2022/23 Better Care Fund Narrative Plan

Health and Wellbeing Board

Hillingdon

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

The 2022/23 Better Care Fund plan has been developed in partnership with the organisations within Hillingdon's Integrated Care Partnership known as Hillingdon Health and Care Partners (HHCP). HHCP includes The Confederation that represents 43 of the borough's 45 GP practices; the Central and North West London NHS Foundation Trust (CNWL), the local community health and community mental health provider; The Hillingdon Hospitals NHS Foundation Trust (THH), the local acute hospital; and a third sector consortium known as H4All. This includes four of the largest third sector organisations operating in Hillingdon, i.e., Age UK, Carers Trust Hillingdon, Disablement Association Hillingdon (DASH) and Harlington Hospice. We also engaged with Healthwatch Hillingdon.

Care home and homecare providers have also been involved, but late publication of the planning requirements means that it has not been possible to engage with a broader range of stakeholders.

How have you gone about involving these stakeholders?

The '*place-based'* governance structure for delivering the priorities within the joint Health and Wellbeing Strategy has been the route through which HHCP partners have been involved in the development of the BCF plan. This is expanded on in section 2: *Governance*.

The involvement of care home and homecare providers has been through their respective forums.

1. Executive Summary

This should include:

- Priorities for 2022/23
- Key changes since previous BCF plan.

1.1 2022/23 Priorities

The 2022/23 BCF plan includes eight schemes, and these are as follows:

- Scheme 1: Neighbourhood development
- Scheme 2: Supporting carers
- Scheme 3: Better care at end of life
- Scheme 4: Urgent and emergency care
- Scheme 5: Improving care market management and development

- Scheme 6: Living well with dementia.
- Scheme 7: Integrated care and support for children and young people
- Scheme 8: Integrated care and support for people with learning disabilities

The priorities for 2022/23 by scheme are:

Scheme 1

- Embedding population health management and addressing areas of inequality (including those identified in the NHS Core20Plus5 model) to determine operating model for integrated neighbourhood teams.
- Delivering national and NWL enhanced services to national/NWL targets.

Scheme 2

- Developing a refreshed all age Joint Carers Strategy, 2023 – 2028.
- Completing the *'Are you a carer?* leaflet.
- Restoring carer leads in GP surgeries.
- Ensure that the electronic patient record (EPR) system is developed so that asking if a patient has a carer or is a carer is a mandatory aspect of assessment at Hillingdon Hospital.
- Reviewing the Carer Support Service delivery model prior to retendering.

Scheme 3

- Establishing a coordination hub for patients, carers and health professionals to access specialist care and support

Scheme 4

- Increasing capacity for same day emergency care (SDEC), including establishing intravenous antibiotic administration in the community.
- Piloting an integrated neuro-rehab community service
- Establishing a frailty virtual ward model to reduce admissions and length of stay.
- Roll out falls training package for care homes and ongoing falls population health work.
- Ensuring availability of community capacity to respond to winter demand surge.

Scheme 5

- Implementing a coordinated approach to supporting the sustainability of the regulated care market.
- Undertaking a fair cost of care exercise and developing a Market Sustainability Plan.
- Embedding integrated brokerage arrangements to expedite hospital discharge**.**

- Establishing block contracts for pathways 2 and 3 discharge and admissions avoidance.

Scheme 6

- Improving dementia diagnosis rates.
- Developing and maintaining alternative solutions to institutional care for people living with dementia.

Scheme 7

- Delivering integrated family hub services.
- Developing 0-19 services focussed on needs of local population.
- Establishing mental health support roles in neighbourhood teams.
- Establishing a dynamic support register (DSR) for CYP with LD and /or Autism to enable partners to identify CYP at risk and consider community solutions.

Scheme 8

- Developing crisis pathways for people with learning disabilities and/or autistic people.
- Developing an all-age Joint Autism Strategy, 2023 – 2026.
- Completion of Joint Strategic Needs Assessment for autism.
- Delivery of LD health checks to national target.

1.2 Key changes since 2021/22 BCF plan

Due to ongoing recovery and rebuilding priorities following the Covid pandemic, the local system has agreed to make no substantive changes to the schemes in the 2021/22 Plan. The 2022/23 Plan is intended to consolidate and build on the schemes from the previous year. However, discussions are in progress that are expected to lead to the inclusion of adult mental health within the BCF and also the inclusion of a local NHS provider as a signatory to the section 75 agreement.

Changes in respect of hospital discharge are addressed in section 4: *Implementing the BCF policy objectives*. Other changes that have been made in 2022/23 include:

- **Scheme 1:** Optum Consultancy has been engaged to work across the North West London sector to build a population health approach as proof of concept to improve care delivery across key risk groups. There is further expansion on this in section 4: *Implementing the BCF policy objectives* and section 7: *Equality and health inequalities*.

- **Scheme 2**: The separate funding provided by NHS NWL for a carer support worker will be integrated by variation into the Council's contract for the Carer Support Service.

2. Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

2.1 BCF schemes and transformation workstream alignment

The alignment of BCF schemes with the transformation workstreams to make them indistinguishable and therefore avoid unnecessary confusion is illustrated in the table below.

Alignment of BCF Schemes and Transformation Workstreams	
BCF Scheme	**Transformation Workstream**
Scheme 1: Neighbourhood development.	**Workstream 1:** Neighbourhood Based Proactive Care.
Scheme 2: Supporting carers.	Enabler
Scheme 3: Better care at end of life.	**Workstream 3:** End of Life Care.
Scheme 4: Urgent and emergency care.	**Workstream 2:** Urgent and Emergency Care.
Scheme 5: Improved market management and development.	Enabler
Scheme 6: Living well with dementia.	**Workstream 6:** Care and support for adults with mental health challenges and/or people with learning disabilities and/or autism.
Scheme 7: Integrated care and support for children and young people.	**Workstream 5:** Care and support for children and young people
Scheme 8: Integrated support for people with learning disabilities and/or autistic people.	**Workstream 6:** Care and support for adults with mental health challenges and/or people with learning disabilities and/or autism.

