Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**London Borough of Hillingdon**
Clinical Commissioning Groups	**Hillingdon Clinical Commissioning Group**
Boundary Differences	**Boundaries are co-terminus**
Date agreed at Health and Well-Being Board:	**06 February 2014**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£4,772,000**
2015/16	**£17,991,000**
Total agreed value of pooled budget: 2014/15	**£4,772,000**
2015/16	**£17,991,000**

b) Authorisation and signoff

Signed on behalf of the Hillingdon Clinical Commissioning Group	
By	Dr Ian Goodman
Position	Chair Hillingdon CCG
Date	

Signed on behalf of London Borough of Hillingdon	
By	Cllr Ray Puddifoot MBE
Position	Leader of Hillingdon Council
Date	

Signed on behalf of the Hillingdon Health and Wellbeing Board	
By Chairman of Health and Wellbeing Board	Cllr Ray Pudifoot MBE
Date	

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

The Hillingdon Hospital (THH) and Central and North West London NHS FT (CNWL) are members of Hillingdon's Health and Wellbeing Board, which has set up a sub-committee specifically to take forward our work on integration. The hospital is also a member of the sub-committee.

The sub-committee has charged an officer and partner group to take forward these proposals and to work up schemes, vision, scope, changes and outcomes. Again CNWL and THH are both actively involved in these discussions.

In addition (see answer to d) below) wider providers in the voluntary and community sector in Hillingdon attended a workshop on the 17th January 2014 to share approaches and invite feedback on these proposals. This was agreed to be the start of ongoing discussions on the development of the Hillingdon BCF plan.

Schemes in the Hillingdon plan build on existing co - production work with providers as part of multiagency working on Integrated Care, intermediate care, end of life, community transformation and out of hospital care work streams. The BCF is also part of the wider whole systems work in Hillingdon, with providers fully engaged in the development of provider networks and seven day working.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Hillingdon Council and Hillingdon CCG regularly engage with and seek views from local residents, service users and carers to guide service redesign, maintain quality and safety, and inform commissioning intentions. In developing the BCF plans, both organisations have used this approach to inform the strategic direction.

As a first step the Council and the CCG amalgamated intelligence gathered across a two year period, from forums such as the older people's assembly, *meet the CCG* public events, disabled tenants' forum, patient and carer focus groups and public board meetings.

These findings were then cross referenced with intelligence gathered by Healthwatch Hillingdon, evidence from the Hillingdon JSNA and with local and national patient and carer satisfaction surveys to inform draft plans.

Some themes emerge from these sources, including:

- People in Hillingdon want to remain at home and as independent as possible for as long as possible.
- Telecare line is seen as important in supporting older people and in "taking away worries".
- On domiciliary care, carers and service users value the personal touch and a single point of contact.
- Feedback from forums identify need for easily accessible services in the community,

locally from GP services

- Older people have said they want to access activities in the community that promote and maintain a healthy lifestyle.
- Residents also want better access and consistency from GP services

The initial plan for greater integration and the Better Care Fund has been shared with members of the public, patients and carers via the following forums:

Patient in Partnership (PIP) public event (hosted by The Hillingdon Hospital Foundation Trust)

Better Care Fund Stakeholder Workshop (hosted jointly by HCCG and the Council) 17 January 2014 with over 20 key local community and voluntary sector organisations present.

