NHS
Hillingdon
Clinical Commissioning Group

Better Care Fund Plan 2016/17

HILLINGDON
LONDON

March 2016

Better Care Fund Plan 2016/17
Contents

2016/17 Better Care Fund Plan

1. PLAN DETAILS

1.1 Summary of Plan

Local Authority	**London Borough of Hillingdon**
Clinical Commissioning Groups	**Hillingdon Clinical Commissioning Group (NHS Hillingdon)**
Boundary Differences	**Boundaries are co-terminus**
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Total agreed value of pooled budget:	
2015/16	**£17,991,000**
2016/17	**£22,531,000**

1.2 Authorisation and signoff

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

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

Signed on behalf of the Health and Wellbeing Board	Hillingdon Health and Wellbeing Board
By Chairman of Health and Wellbeing Board	Cllr Ray Puddifoot MBE
Date	<date>

2. CONFIRMATION OF FUNDING CONTRIBUTIONS

2.1 All minimum funding contributions are met

The contribution of the CCG and the Council to the BCF plan is as follows:

- HCCG - £11,965k
- LBH - £10,566k

This compares to the following in 2015/16:

- HCCG - £10,032k
- LBH - £7,959k

The detailed scheme descriptions in **Annex 1** provide a breakdown of allocated funding by scheme.

2.2 Agreed plan for use of Disabled Facility Grant monies

As an upper tier local authority, the DFG funds will be utilised to support older and disabled residents in line with previous practice. Scheme 5: *Integrated Community-based Care and Support* in **Annex 1** explains how DFGs will be promoted within primary care.

3. VISION FOR HEALTH AND CARE SERVICES

3.1 How services will be transformed to implement the vision in the Five Year Forward View and moving towards integrated health and social care by 2020 and the role of the 2016/17 BCF.

Introduction

This plan builds on Hillingdon's 2015/16 Better Care Fund Plan. Our continuing vision is that by 2019/20, 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.

There will be a shift to planning for anticipated care needs rather than crisis management and reactive provision of services. The range of services and capacity and competencies of the workforce will meet the physical health, mental health and social care needs of the residents of Hillingdon and be delivered in a way that is integrated and seamless from a service user point of view, in their usual place of residence.

In 2015/16 the BCF was targeted at Hillingdon's 65 and over population and primarily frail elderly people against an agreed definition of frailty. The focus during 2015/16 was:

- All of Hillingdon's residents aged 85 and over
- Frail older people aged 75 and over with one or more long-term conditions
- Older people who are at risk of dementia
- Older people who are at risk of falling for a first time.
- Older people who are socially isolated

The 2015/16 plan has enabled progress to be made in achieving greater functional integration and alignment between health and care services to deliver an improved model of care for older people by 2020. The intention for 2016/17 is to take Hillingdon further along the path to greater integration between health and social care. Although the focus for the 2016/17 plan will once again be Hillingdon's older people population, the success of 2015/16 enables the ambition to extend schemes to cover the needs of other population groups where there are clear benefits and better outcomes for residents, e.g. where the development of particular markets are concerned such as supported living and homecare or where a strategic approach will be more effective if considered across age groups, as is the case with carers.

During 2016/17 the Council and the CCG will be working with partners to develop a longer-term integration plan that will set out a roadmap to achieve full integration between health and social care by 2020. The assumption is made that if the model of care, and wider enablers for integration for older people are further developed in 2016/17, this can deliver both better outcomes for older people, and work equally well for other residents and population groups. The BCF plan for 2016/17 will therefore scale up and build on progress to date, creating another incremental step to achieving further integration in 2017 - 2020.

2015/16 has also seen the development of an Accountable Care Partnership (ACP), which is Hillingdon CCG's preferred model of delivery for integrated care. This presents an opportunity to deliver a new model for addressing the health and wellbeing needs of Hillingdon's residents in line with the Five Year Forward View (5YFV).

Commissioning integrated care from the ACP will initially be for older people with long term conditions, but will progress in scope to all older people and other population groups with long term conditions. Hillingdon CCG and shadow ACP are discussing the scale and pace of this ambition linked to benefits for people in Hillingdon.