2.2 2022/23 governance arrangements

The governance arrangements for the BCF plan and its implementation have not changed significantly since 2021/22. **Annex A** summarises the governance structure. In summary, there is a Transformation Board with an executive lead from one of the health and care partners or the Council for all workstreams, e.g., workstream 1 is led by the chief executive from The Confederation, workstream 2 by the managing director for HHCP, workstream 3 by the chief executive of Harlington Hospice and workstream 5 is jointly led by the HHCP managing director and the Council's Executive Director of Children and Young People's Services. As in 2021/22 delivery at a more operational level is monitored by the HHCP Senior Operational Leads Team (SOLT) that also includes Council representation. This meets monthly and is chaired by the HHCP Managing Director. More strategic monitoring is undertaken by the HHCP Delivery Board that has executive level membership and also meets on a monthly basis. This also has Council representation and reports to the Health and Wellbeing Board (HWB), which provides senior "*Leadership of Place*" across the system and has the statutory responsibility for the development and implementation of the Joint Health and

Wellbeing Strategy. As a result of changes introduced in 2021, the HWB is now co-chaired by the Cabinet Member for Health and Social Care, an elected Member of the Council and the HHCP Managing Director. The HWB meets quarterly and the co-chairs each chair two meetings a year.

The importance of housing as one of the key social determinants of health is recognised in Hillingdon and a new housing strategy has been developed. In order to monitor delivery of the new strategy the Strategic Housing Board was established in 2021/22 that is chaired by the Council's Corporate Director of Place. **Annex A** illustrates how this board fits into the broader place-based health and wellbeing strategy delivery governance structure.

In 2021/22 the integrated performance report received by the HWB was adapted to reflect the workstreams in the refreshed Joint Health and Wellbeing Strategy. The practice of having a single system performance report considered by the HWB as a standing agenda item has continued into 2022/23. The September 2022 report to the Board can be accessed via the following link London Borough of Hillingdon - Agenda for Health and Wellbeing Board on Tuesday, 20th September, 2022, 2.30 pm

The integrated performance report is also considered by the HHCP Delivery Board.

3. Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person-centred health, social care and housing services, including:

- Joint priorities for 2022/23
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022/23.

3.1 Overview

As reported for Hillingdon's 2021/22 BCF plan, our refreshed Joint Health and Wellbeing Strategy, 2022 – 2025, aims to '*improve the health and wellbeing of all our residents and to reduce disparities in health and care across our communities'.* The strategy identifies priorities for achieving this aim that reflect the national policy direction, including the NHS Long-term Plan and feedback from our residents. Our priorities for 2022 – 2025 are:

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

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

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

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

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

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

The refreshed strategy was developed within the context of a major infrastructure investment in the borough in the form of a new hospital on the site of the existing Hillingdon Hospitals Foundation Trust main site. The size of the proposed new hospital is based on the development of new models of care intended to support residents in a community setting. Where treatment in a hospital setting is necessary and appropriate our models of care seek to expedite return home to a person's usual place of residence. Our approach is that time in hospital should only be for the minimum period necessary, and this is an underlying theme of our strategy.

HHCP is the borough-based partnership that serves as the vehicle for delivering integration across health services and the BCF provides the legal framework for delivering the place-based priorities set out in the Joint Health and Wellbeing Strategy that are dependent on integration between health and social care and/or closer working locally between the NHS and the Council for delivery. The BCF section 75 is identified as enabling delivery of a place-based health and care budget as reflected in the Government's health and care integration white paper '*Joining up care for people, places and populations: The government's proposals for health and care integration'* (DHSC Feb 2022) and discussions are in progress to develop this further in 2023/24.

3.2 Joint priorities for 2022/23

Please see section 1: *Executive Summary* and also section 5: *Supporting unpaid carers*.

3.3 Approaches to joint/collaborative commissioning

Hillingdon's approach to joint/collaborative commissioning remains consistent with our 2021/22 plan.

HHCP has to date used an '*alliance agreement'* to underpin shared resources, information sharing and the use of partnership investments with agreed benefits and outcomes. This mechanism has enabled the development and delivery of integrated services designed to deliver proactive joined up care to our residents. The BCF has provided an opportunity to take a more integrated approach to market management and development which underpins the broader health and care system. As reported in 2021/22, this has been shaped by the experience of the pandemic. Our approach has also been shaped by continued recognition that:

- 92% of the Council's spend on care and support services for adults is on independent sector provided services and is commissioning for significantly greater numbers than the NHS, therefore making it the dominant purchaser in the marketplace;

- Commissioning jointly with the local authority avoids the NHS paying a premium that can impact on the supply and overall cost of care for the local system;

- Local residents want locally based care and support solutions and longer lengths of stay in hospital are more likely to occur where only out of borough care solutions are offered or where these are the only ones available.

- The care and support providers necessary to enable residents to live independently in the community operate on a borough or locality basis rather than across an '*ICS*' footprint;

- In respect of children and young people's services, a combination of the Council's statutory children's social care responsibilities, an understanding of the independent sector market for service provision to this population group and established strategic relationship with schools mean that the local authority is best place to act as lead commissioner.

- The Council's £2,086k core grants programme to third sector organisations promotes a more resilient sector and strengthens capacity for early support and prevention.

The Council has long undertaken the brokerage function to access independent sector provided services on behalf of the NHS NWL in respect of people with learning disabilities in receipt of Continuing Healthcare funding, children and young people and also people subject to s117 of the Mental Health Act. The expansion of the role of the brokerage team in supporting hospital discharge emanating from developments in 2021/22 is addressed in section 4: *Implementing the BCF policy objectives.*

Approaches to joint/collaborative commissioning in respect of hospital discharge are also addressed in section 4.