Better Care Fund Public Meeting proposed for February 2014 (hosted jointly by the HCCG and the Council)

Feedback from these meetings has been incorporated into the plans presented. The Council and the CCG will have also utilised a number of communications channels to inform residents and stakeholders of its local plans via the following channels:

HCCG, LBH and Healthwatch Hillingdon public facing website

Hillingdon People (Borough wide magazine publication)

Under the plan this initial engagement is seen as the start of journey in working with partners, commissioners, patients, carers and providers to design a truly integrated approach that better serves Hillingdon residents. The voluntary and community sector group will be actively involved in the development of the plan.

e) **Related documentation – Please** include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Joint Strategic Needs Assessment	The Joint Strategic Needs Assessment (JSNA) is the means by which Hillingdon and its partners will describe the current and future health, care and wellbeing needs of our population and the strategic direction of service delivery to meet those needs.
Joint Health & Wellbeing Strategy	The Joint Health and Wellbeing strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out for the period 2013 to 2016
Hillingdon Out of Hospital Strategy	The Hillingdon Out of Hospital strategy sets out five priorities for improving access; experience of care; and the provision of care closer to home for people in Hillingdon. The BCF and development of Hillingdon Out of Hospital Hubs are aligned for care of frail older people.

Intermediate care and admissions avoidance	*Intermediate Care: review of phase one implementation* Libera Partners LLP May 2013 Briefly reviewed the efficacy of the first phase of implementation of Rapid Response at THH alongside wider admissions avoidance and early discharge initiatives.
Recovery Programme Board paper July 2013	In July 2013 the Recovery Programme Board agreed priority areas that would promote a sustainable health and care system over the short, medium and longer term. This focused on working as a whole system to reduce growth into highest risk needs from lower and medium risk groups through an integrated system of early detection and support.
Mental Health strategy and Dementia Action plan 2013-16	In March 2012, Hillingdon Clinical Commissioning Group (Hillingdon CCG) and the London Borough of Hillingdon (LBH) initiated a refresh of the strategy for adults with mental health problems aged 18-64 years[1] and the development of a plan to improve services for people with dementia in order to create a new all age adult mental health services strategy/plan.
Primary Care Development and Delivery Plan	This document sets out plans for the wider development of primary care in Hillingdon in the context of wider NW London plans.

[1] A strategy for adult services for mental health and wellbeing, 2008-13, NHS Hillingdon and London Borough of Hillingdon, 2008

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our vision is that by 2019, the residents of Hillingdon will be able to *plan their own care; with professionals working together to understand their needs and those of their carer(s), so that they have control over services and that these deliver what is important to them*.

Our initial work under the BCF is therefore targeted at Hillingdon's frail elderly. As ever, this term requires further definition as some intervention programmes will be aimed at all older people and others specifically at people aged 85 and older. Our general approach is therefore to work with the population cohort aged 65 years and over with a specific focus on:

- All Hillingdon's residents aged 85 and over
- Frail older people aged 75 and over with two or more conditions
- Mature/older people who are at risk of dementia
- Mature/older people who are at risk of falling for a first time

For the above population segment(s) our services are not as joined up as they should be and this process of integration and alignment is a key objective of our work on the BCF. Having said that, we have made significant strides in addressing their needs in recent years and the programmes below constitute a good platform on which to build:

- Expanded intermediate care programmes, especially in developing the role of rapid response
- An improved and better integrated urgent care pathway
- Early supported discharge programmes
- Integrated care programmes
- Reablement
- The development of GP networks and health hubs
- End of life care including "coordinate my care."

Our plan is to put in place the steps we need to act on to configure and deliver services over the five year period. These changes will involve:

- A focus on improving health outcomes for older frail residents with one or more health

condition or care need

- Better and earlier identification of susceptibility to disease or exacerbation in that cohort alongside joined up management of conditions
- Better coordination of services that are configured around Hillingdon's older residents – including a much stronger focus on case management and prevention
- Reducing the need for older people to go to hospital – and reducing the lengths of stay where they are admitted
- Bringing greater coherence to our present pattern of service initiatives: especially in enabling older people to be treated at or close to their home wherever possible.