The ACP will deliver services in shadow form for a year from April 2016, which will provide an opportunity for all partners to explore the scope for this being a vehicle for the delivery of more integrated services as part of or aligned to the post April 2017 BCF integration plan.

By 2019/20 we expect to have in place a model of care and supporting enablers:

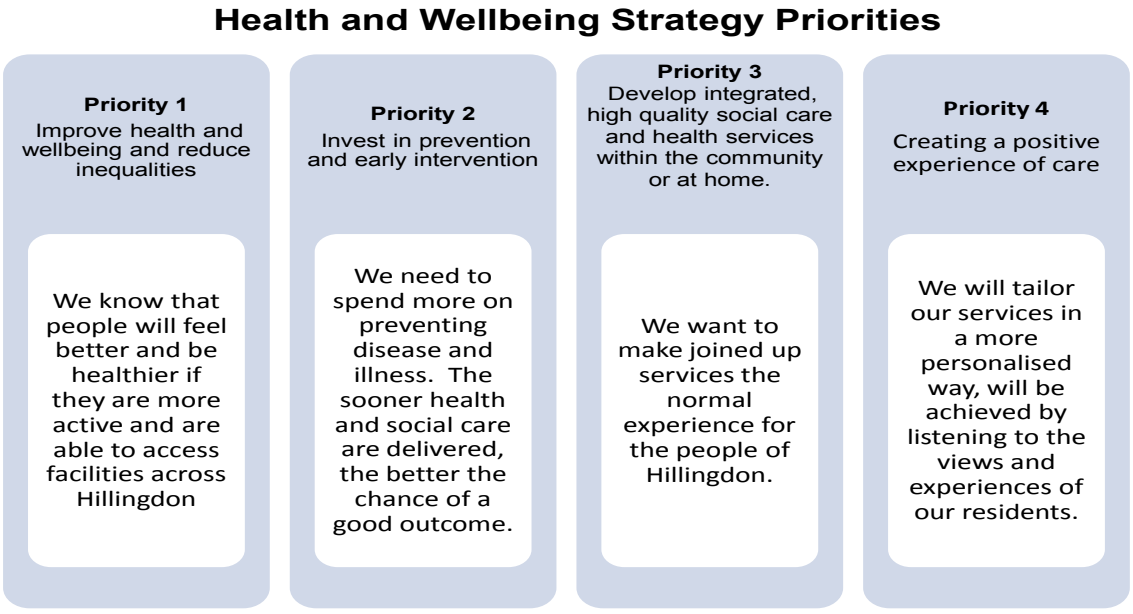
- Where residents have easy access to information and advice about services, including care and support services;
- That has a focus on improving health outcomes for residents with one or more health conditions or care needs;
- Where there is systematic early identification of susceptibility to disease or

exacerbation in the population, alongside integrated management of conditions;

- Where better coordination of services are configured around Hillingdon's residents, including a much stronger focus on case management and prevention;
- Where residents and carers are actively involved in the planning of their care;
- Where people are only admitted to Hillingdon Hospital when they are acutely ill;
- Where a hospital admission is necessary and unavoidable their lengths of stay are reduced;
- That enables people to be treated at or close to their home wherever possible;
- A reduction in the number of people living in residential care; and
- The most effective use of health and care resources is made to achieve best value for the Hillingdon £.
- Enablers such as IT interoperability, development of a sustainable workforce and a vibrant market offering residents/patients quality choices.

Links to the Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy

The data in Hillingdon's JSNA has informed the priorities within Hillingdon's Health and Wellbeing Strategy and these are summarised below.



Whilst the initial focus for the 2016/17 BCF plan is on older people, it is anticipated that other groups with complex needs which can be better met by increased integration of social care and health care provision will be addressed as part of an incremental growth of Hillingdon's integration ambition in the 2017/18 to 2019/20 plan.

3.2 What difference will this make to patient and service user outcomes?

We will know that our plans have delivered our vision if our residents are 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 that I need a stay in 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.'

The 2015/16 BCF plan was a stepping stone for Hillingdon on an integration journey and it is not expected that it will be possible to achieve the above responses as standard from residents and patients as a result of the work that has taken place during this first year of the BCF; it will also not be fully achieved from the 2016/17 plan. However, the Council, the CCG and other partners do expect that this will be an increasingly common experience as the benefits of closer integration and the roll out of an integrated model of care are experienced by more people as we get closer to 2020, with the ability to measure residents' experience and the outcome of care across the whole health and care system.