3.4 How BCF funded services are supporting Hillingdon's approach to integration. Changes from the 2021/22 plan.

Since the inception of the BCF the majority of funding contained within the pooled budget has comprised of investment locked into pre-existing contracts. However, inclusion within the BCF serves the valuable point of providing visibility and transparency about investment by both NHS NWL and the Council into key services that consequently provides opportunities to secure efficiencies. This is consistent with the statement in the February 2022 white paper that '*aligned financial arrangements and pooled budgets will become more widespread and grow to support more integrated models of service delivery, eventually covering much of funding for health and social care services at place level'.*

A combination of factors including the late publication of the 2022/23 planning requirements and the implementation of the Health and Care Act, 2022, has meant that it has not been possible to expand the scope of this year's plan to the extent compatible with local ambition; however, as stated in section 1.2, planning discussions are in progress that could result in the inclusion of adult mental health and also to Hillingdon's community health and community mental health provider becoming a signatory to the BCF section 75 from April 2023.

2022/23 Changes

See section 1.2.

4. Implementing the BCF policy objectives (national condition 4)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care.
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- Steps to personalise care and deliver asset-based approaches.
- Implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches.
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

Objective 1: Enabling people to stay well, safe and independent at home for longer.

***a) The approach to integrating care to deliver better outcomes*.**

In Hillingdon neighbourhoods have been established as a vehicle to deliver improvements to meet the needs of residents through delivering care by multi-disciplinary teams arranged around groups of general practices that form six primary care networks (PCNs). There are a range of neighbourhood-based models of care in place that have demonstrated value both through the quality of care being delivered and also financial savings and these include:

- Care Connection Teams (CCTs).
- Integrated Paediatric Clinics
- Care Home Support Team
- Population Health and Preventative Care

b) How primary, community and social care services are being delivered to support people to remain at home.

HHCP analyse data obtained through the NWL whole systems integrated care database (WSIC), practice-level intelligence, the PAR30 risk analysis tool used in Hillingdon Hospital and the Patient Activation Measure (PAM) tool used by the Wellbeing Service (explained further in (d) below) to assess need. This assists with the deployment of resources either within HHCP or through services secured through a procurement process, e.g., a telehealth system in care homes. Effectiveness is then managed through SOLT and reflected in the performance reports considered by the HHCP Delivery Board (see section 2: *Governance*).

Care Connection Teams

The CCTs comprise of Guided Care Matrons, Care Coordinators, Wellbeing Advisers, a Mental Health Practitioner and GPs. They undertake active case management at neighbourhood level to the top 2% of individuals aged over 18 years at high risk of hospital admission or hospital attendance addressing their escalating care need before they cause any deterioration and therefore reducing acute activity. The Mental Health Practitioners are provided by CNWL. CNWL has also aligned its District Nursing Service to match the neighbourhoods. The structure of the Council's Adult Social Work teams is also aligned to the neighbourhoods.

An analysis of the activity of those on the caseload 3 months pre and post referral showed a reduction of 440 A&E attendances and a reduction of 282 non-elective admissions which together equated to an estimated gross saving of £1,278,047

(This is based on an average PbR cost for this patient group) based on 3 months. It should also be noted that rates of non-elective admissions for the over 65 population in Hillingdon are lower than the NW London average.

The Council has commissioned two block providers to deliver homecare, one in the north of the borough and one in the south with the dividing line being the A40. This has provided an opportunity to establish relationships between neighbourhoods and the providers. Relationships are at different stages, but this will help to support the objective by providing the means of flagging early signs of deterioration and addressing health need to prevent avoidable hospital attendances and/or admissions.

Integrated Paediatric Clinics

The clinics provide a joined up, out of hospital model of care for families who would otherwise be attending outpatient clinics. Clinics have been running since 2018 and rotate through different practices across the borough in order to provide access to residents and clinicians. As well as providing a community setting for specialist care and reducing the outpatient waiting lists the clinics support the development of relationships between primary care and specialist teams and an opportunity for education and training as clinics are shared by GPs and consultants. 2022/23 will see the model expanded to include MDT discussions about children with complex needs (including mental health). Representatives from the Council, CAMHS, the Hospital and community paediatricians, school nursing, voluntary sector as well as GPs attend.

Care Home Support Team

This multi-agency team includes six care home matrons who each have responsibility for supporting specific care homes as well as the four extra care housing schemes developed by the Council. The team also includes a mental health nurse, care home pharmacist, a dietician, speech and language therapist and tissue viability capacity. Specialist medical advice and support is provided by a care of the elderly consultant at Hillingdon Hospital. The team has responsibility for delivering care home direct enhanced services (DES) contract, although it predates the DES as was piloted in 2017.

Population Health and Preventative Care

Population health management lies at the centre of our approach to integrated care in Hillingdon and is at the core of the development of neighbourhood working. It will provide the focus for the operating models of our neighbourhood teams, building on work that has already been established through integrated working on diabetes, learning disabilities and serious mental illness and covid and flu vaccinations. See also (f) below.

High Intensity User (HIU) Service

This service is delivered by H4All and was launched to reduce the attendances and admittances to Hillingdon Hospital of the top 50 patients. The team deliver a holistic model of support that utilises health coaching, integrative counselling, and social prescribing for these patients who do not fit

into traditional systems of support. The service won the Health Service Journal (HSJ) *Urgent and Emergency Care Initiative of the Year 2021 Award* and is a partnership with the Hillingdon Hospital, London Ambulance Service, Police, housing, substance misuse and mental health services. Although the funding for the service currently sits outside of the BCF, it works closely with the services that are funded within it.

c) How BCF funded services will support delivery of the objective.