Changes in patterns and reconfiguration of services

The joint vision is for services that are based in Hillingdon's communities and support the needs of Hillingdon's residents. The following drivers will bear upon the final configuration of services:

- We will build on the momentum of the existing good work on admissions avoidance and supported discharge as these are successful and will form the basis of the future planned discharge service that will have in-reach characteristics
- We will offer an appropriate and consistent level of service to local people every day of the week. In some cases, this will involve reconfiguration of existing satisfactory services. In a few cases, we will need to decommission sub-optimal services and replace them with more appropriate ones
- We will ensure services for frail elderly are focussed on the person – especially those with dementia and with more than one long term health or care need. The focus on mental health will be on anxiety and depression but not initially on crisis
- We will reshape services to identify and support people who are at risk of falling a first or second time
- We will redefine the role for case management in Hillingdon – especially in being clearer about the central responsibility of GPs as system enablers.
- We will further develop reablement to work closer with wider intermediate care schemes both in the community and within the acute hospital setting.

The difference for the residents of Hillingdon

Residents will be able to say:

- I'm helped to take control of my own health and social care provision
- It doesn't matter what day of the week it is – as I get the support appropriate to my health and social care needs
- Social care and health services help me to be proactive. They anticipate my needs before I do and help me to prevent things getting so bad I need hospital

- If I do need to go to hospital, they start to plan for my social and health care in the community from day one of my stay
- I only have to tell my story once and they pass my details on to others with an appropriate role in my care
- Systems are sustainable and what might once have been spent on hospital care for me is now spent to support me at home in my community

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

We have agreed the following aims and objectives:

1. We will build on our present initiatives around admissions avoidance and supported discharge.
2. Hillingdon's residents will experience a shared set of responsibilities exhibited by all the organisations working in health and care.
3. Residents will be able to access the services appropriate to their needs on each day of the week.
4. Health and care providers will persist with a health and care problem until a solution is found, or another provider has taken responsibility for finding it.
5. Our workforce will be better equipped and better skilled to face this challenge: to residents, they will appear as a single system, with an open culture that celebrates success.
6. We will work together to proactively identify the health and care needs of older frail residents and will aim to better manage the care needs of younger people who may be susceptible to frailty as they get older.
7. We will aim to reduce levels of health inequalities in Hillingdon.
8. We will be better at predicting future health and care needs – both across the population and for individual residents.

These aims are agreed with a clear understanding that the redesign of systems or the redesign of organisational boundaries alone will not be enough to meet out aims. Instead, we will give equal weight to behaviours, systems and leadership.

Measuring success – including appropriate health gain

These are set out in detail in the BCF application template excel sheet. The principal measures

of success we will target will include:

National metrics:

1. Reduction in permanent admissions of older people in residential care per 100,000 population
2. Increase in proportion of older people who will still be at home 91 days after discharge from hospital into intermediate care (rehab/reablement)
3. Reduction in delayed transfers of discharge per 100,000 population
4. Reduction in avoidable emergency admissions in secondary care per 100,000 population
5. Patient and services user reported outcomes and reported experience

Local metric:

1. The proportion of people with a care plan who are able to manage their condition.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

New interventions under the Better Care Fund

The short descriptions below set out the new schemes we plan over the first five years of the BCF.

Details of key schemes / changes and how we aim to implement them

The section above provided an overview of the schemes and changes within the health and care system. In this section we will provide details of key schemes and how we plan to implement them across health, social care and the wider system.

Scheme one: Joined up tool for health and social care risk stratification:

We have developed and implemented a risk stratification tool that identifies people with complex health issues and those who are at risk of their condition deteriorating or being admitted to hospital. We know that for older people social risks play a crucial role in defining the outcomes.

As part of a natural progression towards an integrated system, we will:

- Enhance the risk profiling to include social care determinants and factors. This will allow us to identify not just people with health risks but also those with social predictive factors; for example, where changes in social factors such as care requirement, status of partner, social isolation make a difference to outcomes for our population.
- We will also increase the reach of the risk stratification tool to identify people in the lower segments of the risk pyramid (medium risk) i.e. people who are at risk of their health and/or

social care needs becoming more complex. This will allow us to proactively manage them much earlier in a fashion that allows them to retain their independence and improve their overall health and wellbeing.

