Strategic Narrative Tab

What is your approach towards integration of health and social care?

When answering the sections below please highlight any learning or changes you have undertook from the previous planning 2019/20.

A. Person-centred outcomes such as:

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

Promoting choice and independence

The Hillingdon approach to promoting choice and independence includes:

- *An asset-based starting point:* This is a focus on the attributes that residents already have that can be employed to deliver better outcomes for them. It is also focused on what already exists within the community, e.g. within the voluntary and community sector, that can support choice, independence and more fulfilling lives. The criticality of the role of the third sector was demonstrated during the Covid pandemic but this approach still requires a culture shift across health and care partners that will take time to fully embed.

- *Self-help through access to information and advice*: As part of the implementation of its obligations under the Care Act, the Council has developed an online care and support services directory. Online access to information and advice is also available through the Council's website and this includes links to appropriate health services.

- *Promotion of Personal Health Budgets (PHBs) as Direct Payments and integrated budgets*: Since 2014 the Council has long had has managed the process for people taking their PHB as a Direct Payment, which Hillingdon identifies as a proxy measure for how engaged a person is in managing their health condition. At 31st March 2020 there were 19 people in receipt of a PHB as a Direct Payment. The intention is that by the end of 2020/21 this will increase to 30, but this is subject to the progress of the Covid-19 pandemic. The intention is to also encourage the number of people in receipt of integrated budgets. The availability of providers to support people wishing to employ their own personal assistants via a Direct Payment and accessible through a dynamic purchasing system (DPS) provides necessary infrastructure to support residents to pursue more personalised options to address their health and care needs.

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

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

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

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

- *Developing alternatives to institutional care*: Following the lifting of the pandemic lock-down, 2020/21 will see the implementation of the fill strategy for the Council's new extra care scheme, Park View Court, which provides 60 self-contained flats for Hillingdon's older residents. This scheme concludes a supported living programme that will see an additional 148 flats for older residents in premises that have been developed to Stirling University's gold standard for dementia design. Hillingdon's supported living programme has also seen additional schemes for people with learning disabilities and people with mental health needs come on stream over the last three years, which has resulted from innovative partnerships with the independent sector. Continuing a theme from 2019/20, a partnership priority for 2020/21 is to prevent escalation of need that results in people having to step-up to more supported and more restrictive settings. Section B expands on this.

Providing dignity in care.

The approach to delivering dignity in care includes:

- *Joint assessments*: Avoiding the need for residents to tell their story multiple times has been a recurrent theme in all of Hillingdon's plans. Joint assessments contribute to reducing the need for multiple assessments. How this is being taken forward within the context of the development of primary care networks is expanded on in section B.

- A single assessment form has been developed for use by all partners supporting the discharge process from Hillingdon Hospital. Learning from the practical experience of using it means that it is subject to revision to maximise effectiveness.

- *Integrated case management for people with learning disabilities*: For some years the Council has provided a case management

service on behalf of the CCG for people with learning disabilities who qualify for CHC funding as well as those receiving a health contribution under section 117 after care arrangements. The integrated case management service includes brokerage for securing placements and other services required to meet assessed needs. The intention is to create a seamless service for people with learning disabilities. A review of this provision was started in 2019/20 but overtaken by the pandemic and the intention is to conclude this work in 2020/21 and secure agreement on a model that will maximise the independence of people with learning disabilities and manage need more effectively. Any agreed model would then be implemented during 2021/22.

- *Data sharing*: The easing of restrictions on data sharing during the period of the pandemic has assisted in the sharing of information between partners to facilitate integrated care for Hillingdon residents. In addition, the Council has become a signatory to the North West London Whole Systems Information Sharing Agreement, which has provided the governance structure to support appropriate information sharing between partners.

- In order to support hospital discharge the Council has provided restricted access to its care management database, Protocol. Extension of this arrangement to the Neighbourhood Teams once alignment with the PCNs has completed is also being explored.