The BCF services that support the objective are primarily those within scheme 1: *Neighbourhood development*, the focus of which is prevention. The full breakdown of services within this scheme can be found in tab 5a: *Expenditure* of the planning template but can be summarised as follows:

- Access to online information about services (Marketplace and Online Coordinator post)
- Provision of community-based information, advice and support via VCS providers, including provision of services to address, for example, social isolation.
- Staffing to fund integrated care at neighbourhood level, including Care Connection Teams.
- VCS capacity building via H4All consortium
- Falls Prevention Service
- Telecare to support people in their own home (see also section 6: *Disabled Facilities Grants and wider services*)
- Care Home Support Team and Council's Quality Assurance Team supporting care home providers and also homecare providers in respect of the latter.

Further examples of services within the BCF that support the objective include integrated homecare in scheme 5: *Market management and development*, the dementia resource centre referred to in scheme 6: *Living well with dementia* and the range of community services delivered by CNWL referred to in objective 2 below.

d) Steps to personalise care and deliver asset-based approaches.

The components of Hillingdon's approach that are intended to maximise resident choice and control are:

- *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 the functionality of which has evolved over time. The new care and support directory called '*Marketplace*' now includes provision for children and young people as well as adults.

- *Self*-assessment – Included within the functionality of Marketplace is the ability of adults to undertake their own self-assessment to identify whether they are likely to satisfy the National Eligibility Criteria for adult social care. This option is also available for carers. Financial assessments can also be undertaken online.

- *Promotion of Personal Health Budgets (PHB) as Direct Payments and Integrated Budgets* – Partners identify the willingness of an individual to take their PHB as a Direct Payment as a proxy measure for how engaged they are in managing their own health condition (s). With the exception of PHB direct payments for wheelchairs, the Council has managed the process since 2014. This has avoided the necessity of establishing systems that replicates the direct payment process already operated by the local authority. As of 31st March 2022, there were 437 people in receipt of Direct Payments from the Council, which is a small increase (12) on the same period in 2021. The scope for PHBs as Direct Payments to support hospital discharge is currently being explored.

- *Empowering the resident voice* – The provision of advocacy ensures that people who may have difficulty expressing themselves are able to give 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.

  A separate arrangement is in place to support people who wish to make complaints against NHS bodies. The contract for this provision will be retendered in 2023/24 and meanwhile additional capacity is being built into Care Act Advocacy provision to reflect the expectation of increased demand arising from the Adult Social Care funding reforms that it is expected from early in 2023/24.

- *Strong partnership with the voluntary and community sector* – The H4All consortium has a highly active role within HHCP and is commissioned by NHS NWL to deliver the Wellbeing Service, which has staff attached to PCNs. The Wellbeing Service supports people with long-term conditions who are at risk of escalating needs via multi-disciplinary work undertaken by the CCTs and works with them taking a strengths or asset-based approach to make best use of the positive attributes that a person already has. The Patient Activation Measure (PAM) tool is used to identify how motivated a person is to manage their long-term condition at the start of a period of person and whether this has improved at the end. Social prescribing is a tool available to the service to address identified need. Additional grant aid has been made available to H4All by the Council to support the development of community capacity over 2022/23. However, it is anticipated that the increasing costs related to the cost of living crisis will challenge the ability of the sector to meet demand.

- *Strengths-based social work practice* – This focuses on the personal strengths and assets that an individual brings with them as well as the strengths and assets of their local community. This approach is integral to the discharge of the social care assessment duty under the Care Act as it maximises the independence and control that people have over managing their care needs.

f) Implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches.

NWL ICS has commissioned a firm named Optum to work with HHCP in support of borough based Population Health Management (PHM) activities. A series of action learning sets involving partners across HHCP, and the Council has resulted in four priority areas being identified and these are:

- Emergency presentations of working age men for chest pain.
- Frequent attenders – mapping of these people to look for flags for what drives this behaviour.
- Frailty and falls.
- High care users – the relationship between high care packages and health.

The initial priority for 2022/23 is frailty and falls with a focus on the Hayes area. This is pending the identification and implementation of a process for addressing the other priorities, which will take the system into 2023/24. The intention is that the PHM approach and methodology is developed in Hillingdon and amongst partners and able to the rolled out across the Borough to review and agree further issues at the PCN level over the coming years.

The BCF services directly related to addressing the frailty and falls priority are:
- CNWL's Falls Prevention Service (scheme 1)
- The Confederation's Weekend Visiting Service (scheme 1)
- Telecare Service (scheme 1)
- Reablement (scheme 4)
- CNWL's Care Home Support Service (scheme 5)

A key focus of the frailty and falls response work is on care homes, as falling is one of the main causes of admission of people living in this setting.

g) Multidisciplinary teams at place or neighbourhood level.

The operation of multidisciplinary teams at neighbourhood level is addressed in a (a) and (b) above.

Objective 2: Providing the right care in the right place at the right time.

a) The approach to integrating care to deliver better outcomes and how BCF funded services will support delivery of the objective.

Hillingdon has a single general acute trust within its geographical boundaries and approximately 83% of its activity is from people resident in the borough. 94.4% of activity relating to people registered with Hillingdon GPs is also attributed to people resident in the borough. For general acute, the focus of the Hillingdon health and care system is therefore on preventing admission to Hillingdon Hospital and expediting discharge from it. All partners within HHCP and the Council have a significant role in securing timely discharge from hospital and have had regard to the High Impact Change Model (HICM) in developing our approach and a self-assessment against the nine changes was undertaken in July 2022.
The approach and actions arising from the self-assessment are summarised below.