As part of implementation, we will develop joint health/care assessment approach and incorporate it in the risk stratification tool. In order to do that, we are exploring ways of incorporating key datasets within a common database.

Scheme two: Proactive early identification of people with susceptibility to falls, dementia and social isolation

People with dementia; susceptibility to falls; and/or in social isolation are disproportionately represented in our non elective admissions and admissions to long term residential. Too Many Most of these are identified when people reach a complex stage. There is a loss of opportunity in not being able to identify people with these conditions early on in the stage and intervene. The potential impact on outcome in the medium to long term could be significant.

Too many of these people are visible only to parts of the system such as carers, social workers, GPs, the third sector and alarm services. Hence, it is difficult to pick them up from the risk stratification tool only. We therefore need the entire system to understand factors that create susceptibility to these health and social care conditions.

Key initiatives include:

- Development of frontline workforce: brief intervention training to frontline workers for them to identify people who are susceptible. For example: carers / social workers / GPs / district nursing etc need to understand the key signs of when a person might be becoming socially isolated or susceptible to falling (history of recurrent falls without getting hurt).
- Supporting and developing the role of third sector providers to work with people in their homes and communities.
- Support to carers and caring families including the provision of respite care.
- Defining a system-wide response to these issues: setting out what to do when we identify people with this susceptibility. We have embarked on a number of initiatives such as a centralised falls service (with multifactorial assessment and management) but other areas will be developed over the next three months.
- One key outcome of this scheme will be to reduce the movement from lower tiers of risk into higher tiers of risk (medium / high risk)
- Defining risk factors for each condition, who does it and how we respond to that.

Scheme three: Further development of care plans that are shared, agreed and implemented jointly

We successfully implemented robust care plans for a proportion of identified patients with diabetes and frail elderly people with complex needs as identified through risk stratification and other means. The care plans are developed by a multidisciplinary group (MDG) of health and care professionals and signed-off by the service user or patient.

We will extend this further to: scale it to all people with complex health and care needs; and include people with medium risk who will benefit from care planning and introduction of self-care pathways.

Key aspects of this scheme are:

- The care plans will be delivered around the MDGs at the level of (or aligned to) emerging GP networks
- The plans will be personalised and centred around the person and agreed with the service user
- They will be developed by integrated and virtual provider networks representing health, social care and third sector.
- An absolute focus on optimising the independence of the person and development of self-care plans in collaboration with service users and carers
- Shared accountability and governance
- Involvement of the third sector especially in provision of health trainers (lifestyle coach or behaviour change agents) to support people, one to one or in groups
- Sharing and the active management of care plans are crucial enablers. We will explore the use of a shared record system can be part of the solution.

The following table shows the care planning spectrum and what we plan to do at each level.

Table: care actions across the planning spectrum

Low risk	Medium risk	Complex
People early in the stage, identified with one or two factors *(low risk is not to be a focus on BCF*)	People with two or more health and care issues *(need to refine the definition)*	People with multiple and complex health and care issues
Care planning will cover: • Self-management plans • Behavioural change support (groups) • Pre-diagnosis pathway (in case of diabetes) • Social factor risk mitigation (such as in social isolation)	Care planning will cover: • Self-management plans • Behavioural change support (one to one, groups) • Specific health and care interventions • Care navigation (signposting and informing how to access the system) • Social factor risk mitigation	Care planning will cover: • Self-management plans • Behavioural change support (one to one, groups) • Specific health and care interventions • Case management (proactive management of health and care conditions with a nominated lead professional) • Care coordination (active support in accessing the system using a support worker, potentially from third sector) • Social factor risk mitigation and counselling with person,

family and carer(s)

- Pre-crisis management: Availability of rapid care bundle (includes: medical monitoring support, domiciliary care, telecare, helpline and others as necessary)

Scheme four: Integrated case management and care coordination

People with complex health needs often have social care needs and vice versa. It is prudent to manage both aspects together creating a more efficient and seamless system built around the individual. We have a team of community matrons that manages complex cases in the community and a separate team of social workers that manages cases with complex social care needs. We have identified that a significant proportion of the current workload is in respect of the same cohort of residents. As part of the ICP, we will develop an integrated community team with health, social care, mental health and third sector.

