - Should lead to early identification of Carers who may be in employment and provision of timely support following a Carer's assessment may enable them to continue in employment for longer with the benefits as described above. Scheme 5 - The integrated commissioning proposals for homecare require providers to pay their workforce a minimum amount that is above the National Living wage, which should contribute to a more stable workforce and therefore a better experience of care for people receiving the service.

	Schemes 1 and 6: *Living well with dementia* - Early identification of people living with dementia and their Carers may help to ensure early access to appropriate treatments that may enable them to retain employment longer.
Access to healthcare	*Scheme 1* - The early identification of people at risk of escalated need will ensure timely access to appropriate healthcare as well as other care and support services. This will allow for more effective care planning where required and prevent deterioration in need that can lead to a loss of independence and more expensive healthcare interventions. The Care Connection Teams (CCTs) will have a critical role in delivering this within the Neighbourhood Teams. *Scheme 3: Better care at end of life* - This will support people to die in their preferred place of care, which is generally at home. As well as being a more comforting environment for the person in the last days of their life (as well as their family). The scheme will lead to a more effective coordination of the required services. *Scheme 1* - This should result in the health needs of residents being addressed at a more local level. Taken in conjunction with the other schemes within the BCF Plan and other integrated care system enablers such as improved care planning, care navigation and multi-disciplinary team working, the result should be a more efficient use of resources. *Scheme 5*: *Improving care market management and development* - The creation of a dedicated social care resource to support extra care and link in with the CCTs will help to ensure timely access to appropriate healthcare services. The wrap-around primary care service proposals also support this. Scheme 7: *Integrated therapies for children and young people* - Under the 2019/20 plan earlier access to speech and language therapy (SaLT), occupational therapy and physiotherapy should help to address the current disjointed approach leads to issues such as: ● There is little or no SaLT support for children without an Education, Health and Care Plan (EHCP); ● Children with Special Education Needs (SEN) but without an EHCP are not receiving the level of support

	they require; ● Capacity constraints within the existing service mean that children with a level of support deemed to be below *'moderate to severe'* are not currently accepted into therapy services; ● The unmet needs of CYP with speech, language and communication difficulties often culminates in a display of challenging behaviour, which leads to additional stress on parents and more costly interventions in order to address; ● Challenging behaviour from people on the autistic spectrum often results from sensory issues that could be addressed through management strategies developed as a result of OT interventions that are not currently taking place early enough to prevent crises occurring. The key tasks under Scheme 8: *Integrated care and support for people with learning disabilities and/or autism* should contribute to improved and timely access to healthcare services.
Self-care	*Schemes 1, 2, 3* and 4 promote self-care as a means of putting individuals more in control of managing their own health and care needs, thus preventing or delaying a escalation in their needs and the loss of independence that can arise from this. The H4All Wellbeing Service should have an increasingly significant impact in empowering people to take more control and navigate the health and care system in a better way. The taking of a Personal Health Budget (PHB) as a direct payment is a proxy measure for the level of motivation a person has in managing their own long-term condition. The promotion of PHBs as direct payments under scheme 5 will provide opportunities for more personalised approaches for patients to address their health needs and also social care needs where integrated budgets can be pursued. This will help residents to obtain better outcomes.
Social inclusion	*Scheme 1* - The implementation of the CCTs across the borough creates an opportunity to identify people who are either socially isolated or at risk of social isolation and through the H4All Wellbeing Service present them with options to engage with their local communities. This could include opportunities to volunteer with third sector

	organisations. It was noted that action under scheme 7: *Integrated therapies for children and young people* and scheme 8: *Integrated care and support for children and young people* should enhance social inclusion and mental wellness.
Mental wellness	*Scheme 1* - Early identification of those living with dementia can help to ensure timely access to treatment that may arrest the progress of the condition. Access to advice about changes in lifestyle habits that may contribute to and/or accelerate progress of the condition could also have the same effect. Engaging with people who are socially isolated can help prevent adverse health impacts, such as depression, that can also lead to other physical health problems. *Scheme 2*: Better management of the end of life pathway should relieve some of the stress experienced both by the person at the end of their life and also their family. Figures in section 2 showed the most data for suicides for people aged 65 and over in Hillingdon. *Schemes 1, 2 and 3* in particular would seek to address some of the issues that can lead to suicide.
Lifestyle	*Schemes 1, 2, 3 and 6* will identify particular lifestyle issues, e.g. diet, smoking, alcohol abuse, through visits to patients' homes. The result will be referrals to appropriate professionals and/or third sector organisations to provide advice and support. There development and promotion of activities for older people should assist in addressing some of the lifestyle-related health issues identified from the data in Step B of this document.
Infectious disease	Key objectives of the BCF Plan are to prevent non-elective admissions and to reduce Length of Stay (LOS) in the event of an admission. Achieving this will help to prevent the risk of hospital acquired infections. *Scheme 5* - Support provided to care homes should help to improve standards and reduce the number of care home residents acquiring infections that can lead to hospital admission and a rapid deterioration in mental wellbeing as well as physical health.