3.3 Relationship between the BCF, the CCG's 2016/17 Operating Plan and the longer-term Sustainability and Transformation Plans

Hillingdon CCG 5-year Sustainability and Transformation Plan (STP)

There are no schemes in the 2016/17 BCF that do not align with Hillingdon CCG's 5 year plan. Going forward, the partners recognise that the BCF plan will be a key mechanism for local delivery of many of the themes contained within the STP.

Hillingdon CCG 2016/17 Operating Plan

BCF alignment with Hillingdon CCG 1 year operating plan includes:

- Contribution to reduction in non elective admissions
- Local quality priority: to reduce admissions as a result of falls

3.4 Alignment with other locally relevant strategic plans and initiatives related to care and support underway in Hillingdon.

Hillingdon Sustainable Communities Strategy, 2011 - 2018

The BCF plan is aligned to the Local Strategic Partnership's statutory Sustainable Community Strategy and will contribute to delivering the following priority under the strategy:

- Help people to lead healthier, more independent lives.

Hillingdon Joint Health and Wellbeing Strategy, 2014 - 2017

The Better Care Fund workstreams support the priorities of Hillingdon's Health and Wellbeing Strategy, especially in regard to developing integrated, high quality social care and health services within the community or at home.

Hillingdon's Joint Health and Wellbeing Strategy action plan has been revised to incorporate the new BCF objectives in support of its priorities.

Integrated Care System Enablers

2015/16 has seen considerable progress in developing an integrated model of care for older people as part of the early adopter pioneer programme approved by the Department of Health in March 2014. This has enabled accelerated progress of delivery of the 2016/17 BCF plan, including:

- Development of a common model of care for frail elderly people;
- Care and support planning by GP networks, shifting to planning for anticipated needs with GPs as lead professional;
- Improved care planning, including risk stratification, care navigation and Multi-disciplinary Team (MDT) working;
- Roll out of an agreed screening tool for older people not known to services;
- Development of effective IT solutions that will support data sharing and facilitate residents and patients only having to tell their story once. See Data Sharing and IT Interoperability under National Conditions.
- Ability to track patients across the whole care system and identify outcomes and experience of care.
- Development of a model to improve people's engagement with their own care through evidence-based use of Patient Activation Measure tools and access via GP networks to a voluntary sector provided Health and Wellbeing Service.

As previously mentioned, 2016/17 will see the ACP operating in shadow form for one year. Alignment of integration initiatives is being overseen by a multi-agency Integrated Care Steering Group and Older People's Model of Care Delivery Group. A joint communication and engagement plan with identified leads is in development that will ensure alignment across initiatives to avoid confusion and particularly maximise ownership and effectiveness of the post April 2017 BCF integration plan.

Hillingdon Resilience and Urgent Care Plans

Initiatives to support reduction in non-elective admissions are aligned with both the Hillingdon Resilience Plan and the Hillingdon Urgent Care Board plans. Several of the

BCF schemes will be contributing to the reduction in non-elective admissions target contained within the CCG's Operating Plan and there is also alignment with the mental health urgent care pathway programme and the mental health frequent flyers programme. For example, the Adult Social Care contribution to the BCF includes funding for mental health social workers in A & E to help prevent avoidable admissions. It also funds a registered mental health nurse in the Rapid Response Team.

The BCF plan will align with funds, e.g. operational resilience, to develop a whole system approach to support admission avoidance, improved initial access points and prevention and community management. The out of hours Approved Mental Health Practitioner (AMHP) in A & E, which is short-term funding from the operational resilience funding stream, is an example of this.

Prime Minister's Challenge Fund

BCF is aligned to improvement in access in primary care. Through use of the Prime Ministers challenge fund, GP practices have been supported to focus on improvements where specific enhancements have been identified to improve the modl of care for older people.

Public Health

There are already a range of initiatives being undertaken by Public Health in partnership with the Library Service, the Sports and Leisure Service and the third sector to help keep older people physically and mentally active. The plan is aligned with this existing activity, which will help to support delivery of Scheme 1: *Early identification of people susceptible to falls, dementia, stroke and/or social isolation*. Included within this scheme is the development within the Council of a new Wellbeing Service, which will see some of the services mentioned above brought together in a more coordinated way to deliver better outcomes for residents and support the prevention agenda.