Key attributes of this approach include:

- An approach built around emerging GP networks with a named case manager per person
- Managing health issues, providing reablement/rehabilitation, promoting independence and managing risk factors. A key objective is to manage complex cases in the community and provide care coordination.
- Coordinate with other services in the community such as specialist nursing, district nursing, palliative care teams, assistive technology, equipment, intermediate care (rehabilitation and reablement) and other services as necessary
- Support from care of the elderly physician for case conferences and advice
- Single (or trusted) assessment for mobilisation of resources, reducing duplication

An important point to understand is the continuum along with health and social care spectrum of risk. People who are being case managed have a high risk of deterioration in health or social risk factors. If not managed well in the community, they may end up in hospital or require a high level of care support or potential admission into care homes.

Scheme five: Review and realignment community services to emerging GP networks

We have improved the efficiency of our community health services. However, more work needs to be done to ensure that we get value for money from our existing services and that they are better integrated between health, social care and the third sector. We will therefore do the following:

- Review current community service configuration and realign resources around the emerging GP networks
- Integrate teams based around primary care teams focused on older people. This will aim to streamline access to services by ensuring a co-ordinated response to needs at any point of entry into the service system with integrated serviced provision.

- Develop programmes to support step down from core community services to less intensive care (care bundles).
- Short term assessment followed by signposting to services for target groups e.g. older people and populations with highest needs. Multi-agency signposting including health, housing, social care and benefits.
- Mainstream individual care planning and the development of personalised care planning and patient participation with all professionals

Scheme six: Rapid response and joined up intermediate care

Hillingdon currently has a rapid response service led by CNWL. This service has presence both in the A&E as well as in the community and supports people to stay at home, thus avoiding inappropriate admissions to secondary care.

As part of Better Care Fund, we will develop the model further by:

- Embedding social care within the current team to ensure that joint assessments and planning is undertaken for residents
- Including mental health liaison as part of the core offering
- Enhancing the use of the third sector in supporting residents to be transported back home and in providing support for the few hours until mainstream services commence.
- Scaling up the integrated team to ensure that every resident who could be supported at home rather than a hospital receives an opportunity to be so supported
- Embedding seven day working across all the contributors to rapid response
- Creating a joined up, single, intermediate care team which will include reablement, community rehabilitation, equipment, telecare and homecare.

Scheme seven: Early supported discharge

We have initiated an early supported discharge initiative in conjunction with system-partners. As part of the new development, we will:

- Scale the service further to its optimal level with a significant impact on number of overall bed days required, delayed transfers of care and excess bed days for non elective care.
- Develop a proactive cross-service hospital discharge team with input from social care, community services and the third sector
- Agree a discharge protocol and process that starts on the day of admission of an older person to hospital
- Draw up appropriate risk protocols shared between hospital clinicians, community clinicians and social care with proactive case finding within the wards
- Bring primary care fully into the discharge process
- Ensure that services in the community facilitate discharge out of hospital in a safe and effective way

Scheme eight: Better care for people at the end of their life

We will realign and better integrate the services we provide to people towards the end of their life. Our processes will me more seamless and enable health and social care staff alongside the third sector to provide support to patients and their families and carers around end of life care.

Key components will include shared care plans, aligned budgets and common development activity. We will also work towards a trusted assessment framework and local operating model between health and social care.

Scheme nine: Care / nursing homes initiative

Too many of our hospital admissions are from care homes directly. A number of case studies show how the level of care in care and nursing homes can be enhanced by proactive support from multi-disciplinary teams from health and social care.