HICM Change 1: Discharge planning – Patient Flow Coordinators (PFCs) have allocated wards and facilitate identification of people who do not meet the criteria to reside and the referral of people to the Integrated Discharge Team (IDT). This team comprises of Hospital Discharge Coordinators and PFCs; CNWL's Rapid Response Team reps; Adult Social Care reps as well as representatives from the independent sector company contracted with the Council to provide the Bridging Care Service, the Reablement Service and also intermediate care provision within Park View Court extra care scheme, i.e., Comfort Care Services Ltd (CCS). An additional 8A nurse and 8A therapist has been added to the IDT to work across organisational boundaries and support the discharge planning process.

Key actions arising from the self-assessment are:

- Implementation of the medical admissions proforma called Redcoatt.
- Completion of patient discharge passport following consideration by the Hospital's Patient Forum.
- Continued roll out of SAFER patient flow bundle, including criteria-led discharge.
- Explore scope for re-establishing the '*red bag'* scheme.
- Developing a discharge checklist for the Hospital Emergency Department
- Developing a standardised discharge checklist for all adult inpatient wards

HICM Change 2: Monitoring and responding to system demand and capacity – Discharge monitoring and escalation meetings are taking place three times a day Monday to Friday and twice daily at weekends. These are led by an executive level partner representative. These are supported by daily activity data updates provided to senior partner representatives that include information about system capacity, i.e., Rapid Response, Hawthorn Intermediate Care Unit, Franklin House step-down beds, Bridging Care, Age UK services, etc. Independent sector capacity is monitored by the Council's Brokerage Team which has responsibility for brokering ongoing homecare packages of care for people supported by the Bridging Care Service and care home placements for people requiring short and long-term care home placements. Additional brokerage capacity introduced during the winter of 2021/22 to support weekend working has been retained in 2022/23.

Capacity Tracker is a key tool used to identify potential provider capacity. It is anticipated that Capacity Tracker supply data will become more accurate following the issue of a statutory information requirement notice under the Health and Care Act, 2022 in July 2022.

Key action arising from self-assessment:

- Implement results of the short-term bed-based care block contract tender, which will result in a contract to deliver four beds for people who are non-weight bearing for up to four years.

These beds will be funded from the NHS additional voluntary contribution.

HICM Change 3: Multi-disciplinary working – The MDT approach is embedded within operational practice. IDT triage meetings are taking place three times daily Monday to Friday and twice daily Saturday and Sunday. Monday to Friday meetings include Adult Social Care as well as CCS and Rapid response. The

focus on securing discharge at weekends means that CCS involvement is the priority.

The IDT also works closely with CNWL's Psychiatric Liaison Team (PLT) who are based at the Hillingdon Hospital main site and are available 24/7 to support people who present with a mental health need. The PLT also works in close liaison with the Hospital Discharge Mental Health Social Work Team.

No additional actions resulted from the self-assessment.

HICM Change 4: Home First - Homefirst was embedded within the culture across our health and care system and assessments were routinely taking place either in people's own homes or in step-down provision. However, changes in D2A funding arrangements mean that Care Act assessments in hospital have been restored for the first time in two years to initiate the Adult Social Care charging policy at point of entry into services. The following aspects of this process will impact on the discharge timeline and the resultant patient length of stay:

- Time between point of referral and completion of assessment.
- Time to write-up assessment and create a support plan.
- Identifying appropriate discharge placement; agreeing with family members, as appropriate; and implementing discharge operationally.

The existence of the CCS Bridging Care Service that has been funded by the NHS via its voluntary contribution to the BCF since 2018/19. The Bridging Care Service provides an onward referral route to the Reablement Team or long-term packages of care.

P2 support provided via HICU or in step-down bedded provision pending access to active rehab via HICU.

A contribution to costs incurred by the local authority for the provision of short-term care home placements from the NHS minimum contribution to out of hospital services and protecting adult social care as well as the NHS additional contribution will assist with flow through the Hospital of people meeting the criteria for discharge. It should be noted that in the planning template (tab 5a: *Expenditure*), applying the available drop-down options, these are identified as pathway 3 placements. For avoidance of doubt, Hillingdon's Reablement Service funded through the BCF is not being delivered in care homes. Funding for short-term placements from the Council that are included within the BCF pooled budget will be from the iBCF.

HICM Change 5: Flexible working patterns – Decision making arrangements in the hospital, including criteria-led discharge, as well as improvements to pharmacy and transport availability have led to improvements in weekend discharges but there is still work required to ensure that this is maintained consistently. Most care homes do not have the resources available to undertake assessments for long-term care more than five days a week. Rapid Response and Bridging Care are also available at weekends.

No additional actions resulted from the self-assessment.

HICM Change 6: Trusted assessment – There is a single referral form used in the Hospital that is accepted by all statutory partners, but no one form that is accepted by community providers. D2A funding changes do not affect the principle that no decision about ongoing care needs should be undertaken in an acute hospital setting. The end of year (2022/23) position is that 9 out of 10 assessments about ongoing care needs will be conducted in people's own homes or in step-down facilities and that 9 out of 10 assessments will be undertaken in the right setting and within time limits.

No additional actions resulted from the self-assessment.

HICM Change 7: Engagement and choice – Work is in progress with NHS NWL to revise standard information available to patients and their families. Regarding the choice protocol, the publication of new national policy is awaited.
Key actions arising from the self-assessment are:

- Deploy new standard information for patients once released by NHS NWL.
- Disseminate information about the national choice policy once published.

HICM Change 8: Improved discharge to care homes – A key route for Hillingdon's health and care system to engage with care home providers is through the monthly care home managers' forum that is chaired by the Council. Discharge is a regular item for which the health and care system's Head of Integrated Care attends. As previously stated, the Council's Brokerage Team is responsible for brokering short-term placements for people being discharged from hospital and the process also features regularly as part of the discussion about discharge.