Health inequalities	The BCF Plan seeks to address health inequalities faced by Hillingdon's more vulnerable older population, children and young people with special educational needs and people with learning disabilities and/or autism. However, the disparity in social and economic wellbeing between older people in the north of the borough and those in the relatively more deprived, more culturally diverse wards in the south, particular consideration will have to be given as to how communities will be accessed. It is envisaged that this will be accomplished by close working with faith and other community-based groups. The provision of Personal Health Budgets as direct payments for people with health needs (including those meeting Continuing Health Care (CHC) thresholds) as well as Personal Budgets for people meeting the National Adult Social Care eligibility criteria, provides opportunities for a more personalised approach to addressing need that would reflect cultural and religious diversity. The development of a model of care and support for people with learning disabilities and/or autism who are in a supported living setting that maximises their independence and supports their health and wellbeing will help to ensure that residents are able to live their lives in the least restrictive environment possible.

D) Conclusions

The assessment has shown that the health implications of the 2019/20 BCF Plan are overwhelmingly positive for the residents of Hillingdon, which should consequently result in financial benefits for the local health and social care economy.

Key areas that need further consideration are:

- The impact of any functional or structural changes arising from the integrated hospital discharge proposals on staff, including seven day working, will be managed through the application of good employment practices.
- Flow management through third sector services will be monitored through the contract review process for the Integrated Care Partnership.
- The suitability of existing services to meet the needs of people identified from the more proactive case finding approach set out in *scheme 1* will be kept under review.
- Patient expectations regarding service provision as a result of the D2A model, which can be managed through appropriate information provision.
- The impact of Enhanced Support for Care Homes and Extra Care Schemes on relieving pressure on GP practices and in preventing emergency admissions.
- Escalation processes will be put in place for GPs where they asked to visit the extra care schemes to see tenants who could have attended their surgeries.

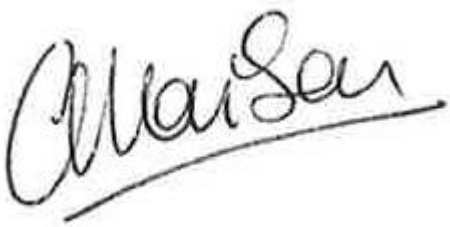
The impact of all of the schemes will be monitored as part of the governance process for the BCF Plan.

Signed and dated:

28/08/19

Name and position: **Tony Zaman, Corporate Director Adults, Children & Young People's Services**

Signed and dated:



28/08/19

Name and position: **Caroline Morison, Managing Director, Hillingdon CCG**

Appendix 1

BCF Scheme Summaries

Scheme Number	Scheme Title	Scheme Aim(s)
1.	Early intervention and prevention.	To manage demand arising from demographic pressures by reducing the movement of Hillingdon residents/patients from lower tiers of risk into higher tiers of risk through proactive early identification and facilitating access to preventative pathways.
2.	An integrated approach to supporting Carers.	To maximise the amount of time that Carers are willing and able to undertake a caring role.
3.	Better care at end of life.	To realign and better integrate the services provided to support people towards the end of their life in order to deliver the ethos of a 'good death.' The main goals of the scheme are to: • Ensure that people at end of life are able to be cared for and die in their preferred place of care; and • To ensure that people at end of life are only admitted to hospital where this is clinically necessary or where a hospital is their preferred place of care or death.
4.	Integrated hospital discharge and the intermediate tier.	This scheme seeks to prevent admission and readmission to acute care following an event or a health exacerbation and enabling recovery through intermediate care interventions with the aim of maximising the person's independence, ability to self-care and remain in their usual place of residence for as long as possible. A further objective of this scheme is to support discharge from mental health community beds in recognition of the impact of these delays on patient flow through Hillingdon Hospital.

5.	Improving care market management and development.	This scheme is intended to contribute to the STP 2020/21 outcomes of achieving: • A market capable of meeting the health and care needs of the local population within financial constraints; and • A diverse market of quality providers maximising choice for local people.
6.	Living well with dementia	The objective of this scheme is that people with dementia and their family carers are enabled to live well with dementia and are able to say: • *I was diagnosed in a timely way.* • *I know what I can do to help myself and who else can help me.* • *Those around me and looking after me are well supported.* • *I get the treatment and support, best for my dementia, and for my life.* • *I feel included as part of society.* • *I understand so I am able to make decisions.* • *I am treated with dignity and respect.* • *I am confident my end of life wishes will be respected. I can expect a good death.*
7.	Integrated therapies for children and young people.	This scheme seeks to: • Provide early intervention therapy services that offer early assessment and advice, support self-care and reduce dependence on services in future years. • Provide a robust integrated triage process that directs children and young people to the most appropriate therapy and support without delay.
8.	Integrated care and support for people	This scheme aims to:

	with learning disabilities and/or autism.	• To improve the quality of care for people with a learning disability and/or autism; • To improve quality of life for people with a learning disability and/or autism; • To support people with a learning disability and/or autism down pathways of care to the least restrictive setting; • To ensure that services are user focused and responsive to identified needs.