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

B. Neighbourhood/HWB Level

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

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

Joint Commissioning Arrangements

The care and support providers required to ensure that residents are able to live as independently as possible in their own homes tend to operate on a borough or locality level rather than across an ICS, as has been demonstrated by the experience from the pandemic. In Hillingdon the BCF has provided an opportunity to take a more integrated approach to market development and 2020/21 has seen this develop further, particularly in the context of the impact of the Covid-19 pandemic. The expectation is that some changes will not be implemented until 2021/22.

In accordance with *COVID-19 Hospital Discharge Service Requirements* guidance published on 19/03/20, the Council has led on the commissioning of homecare and the CCG on nursing care home provision. The intention in 2020/21 is that the Council will continue to lead on homecare, which will entail the implementation of new provision arrangements across the borough following a tender process in 2019/20. This means that a single provider will be delivering homecare in the north of the borough and in the borough's four extra care sheltered housing also referred to in section A. This provider will also be responsible for the discharge from hospital to assess (D2A) service as well as night care provision, 24/7 care, the Reablement Service and the mobile response service linked to the TeleCareLine Service. Concentration of these services with a single provider creates volume and scale that helps to ensure sustainability. The scale also creates opportunities to employ a multi-skilled workforce that can be more easily deployed to meet presenting needs, which presents significant benefits to Hillingdon's health and care system. This can be seen in the fact that the CCG already funds the D2A and will have access to the homecare and relevant specialist services under this contract. Having a single main homecare contractor in the south of the borough also creates opportunities for relationships to be developed between homecare providers and the emerging PCNs that will help to support the health and wellbeing of local residents.

Building on a pilot undertaken in 2018/19 and experience during the pandemic, it is intended to further develop proposals for an integrated brokerage service delivered by the Council and covering access to homecare and long and short-term nursing home placements for children and adults irrespective of whether the funder is the NHS or the Council. As part of its market management and development responsibilities under the Care Act, it is also intended that the Council will take the lead in the commissioning of nursing care home placements. All contracts will be held by the Council and there will be a central point of contact for providers,

thus alleviating confusion and complexity for them.

Hillingdon's 2019/20 plan included the implementation of an integrated therapies service for children and young people (CYP) that will be led by the Council. This service brought three contacts for Integrated Speech and Language Therapy, Physiotherapy and Occupational Therapy Service into one for a pilot that enables a test of concept to be undertaken to deliver an early intervention and prevention model that should improve the quality of life of CYP and help reduce resource pressures once they have progressed to adulthood. Agreement on the next steps will be sought during 2020/21 for implementation during 2021/22.

2020/21 will see the regularisation of provision arrangements for the Speech and Language Therapy in the Youth Justice Service and the Designated Clinical Officer in Special Educational Need and Disability (SEND), the latter resulting in increased investment from both the Council and the CCG.

Alignment with primary care services (including PCNs)

It is proposed that Hillingdon's eight multi-disciplinary Neighbourhood Teams become coterminous with the new Hillingdon Primary Care Networks required under the LTP to ensure that they are supporting the same populations. Relevant CNWL community staff and H4All Wellbeing Service staff have already been aligned to the Neighbourhood Teams (NTs) and further changes in configuration may require some realignment. Social Care Teams have been restructured into localities that broadly align with the catchment areas of the Neighbourhood Teams. Named Social Care contacts have been provided to the Neighbourhood Teams to foster relationship development. Social care staff also participate in monthly meetings with community matrons. The effectiveness of this approach will be kept under review over the next two years as the configurations of the NTs and PCNs evolve and consideration will be given to alternative structures should this prove necessary to deliver better outcomes for residents and patients.

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

A key priority during 2020/21 will be the implementation of the Care Direct Enhanced Service (DES) for Care Homes contract. Hillingdon's pre-existing Care Home Support Team, which also supported extra care sheltered housing, provided a good foundation for the implementation of the DES. A multi-agency implementation group has been established involving GP Confederation and community health and community mental health partners, care home providers covering the range of need supported by the borough's care homes and the Council. A key challenge is to establish a systematic level of support that has parity with that

available to care homes for older people.