Admissions to care homes of people discharged from hospital at weekends is also a regular topic of discussion. A combination of staffing issues in care homes at weekends and negative discharge experiences also continues to make this a very difficult goal to achieve at this time.

Direct support is provided to care homes through the Care Home Support Team and all care homes have a named Care Home Matron who contacts the homes for older people on a daily basis and those supporting people with learning disabilities and/or mental health needs on a weekly basis.

Data about LAS attendances at care homes, conveyances and admissions to hospital is received and considered as part of the regulated provider care governance process. This has become more systemised since 2021/22 but there is still work to do to ensure that the data is used effectively to support care homes and their residents.

HICM Change 9: Housing and related services – This is addressed in section 7: *Disabled Facilities Grant (DFG) and Wider Services.*

Discharges of people who are able to return home with a package of care are supported by a service delivered by an independent sector provider and funded through NHS additional contribution. This service supports people who have been discharged from hospital pending a full assessment of their need in their home environment. The same provider is also responsible for the Reablement Service, which is funded partly through the NHS minimum contribution to protecting Adult Social Care and also from the NHS additional voluntary contribution. The Hospital

Social Work Team that is responsible for undertaking assessments is funded via the protecting social care funding stream.

Age UK is a key partner in supporting the return home of older people attending the hospital who do not require an admission. They also support the discharge of older residents who do not require a package of care but would benefit from short-term support after returning home. This would previously have been described as D2A pathway 0. These services are funded through a combination of the protecting social care and NHS minimum contribution to out of hospital services.

Care home and homecare provision to support discharge is funded through a combination of protecting social care money, iBCF and local authority additional voluntary contribution.

Included within the out of hospital mandated NHS contribution to the BCF are a range of services that are provided by CNWL, and these include:

- Rapid Response
- Community Adult Rehab
- Community Homesafe
- Community Matrons
- District Nursing
- Continence Service
- Tissue Viability Service
- Twilight Service

Pathway 2 services funded from the NHS minimum contribution to out of hospital provision include:

- Hawthorn Intermediate Care Unit (HICU)
- Franklin House step-down beds
- Aston House step-down

5. Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carer breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

5.1 Overview

In Hillingdon the importance of supporting carers is recognised by all health and care partners as being critical to the sustainability of the local health and care system.

At a strategic level, the all-age, multi-agency Carers Strategy Group (CSG) has responsibility for the development of the Joint Carers Strategy, a refresh of which is currently in progress. The CSG is chaired by the Council and 2021/22 has seen its membership expand to include representatives from the ICB, CNWL (community health and mental health), The Confederation and Hillingdon Hospital. This is in addition to representatives from Adult, Children and Education Services within the Council. The VCS has a critical role in supporting carers and is crucial to the proper functioning of the CSG. The sector is therefore represented by Carers Trust Hillingdon. Consistent representation from carers who are both willing to be

involved and have the necessary objectivity has proved a challenge and steps to develop this will be a continuing priority for 2022/23.

Annex 1 shows the CSG's position within the governance arrangements for Hillingdon's health and care system. As an illustration of the importance attributed to supporting carers, an annual update on the implementation of the carers' strategy delivery plan is considered by the Council's Cabinet and the HHCP SOLT group. Prior to going to Cabinet, the Council's Health and Social Care Select Committee is given the opportunity to review and comment on the implementation of the delivery plan and subsequent year's priorities. The following link can be used to access the report that was considered by the Committee in June 2022 (item 9) London Borough of Hillingdon - Agenda for Health and Social Care Select Committee on Wednesday, 22nd June, 2022, 6.30 pm

5.2 Carers and Covid-19

2020/21 and 2021/22 have been dominated by the Covid-19 pandemic, which has had a significant impact on carers. Some of the challenges that this has presented include:

- People having to undertake caring responsibilities unexpectedly but not recognising themselves as carers.
- The reluctance of carers to take up short break opportunities over infection prevention and control concerns.
- Limited availability of some short break options during covid-related restrictions.
- Mental health implications of caring during covid-related restrictions, i.e., coping with the pressures of being a carer.
- Managing the financial implications of being a carer.

Responses to the above include Hillingdon Mind (core grant funded via the BCF) increasing outreach with primary and secondary mental health services to improve communications and coordination of support packages for carers and additional psychotherapeutic and peer support groups being added to their psychotherapy programme. CNWL also added additional staff resources to support the Child and Adolescent Mental Health Service (CAMHS) and this has been retained into 2022/23. The funding of CAMHS is currently external to the BCF.

5.3 Delivering Outcomes for Carers

Partners are working with and for carers to deliver the following outcomes:

- **Outcome 1:** The physical and mental health and wellbeing of carers of all ages is supported.
- **Outcome 2:** The financial impact of being a carer is minimised.

- **Outcome 3:** Carers are identified, recognised and able to make a positive contribution.
- **Outcome 4:** Carers have a life alongside caring.
- **Outcome 5:** Carers have access to quality information and advice at any point in their caring journey and know where to find this.
- **Outcome 6:** Carers have the skills they need for safe caring.
- **Outcome 7:** Young carers are supported from inappropriate caring and provided with the support they need to learn, develop and thrive and enjoy being a young person.

The 2022/23 priorities for carers are set out in section 1.1: *2022/23 Priorities*. The main offer of support to young and adult carers in the borough comes through the Carer Support Service contract between the Council and Carers' Trust Hillingdon (CTH), which is the lead organisation for the Hillingdon Carers' Partnership. The latter is a consortium of local VCS organisations that has been created to support carers in the borough. In addition to Carers' Trust, the consortium includes the Alzheimer's Society, Harlington Hospice (including their homecare arm called Harlington Care) and Hillingdon Mind. The funding for this service, i.e., £659k, is included in the Better Care Fund (BCF) from the Council's additional voluntary contribution. The scope of this contract is summarised below and addresses key aspects of the Council's Care Act responsibilities to carers:

- Information, advice and support to access health and wellbeing and universal services

- Home-based short break provision for carers who would satisfy the national eligibility criteria.