We have already initiated a number of workstreams such as provision of mental health liaison and diabetes management support but we acknowledge that more needs to be done to support people within care and nursing homes to improve their quality of life and retention of independence.

Key aspects of our proposals are as follows:

- Focus of learning and development of staff within care and nursing homes through an integrated community team consisting of case managers (nurse), contracting leads, social care and care co-ordinator.
- Support from specialist clinical staff and nursing teams as appropriate and aligned input from social care teams
- The team will also support in monitoring improvements in care to people admitted in those care / nursing homes and ensure care homes understand and implement robust environmental risk assessment and dignity challenge
- Focus on managing people optimally in care / nursing homes and reduce inappropriate emergency admissions from care homes to secondary care

The first phase of implementation will commence in 2014/15 and will focus on care / nursing homes with the highest rates of admission with an objective to undertake risk assessments of complex care home residents, identify those patients in need of an advanced care plan, provide clinical support and training to manage conditions in the setting, identify the areas where staff in settings require skills' development.

We will also work with settings to develop skills at dealing with patients with complex conditions.

Scheme ten: Seven day working initiative

We will work to meet the needs of services users and their families appropriately every day of the week to improve outcomes. We want to ensure that the Hillingdon system provides a consistent service that meets what is expected by our residents. Our proposed seven day cover will support early / timely discharge from hospital and better care at for people at home.

In liaison with all our providers, The Hillingdon Hospital is to be an "early adopter" of the seven day working model in the NHS. The key areas for the seven day cover at THH include:

- Establishing seven day mental health liaison (psychiatry)
- Enhancing consultant cover during weekends (12 hour consultant cover, second consultant cover for 'downstream' wards, surgical consultant cover twice daily rounds during weekends),

increased support to junior staff from consultants
- Development of a virtual ward patient monitoring system
- Enhancing early supported discharge (Homesafe) with voluntary service access

Our additional focus will be on extending short term assessment, rehabilitation and reablement over the weekend to facilitate discharge from hospital and continuing to support people at home.

In primary care, GPs will explore models of co-operation across localities to ensure seven day cover through GP networks, provision of telephone triage and integrating all providers to provide a holistic service seven days a week.

Scheme eleven: Development of IT system across health and social care with enhanced interoperability

This is an important aspect of the delivery of integrated care in Hillingdon.

We also aim to enhance the interoperability of IT systems across health and social care organisations. As part of information sharing and governance (as part of the ICP), Hillingdon is working towards the creation of a single client centred identifier and shared information across different providers. Further work is required to ensure that care plans are accessible to social care and other parts of the system.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Implications for the acute sector

Our BCF plans have been developed with both acute and community providers. The BCF proposals have been fully aligned with the detailed plans for The Hillingdon Hospital set out in *Shaping a healthier future* (the overarching plan for NW London's hospital provision) and Hillingdon's Out of Hospital Strategy. These set out a clear vision for the range of services to be offered by THH. Nothing presently planned under BCF will threaten the fundamental integrity of those plans.

Work to date on the development of Out of Hospital Hubs in Hillingdon has incorporated projected changes from integrated working for older people including new ways of working and seven day working.

The successful implementation of the BCF proposals should mean both fewer non-elective admissions of older people to THH and a shorter length of stay. These outcomes are jointly agreed by THH and the rest of the health and care system in the Borough. Initial modelling on assumptions, impact and outcomes for schemes that will impact on unscheduled admissions to hospital has been completed as part of Hillingdon's 14/15 plans. The projected impact on THH for 14/15 is that a minimum of seven patients a day would have their admission avoided through the provision of appropriate rapid response and community based intermediate care services.

Around 25% of Hillingdon's acute activity by cost is actually provided by other institutions and we are in the process of consulting these bodies about future commissioning intentions. Many

provide specialist services to our health and care economy and we would anticipate that flow of patients continuing in the short to medium term.