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

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

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

Disabled Facilities Grants

Hillingdon is a unitary authority and therefore incorporates housing responsibilities contained within the Housing Grants, Construction and Regeneration Act, 1996, i.e. disabled facilities grants, within its sphere of responsibility. DFGs will continue to be utilised to support older and disabled residents to remain in their own homes. In 2019/20 222 people were assisted with DFGs and of these 22% (49) were people aged 60 and over. 14% (31) of older people receiving DFGs were owner occupiers, 6% (13) were social housing tenants and 2% (5) were private tenants.

In 2018/19 DFG flexibilities were used to establish the Hospital Discharge Grant to fund house and/or garden clearances, deep cleans and a range of other home-based activities where difficulties in arranging help can delay the return home of people no longer needing to be in hospital for treatment. Following the successful outcome of the pilot the grant has become part of the Council's permanent offer to support hospital discharge and £250k funding allocated for 2020/21.

Relevant housing officers have been involved in the development of the 2020/21 plan. At an elected member level, it should be noted that the Cabinet Member for Housing and the Environment is also a member of the Health and Wellbeing.

Other Council services

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

- *Assistive technology* - The Council has established staffing capacity to actively promote assistive technology such as telecare, which is available free of charge to people aged 75 and above. The Council's telecare offer also includes access to a responder service (see section B above) for people who may not have any relatives or friends that can assist in the event of a call going through to the Council's TeleCareLine Service.

- *Housing Services* - Good housing is recognised as critical to being able to address the health and wellbeing of residents. As a

unitary authority the Council also has within its remit the homelessness and housing allocations obligations under the 1996 Housing Act and works with partners to identify appropriate housing solutions.

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

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

Effective use of the Council's Estate

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

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

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

- A brief description of joint governance arrangements

Overview

Hillingdon's overall vision for integrated care and support within the geographical boundary of the borough is set out within our STP submission and was reflected in the 2017/19 plan. This continues into 2020/21 and can be seen in **Annex 1**, which also includes scheme summaries.

The BCF is key to the delivery of some aspects of the North West London (NWL) Sustainability and Transformation Partnerships

(STP) plan that are dependent on integration between health and social care or closer working between the NHS and the Council. The Hillingdon place-based aspects of the STP, including the relevant delivery areas, are reflected in the 2018-2021 Joint Health and Wellbeing Strategy and the schemes within the 2017/19 plan were devised to contribute to the implementation of the relevant STP delivery areas. Subsequent iterations of the plan have expanded beyond older people and Carers of all ages to include children and young people with special educational needs (SEND) and people with learning disabilities and/or autism. This therefore increases the number of STP delivery areas to which the BCF will be contributing.

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

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

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

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

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

The nine schemes within the 2020/21 BCF plan are:

- *Scheme 1*: Early intervention and prevention.

- *Scheme 2*: An integrated approach to supporting Carers.
- *Scheme 3*: Better care at end of life.
- *Scheme 4*: Covid-19 and Hospital Discharge
- *Scheme 4A*: Integrated hospital discharge and the intermediate tier.
- *Scheme 5*: Improving care market management and development.
- *Scheme 6*: Living well with dementia.
- *Scheme 7*: Integrated therapies for children and young people.
- *Scheme 8*: Integrated care and support for people with learning disabilities.

Alignment of services and the approach to partnerships with the VCS

The main vehicle for the delivery of integrated care in Hillingdon is the Integrated Care Partnership (ICP), known as Hillingdon Health and Care Partners (HHCP) and comprising of the GP Confederation, the Central and North West London NHS Foundation Trust (CNWL), The Hillingdon Hospitals NHS Foundation Trust (THH) and the H4All third sector consortium. The latter comprises of Age UK Hillingdon, the Disablement Association Hillingdon (DASH), Harlington Hospice, Hillingdon Carers and Hillingdon Mind. The involvement of H4All within the ICP demonstrates recognition of the vital role of the third sector in supporting residents and preventing or delaying escalation of need. This was exemplified during the pandemic when H4All worked in very close partnership with the Council to provide the Covid-19 Community Hub that supported residents who were shielding or self-isolating. This included linking into local food distribution arrangements and frequent contact with people experiencing loneliness, particularly where they were living on their own.