Strategic Estates Plan

To support the shift in care settings from acute to community Hillingdon is in the process of developing a strategic estates plan that will look at current holdings across statutory partners and consider the opportunities for addressing current and future need going forward. The development of the plan supports delivery of NHS England's Five Year Forward View by taking a collaborative approach to:

- Fully rationalising the NHS estate,
- Maximise use of facilities owned locally by the statutory agencies,
- Deliver value for money, and
- Enhance the resident/patient experience of care.

The draft strategy now needs to be transformed into a strategic planning tool for Hillingdon which will support future premises investment decisions across all stakeholder organisations. This is particularly important as it will inform the investment of Section 106 and CIL contributions and the investment in primary care premises outside of the scope of the proposed hubs.

2020 Digital Roadmap

Partners across health and social care in Hillingdon are engaged in the development of a digital roadmap which will detail how the ambition of being paper-free at the point of care

by 2020 will be achieved. This links with the data sharing and IT interoperability national condition. The target is for the roadmap to be agreed in June 2016 for submission to NHSE.

3.5 Contribution to the ongoing delivery of the aims and changes set out in the Care Act, 2014.

A key underlying theme for Hillingdon's BCF plan for 2016/17 is about ensuring residents have access to relevant support is to help them to achieve the outcomes that matter to them in their life, therefore reflecting the *wellbeing principle* in the 2014 Act. The specific schemes within the plan set out in Annex 1 show that the following responsibilities are addressed:

- Prevention - see in particular scheme 1: *Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation,* but this a theme that runs through all schemes)
- Access to information and advice - see scheme 1 as referred to above.
- Market shaping and management - see in particular schemes 5: *Integrated Community-based Care and Support* and scheme 6: *Care Home and Supported Living Market Development.*
- Managing provider failure - see schemes 5 and 6 as described referred above.
- Supporting Carers - see scheme 7: Supporting Carers, which has been developed specifically to address new responsibilities towards Carers. This scheme in the 2016/17 has been enhanced to address responsibilities under the 2014 Children and Families Act towards young as well. See also Section 7: National Conditions for details of the resource commitment to support Carers in Hillingdon.

4. EVALUATING THE 2015/16 BETTER CARE FUND PLAN

4.1 How successful was the plan?

Although the 2015/16 BCF plan was agreed to be 'first step' in nature and featured pooling only of mandated budgets to minimise the risk to the Council and the CCG, it has provided an opportunity to develop a stronger working relationship between the Council and the CCG and with other health and third sector partners.

In December 2015 an evaluation workshop took place involving representatives from the Council (including Public Health), the CCG, Hillingdon Hospital, CNWL, the local third sector consortium called H4All and Age UK Hillingdon. Using an adapted version of an evaluation tool developed by NHSE, the key conclusions of the workshop are summarised below and these were subsequently tested:

What went well in 2015/16.

- Commitment to work together and the acknowledgement of the importance to do so.
- Closer working between health (including GPs), social care and the voluntary sector.
- Voluntary sector involvement across all schemes.
- Creation of the third sector consortium, H4All (Age UK, Disablement Association Hillingdon, Harlington Hospice, Hillingdon Carers and Hillingdon Mind).
- Creation of the Integrated Discharge Team at Hillingdon Hospital to support timely discharge to the usual place of care.

- Development of the Integrated Care Record and plans to share information about residents/patients across care organisations.
- Joint working to support people at end of life has improved.
- Primary Care Navigators (PCNs): 6 people employed by Age UK but based in Primary Care who support older people with long-term conditions but low level need to access appropriate support and care services.
- Public Health initiatives to keep older people active mentally and physically.
- Development of the online resident services information portal Connect to Support.
- Increasing numbers of carers receiving carers' assessments and support services, including respite.
- Improved joint management of community equipment services to deliver a more effective and efficient system.
- Development of a joint framework to measure older people's outcomes and experience of care.