In the longer term, our separate ambitions around provider networks will have an inevitable impact on the acute sector in Hillingdon, but these changes will be carefully implemented and fully consulted upon.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Proposed governance

There are well-established channels of governance to build on in Hillingdon. Our BCF governance arrangements will mirror those we have in place for the management of funds under Section 75 National Health Services Act 2006, including the s.75 funds being held by the local authority.

The **Hillingdon Health and Wellbeing Board** takes full strategic oversight for health and care systems in the Borough and has been involved from the outset in the planning for BCF. The Board has established a sub-committee specifically to take forward its work on integration in Hillingdon.

The sub-committee has asked a **BCF Officer Governance Group,** consisting of director/chief operating officer from the CCG and Hillingdon Council, finance officers and commissioning programme support (for example, on older people and on Integrated Care) to coordinate planning for the BCF plan.

The BCF Officer Group meets at least monthly with the principal providers of health and care in the Borough in a **BCF Provider and Delivery Forum**. This forum facilitates linkages (for example) with hospital managers and clinicians involved in the seven day working pilot and/or in respect of supported discharge.

The **Governing Body of the CCG** plays a full part in the development of the plans and has signed off the CCG's contribution to the BCF. The Governing Body is also the forum that has facilitated wider access to GPs in developing plans for integration and alignment.

Finally, our local **Healthwatch** has taken a key role in engagement with service users, carers and patients.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

Protecting social care services within the London Borough of Hillingdon means that those identified as being in need of social care support continue to receive the care they require.

The proposals within this plan protect Adult Social care services through managing the demographic pressures; which may otherwise result in a change to the Fair Access to Care eligibility criteria threshold

Please explain how local social care services will be protected within your plans

The NHS transfer monies have been allocated to schemes which support social care and have health benefits.

This plan proposes the continuation of these schemes alongside the funding of new initiatives aimed directly at managing the demographic growth pressures. Furthermore this plan developed from identified gaps within the integration pathway; seeks to shift delivery of care from reactive interventions within an acute setting to a model of personalised joined up care. This supports our vision of Older People living healthy and well maximising their independence and enabling active community engagement. All of which protects social care services and their budgets by optimising independence and supporting people to remain in their own home.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

We will work to meet the needs of services users and their families appropriately every day of the week to improve outcomes. We want to ensure that the Hillingdon system provides a consistent service that meets what is expected by our residents. Our proposed seven day cover will support early / timely discharge from hospital and better care at for people at home.

In liaison with all our providers, The Hillingdon Hospital is to be an “early adopter” of the seven day working model in the NHS. The key areas for the seven day cover at THH include:

- Establishing a seven day mental health liaison (psychiatry)
- Enhancing consultant cover during weekends (12 hour consultant cover, second consultant cover for ‘downstream’ wards, surgical consultant cover twice daily rounds during weekends), increased support to junior staff from consultants
- Development of a virtual ward patient monitoring system
- Enhancing early supported discharge (Homesafe) with voluntary service access

Our additional focus will be on extending short term assessment, rehabilitation and reablement over the weekend to facilitate discharge from hospital and continuing to support people at home.

In primary care, GPs will explore models of co-operation across localities to ensure seven day cover through GP networks, provision of telephone triage and integrating all providers to provide

a holistic service seven days a week.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

All health services use the NHS number as the primary identifier in correspondence.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Our present social care systems already allow the entry of the NHS number. We can adopt this number as a common identifier by 2015 which will allow time for service processes to be amended to ensure the capture of the NHS ID is completed.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to adopting systems that have APIs and Open Standards. Our social care system provider is currently working on developing APIs for this purpose.

Through our PSN connection we already conform to the secure email standards

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Our commitment is demonstrated by our *green light* status on the code of connections for IGSOC, N3 and PSN.