The following are further examples of the extent to which the H4All consortium is integral to delivering system change in Hillingdon:

- *End of life workstream:* The chief executive of Harlington Hospice is the Senior Responsible Officer (SRO) for the delivery of this project, which is a priority within the HHCP Urgent and Emergency Care Transformation Workstream for 2020/21.

- *Wellbeing Service:* This an early intervention and prevention service delivered by H4All that takes referrals of people at risk of escalating need mainly (but not solely) from primary care. Through the application of the nationally recognised Patient Activation Measure (PAM) tool they are able to determine the extent to which a person is motivated to manage their long-term condition and then measure the impact of their intervention. 2019/20 saw the focus of this service move beyond the 65 and over population to a broader adult population and this process will be completed during 2020/21. This service is firmly embedded within the Neighbourhood Teams and this will continue as these teams become aligned to the six PCNs.

- *Prevention of Admission and Readmission:* Age UK is an integral part of Hillingdon's admission prevention and early supported

discharge approach. With a combination of paid staff and volunteers this Age UK is based in A & E to support people home who do not need to be admitted. Support for up to six weeks is also available to enable older people admitted to hospital who have lower levels of need not requiring intervention or involvement of statutory partners to return home at the earliest opportunity.

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

The 2020/21 BCF plan continues the aim of the 2019/20 plan in seeking to address the health inequalities faced by Hillingdon's most vulnerable older people, e.g. people living with long-term conditions, including frailty and dementia, but within a Covid-19 context. The resourcing of the Neighbourhood Teams is intended reflect the concentration of deprivation in the south of the borough, which is manifested in the variation in life expectancy of 6.8 years for men and 5.2 years for women living in the least deprived part of the borough, i.e. Eastcote and East Ruislip, compared to those in the most deprived, i.e. Botwell. Expanding the remit of the plan in 2019/20 to include children and young people with special education needs and adults with learning disabilities was also intended to assist in addressing health inequalities faced by these vulnerable groups and this will continue into 2020/21.

The 2017/19 plan health impact assessment was updated for the 2019/20 plan to support the decision by HCCG's Governing Body and the HWB to approve the plan. This showed that the payment as Direct Payments of Personal Health Budgets (PHBs) for people meeting Continuing Health Care (CHC) thresholds and also for people meeting the National Adult Social Care Eligibility Criteria provides opportunities for more personalised approaches to addressing need that would reflect cultural and religious diversity. It also showed that early identification of people at risk of deterioration and active case management by the Neighbourhood Teams would help to maximise independence through determination of the most appropriate intervention, which may be social prescription to address risk factors such as social isolation. Covid-19 severely impacted on the extent to which these benefits could be realised. As the 2020/21 plan is largely a roll forward but within a Covid-19 context, it has not been considered necessary to update the assessment further.

The 2017/19 plan equality impact assessment was also updated to support the decision of HCCG's Governing Body and the HWB to approve the draft 2019/20 plan. The assessment showed that the impact of the plan was positive for all other characteristics. It should be noted that Hillingdon includes Carers as a protected characteristic and therefore considers their needs in any impact assessment. Once again, it has not been considered necessary for this assessment to be updated further for the 2020/21 plan. Both the health and equality impact assessments will be reviewed as part of the development process for the proposed three-year BCF plan from April 2021.

Governance

The delivery of the BCF plan is overseen by a Core Officer Group comprising of senior officers from the Council and the CCG, including the statutory director of adult and children's social care services and the CCG's managing director. This meets on a monthly basis. To reflect the BCF's role in the broader integration programme in Hillingdon, 2020/21 will see the production of a single performance report to both the HWB and the CCG's Governing Body that will include updates on both the HHCP recovery plan and the BCF delivery plan. The 2019/29 delivery plan is appended as **Annex 2**.

Both the Corporate Director of Adults and Children and Young People's Services and the Director of Provider Services and Commissioned Care from the Council sit on the Hillingdon Health and Care Delivery Board, which is the executive health and care system leadership group for Hillingdon. This representation from the Council also provides the link from the Core Officer Group into the broader integration delivery governance. **Annex 3** illustrates where the governance for the BCF sits within the broader health and care system management arrangements in Hillingdon.