- Development of recreational activities that provide short break opportunities for carers.

- Counselling and emotional support.

- Undertaking triage carer assessments under a trusted assessor model. The purpose of the triage assessment is to enable a carer to identify whether they are likely to meet the National Eligibility for Carers, therefore necessitating a full carer's assessment as a precursor to receiving financial support from the Council.

In 2022/23 there will be a variation to this contract to incorporate into the Carer Support Service contract the £18k additional voluntary contribution by the ICB for a complementary service through a variation. This will reduce duplication of reporting. The expiry of this contract in August 2023 provides an opportunity to develop a more integrated model that will enable health and social care partners to identify and support carers more effectively and this is a priority for 2022/23.

Respite Services and the BCF

£244k of the ICB's minimum contribution to protecting social care is being used to fund respite provision for carers who have had a carer's assessment. There is an

additional £1,330k included within the BCF for this purpose from the Council's additional voluntary contribution.

Carers' Assessments

Carers are routinely identified by Adult Social Care through the Care Act assessment of need process and a carer assessment offered. There were 897 carers' assessments undertaken in 2021/22, which includes 299 triage assessments completed by Carers' Trust (see above). This compares to 995 assessments in 2020/21 and 249 triage assessments undertaken by Carers' Trust. Our experience is that many carers decline the offer. The reasons for declining an assessment include people who consider that the assessed care package for the person they are caring for sufficiently addresses their needs; people not identifying themselves as carers and those who feel that the services available through Carers' Trust meets their needs.

5.3 Carer engagement

Apart from carer issues identified as a result of day to day operational interaction with carers, there are two structured carer forum meetings that take place each year. These are conducted both face to face and virtually. Issues raised are fed through to the CSG to inform priorities. Ensuring that issues identified through the surveys, peer support groups and engagement events held by partners are systematically fed through to the CSG is work in progress.

6. Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Hillingdon is a unitary authority and therefore incorporates housing responsibilities contained within the Housing Grants, Construction and Regeneration Act, 1996, i.e., DFGs. The allocation of housing provisions of the Housing Act, 1996, also fall within the Council's sphere of responsibility. As reported in the 2021/22 submission, an impact of the pandemic has been to increase the interrelationship between health partners, care providers and housing services in order to address the needs of our residents and support the health and care system. This can be summarised as follows:

- ***DFGs****:* DFGs will continue to be utilised to support older and disabled residents to remain in their own homes. In 2021/22 276 people were assisted with DFGs and of these nearly 52% (143) were people aged 65 and over, 39% (109) were aged 18 to 64 and the remaining 9% were aged 0 – 17.

- ***Hospital Discharge Grant***: Since 2018/19 the Council has used DFG flexibilities to establish and maintain the Hospital Discharge Grant. This funds 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. £10k has been

identified within the BCF for the Hospital Discharge Grant for 2022/23 and between April 2021 and March 2022 this assisted 16 people to return home to a safer environment. This is available to support discharges from Hillingdon Hospital and CNWL's acute mental health wards at the Riverside Centre and Woodlands Centre.

- ***Application of DFG flexibilities***: Additional discretionary grants have been introduced that include:

  - *Essential Repair Grant*: Up to £5,000 to address repairs where the resident is aged 60 and above and is in imminent danger.

  - *Safe and Warm Grant*: Up to £5,000 for replacement boilers, draught proofing to doors, windows and loft insulation, solid wall and flat roof insulation and security measures. The grant is available to people aged 60 and above.

  - *Burglar Alarm Assistance*: A free burglar alarm for residents aged 65 and over who are owner occupiers.

- ***Community equipment***: The community equipment service comprises of equipment loans, minor adaptations and door entry systems and is funded through DFGs. Hillingdon is part of the pan-London community equipment consortium led by the Westminster City Council and the Council acts as the lead commissioner on behalf of the ICS. This service has been subject to a competitive tender in 2022/23 and prescribers across health and social care have been involved in the development of a refreshed service specification. A key outcome of the process will be to bring provision of beds and pressure mattresses together within a single contract to avoid coordination issues that can impact on hospital discharge.

- ***Telecare:*** DFG funding is used to purchase telecare equipment and there are currently 7,122 residents in receipt of equipment that ranges from the simple lifeline system to a range of sensors and detectors. 5,991 users of the service are people aged 75 and over to whom it is available free of charge. The Council's telecare offer also includes access to responder service for people who may not have relatives or friends who can assist in the event of a call going through the lifeline service, known as TeleCareLine. 3,717 people subscribe to this service that is delivered by an independent sector provider via the Reablement Service.

- ***Hospital discharge housing links:*** Named links within the Council's Housing Service for staff within Hillingdon Hospital's Integrated Discharge Team have been established and an equivalent arrangement is in place to support discharge from acute mental health wards at the Riverside Centre and Woodlands Centre on the Hillingdon Hospital main site.

- ***Development of extra care:*** The completion in 2020/21 of the Council's extra care sheltered housing programme was reported in the 2021/22 plan. The practice of using six flats within Park View Court as intermediate care provision to support hospital discharge has continued into 2022/23 but will cease in

September so that these flats can be brought into letting. The use of the two consulting rooms within the 88 flat Grassy Meadow Court extra care scheme as the base for the 6 Care Home Matrons employed by the Care Home Support Service has continued and this has been extended to include use of the treatment room at Park View Court to accommodate additional staff.

- ***Supported living programme:*** The Council continues to work in partnership with independent sector providers to deliver additional supported living capacity for people with learning disabilities and/or mental health needs. The new provision will comprise of a combination of self-contained flats and shared houses and the programme is due to complete in the autumn of 2023.

7. Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include:

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and BCF funded services.
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered.
- Any actions moving forward that can contribute to reducing these differences in outcomes.

7.1 Overview

People with Protected Characteristics

The people with protected characteristics most affected by the 2022/23 BCF plan are:

- Older people
- People with physical and/or learning disabilities
- Autistic people
- Children with special education needs and disabilities (SEND)
- People from Black, Asian and minority ethnic communities

Whilst technically outside of the scope of the 2010 Equality Act, the practice in Hillingdon has long been to consider that being a carer is a protected characteristic.

Health Inequalities

The NHSE/I Core20PLUS5 approach to drive targeted action in health inequalities improvement is progressing in Hillingdon. It should be noted that of the five areas of clinical health inequality maternity and serious mental illness are outside of the scope of the 2022/23 BCF plan. The outcome of future planning discussions currently in progress mean that serious mental illness is expected to come within scope of the post April 2023 plan.

Public Health England's index of multiple deprivation (2019) showed that Hillingdon was the 13th least deprived London borough and that our index level was below the average for both England and the London region. However, the 2019 index of multiple deprivation data from the Ministry for Levelling-up, Housing and Communities shows that the average scoring for the Townfield, Yiewsley, West Drayton and Botwell wards is significantly above the average for England, London and the borough average for Hillingdon.

The main causes of death in Hillingdon in 2020 (the most recent year for which data is available) was cancer which accounted for 23% of all deaths in 2020 (25% in males and 21% in females) and circulatory diseases which also caused 23% of all deaths (23% in males and 22% in females). Levels of obesity in school reception age children, Year 6 and the 18 years and over population are significantly higher than the average for England and London and are concentrated in the less affluent areas in the south of the borough.

Covid-19 has exacerbated some of the pre-pandemic challenges faced by older people and people with disabilities, e.g., social isolation, and has contributed to an escalation of people within these population groups with mental health needs. Opportunities for identifying and addressing some of these needs through multi-agency working at neighbourhood level have previously been addressed.

Key inequalities faced by carers concern their physical and mental health and wellbeing that can be detrimentally impacted by the financial implications of undertaking a caring role, e.g., loss of employment or reduction hours available for work. These as well as how services funded via the BCF will address them, are addressed within section 5: *Supporting unpaid carers*.

7.2 How these inequalities are being addressed through the BCF plan and BCF funded services and changes from 2021/22 BCF

The scope of the 2022/23 plan and the people affected by it remains the same as for 2021/22. Among the priorities for 2022/23 that will impact on equality and health inequalities are:

- *Embedding population health management and addressing areas of inequality (including those identified in the NHS Core20Plus5 model) to determine operating model for integrated neighbourhood teams*: Through utilisation of the public health logic model developed by the King's Fund the aim is that by the end of 2022/23 we will have a population health management plan with priorities and measurable outcomes for improvement agreed by the Health and Wellbeing Board. Population health management will also be included into the neighbourhood plans with agreed measurable targets.

- *Developing a Hayes and Harlington Population Health programme to focus on addressing obesity:* Obesity is an established risk factor for many chronic conditions including diabetes, arthritis and heart failure. 36% of Hillingdon's population live in the Hayes and Harlington locality, which has the highest obesity prevalence in the borough for both the 18 and above population and Year 6. The highest proportion of Hillingdon's Black, Asian and minority ethnic population also live in this locality. The BCF funded services that will contribute to the delivery of this priority include:

- Integrated care programme (scheme 1)
- Care Connection Teams (scheme 1)

- *Addressing falls and frailty in Hayes:* Also referred to in objective 1 of section 4: *Implementing BCF policy objectives (national condition 4)*, this initiative will be targeting older people in the more economically deprived locality of the borough. For ease of reference, the BCF funded services that will contribute to the delivery of this priority include:
  - CNWL's Falls Prevention Service (scheme 1)
  - The Confederation's Weekend Visiting Service (scheme 1)
  - Telecare Service (scheme 1)
  - Wellbeing Service (scheme 1)
  - Reablement (scheme 4)
  - Homecare (schemes 4 and 5)
  - CNWL's Care Home Support Service (scheme 5)

- *Delivery of health checks for people with learning disabilities (PLD) to national target:* A cumulative total of 77% of people with learning disabilities on GP registers aged 14 and above was achieved and the intention is that joint working between primary care and social care providers will also lead to performance above the national target (75%) in 2022/23. The BCF funded services that will contribute to the delivery of this priority include:
  - Integrated care programme (scheme 1)
  - Care Connection Teams (scheme 1)
  - Social care staffing (scheme 8)
  - Supported living (scheme 8)
  - PLD CHC case management service (scheme 8)

- *Flu vaccination programme:* This will be led by the PCNs with support from other HHCP partners and the Council and will target the homeless population and improve uptake in pregnant women in addition to the pre-covid priority groups.

- *Covid booster vaccination programme and care homes:* The aim is that joint working between Primary Care, the Care Home Support Team and the Council's Quality Assurance Team will replicate the success of 2021/22 in respect of the proportion of residents and staff in care homes accepting the booster. The BCF funded services that will support this initiative include:
  - Care Home Support Team (scheme 5)
  - Quality Assurance Team (scheme 5)

- *Promotion of PHBs and integrated budgets as direct payments*: These give residents greater opportunity to have both greater control over how their needs are met that is more personalised, e.g., directly employing care workers from their own cultural background. However, the reality is that workforce supply issues means that this approach is not without challenges. The BCF funded service that will contribute to the delivery of this priority include
  - CHC homecare (scheme 5)

7.3 Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered.

Hillingdon has been unable to consider differential outcomes related to protected characteristics in relation to the BCF metrics due to lack of available data.

Annex A - Hillingdon Place-based Governance 2022/23