A bi monthly Information Assurance Meeting (HIAG) chaired by our SIRO has been in place for a number of years and is attended by senior member of the Council's leadership team.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The accountable lead professional and joint assessment will build on our current Integrated Care Programme. Currently 85% of practices use risk stratification tools to enable the development of coordinated care plans for people at risk of admission to hospital. The BIRT tool will be adopted as part of the BCF work stream. We are working jointly with CLAHRC to develop a predictive tool to better aligns social and health factors as part of early detection of risk factors to enable better targeted support.

The lead professional role will be aligned with the development of GP based MDGs and emerging networks. The GP will be the responsible clinician, with care coordinators working at MDG level to ensure those identified with risk factors have individual co-designed interventions and care plan initiated with multi provider input and regular review. Complex people most at risk of

admission (circa 560 people plus include social care number) will be supported by a community matron lead professional working within a primary care based (or community based) integrated service.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
1. Inability to shift resources from acute into community	High	All our BCF plans have been developed in the context of *Shaping a healthier future* and its picture of the core activity of THH. Our plans have thus focussed on alignment of investment and service changes with subsequent reduction in secondary care. We have prioritised schemes in such that schemes with high impact will implement early, driving a marked reduction in need of secondary care resources. Our planning includes performance reporting that will track benefits (or a lack of benefits) in real time.
2. Lack of engagement from frontline/ clinical staff resulting in no behaviour changes in the frontline services	High	This is a long term project for us. We have been working on our integrated system for the last two years (ICP, rapid response and intermediate care) and our frontline staff (including clinicians) have been involved in designing and implementing these changes. Stakeholders have been involved through the development of the BCF plans. We will develop a detailed engagement plan for frontline workers as part of our implementation. It will recognise the deep culture change needed to change ingrained behaviours on all sides. Senior leaders have committed to demonstrating that culture in their everyday work. The clinical leadership of our projects is designed to ensure a greater sense of ownership of the proposals.
3. Continued demographic pressures	Medium	Demographic pressures will grow – addressing them poorly in the key risk. We will approach mitigation in three ways: 1. As part of BCF, we will carefully deploy resources on target groups with complex health and care needs and some whose needs are less complex. The aim being to stop increasing the risk profile and reduce acuity through concurrent investment. 2. We will undertake detailed activity modelling as part of the final submission to better understand the impact of demographic pressures at the micro level (neighbourhood, gender and ethnicity) to ensure that our capacity plans reflect that growth.

Risk	Risk rating	Mitigating Actions
		3. Our plans are based on ensuring that people are better supported holistically at home. There will an intense effort to ensure that complexities are managed through multidisciplinary teams. This will restrict growth in cases within secondary care and care homes.
4. Potential exposure of financial risks if BCF outcomes are not delivered in 13/14 and subsequently	Medium	A strong focus on benefits realisation through detailed planning Real-time performance planning and a common KPI dashboard Realistic common planning around deliverability testing will be put in place
5. Alignment with other whole system integrated care plans for Hillingdon within the time scale for BCF submission	Medium	A common strategic governance system is now in place. We will strengthen programme-level governance to align projects We will work towards jointly-commissioning a number of such initiatives in the future
6. Lack of accurate data and baseline estimates	Medium/ low	We have used clinical audit information and stakeholder validation where data was not accurate and/or easily available. We have modelled for some of the projects in greater detail to mitigate for data inadequacies schemes and intend to do the same for the remainder. We will reconcile this information through 2014/15 to ensure that any discrepancy is highlighted and addresses before project implementation
7. Other competing pressures from within the organisation (efficiency) and outside could decrease the priority in partner organisations	Low	Strong governance and leadership by elected members and the CCG GB will facilitate honest discussion about priorities. Most pressures (eg from the Care Bill as it is enacted) would have shared consequences and we recognise the need to plan together to address these. Our coterminous boundaries mean that the channels of communication are strong.