Areas for further development

- Development of care home market for people with dementia and challenging behaviours.
- Extending integrated models of care to a other population groups.
- Improved communication between strategic and operational staff within partner organisations.
- Greater integration between intermediate care services.
- Evidencing the delivery of outcomes for residents.
- Improving the patient pathway from admission to discharge.
- Using pooled budgets to improve the care experience of residents/patients with health and social care needs.
- Expanding the use of trusted assessors.
- Increasing awareness of Public Health wellbeing and prevention initiatives.
- Reviewing inter-organisational duplication.
- Pursuing joint opportunities to commission services differently, including commissioning for outcomes.
- Improving the standard of care amongst care agencies.
- Improving electronic sharing of resident/patient information across health and care organisation.

Many of the above points have been addressed in the evolution of the schemes for the 2016/17 BCF plan.

Metrics

Hillingdon's reportable metrics are shown in the table below with the projected outturn for 2015/16 based on the position at the end of Quarter 3.

	Reportable Metrics 2015/16

Metric	2015/16 Target or Ceiling	Projected Outturn
1. 3.5% reduction in NEL admissions attributed to 65 + population.	-388 admissions	-556
2. Reduction in permanent admissions to residential & nursing homes (65 +).	150	145
3. Proportion of people (65 +) still at home 91 days of discharge from hospital to reablement.	95.4%	92%
4. Delayed transfers of care (delayed days) 18 +.	4,790	4,335
5. Resident experience: how easy or difficult to access information and advice about support services and benefits.	73% (Source: Adult Social Care Survey)	75%
6. Social care-related quality of life.	19 (Source: Adult Social Care Survey)	18.4

Conclusion

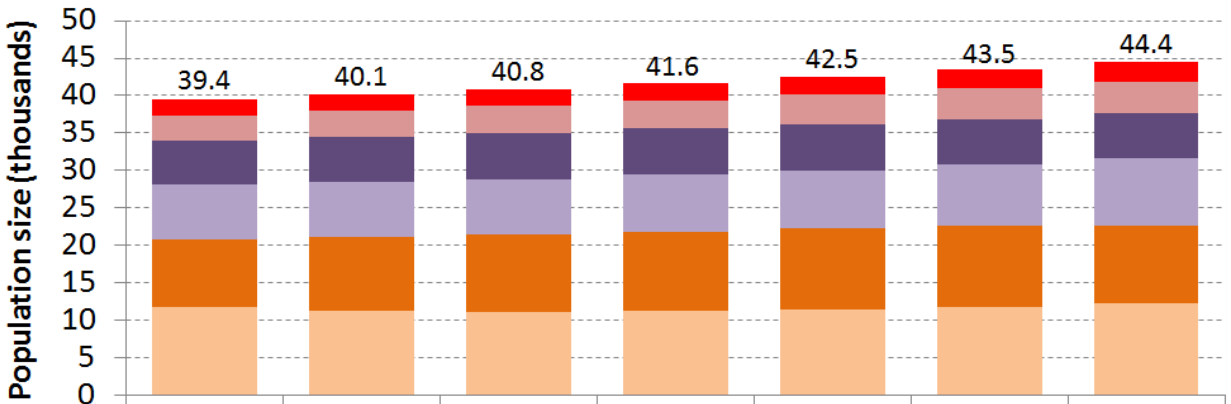
The 2015/16 plan has provided the platform to develop an incrementally more ambitious plan for 2016/17 that will see increased investment from both the Council and the CCG.

5. CASE FOR CHANGE

5.1 Issues the BCF will be used to address within London Borough of Hillingdon

The focus of the 2016/17 BCF Plan will be primarily on older people and the case for change as to why Hillingdon is focusing on this population group set out in the 2015/16 BCF continues to apply. The table below illustrates the steady increase in the 65 and over population and particularly those people aged 80 and over during the period 2016 to 2022.

The 65+ years population size, Hillingdon (2016 to 2022)



	2016	2017	2018	2019	2020	2021	2022
90+	2.1	2.1	2.2	2.3	2.4	2.5	2.7
85-89	3.4	3.5	3.6	3.8	3.9	4.0	4.2
80-84	5.8	6.0	6.1	6.2	6.2	6.0	6.0
75-79	7.4	7.3	7.4	7.6	7.8	8.2	9.0
70-74	9.1	9.9	10.3	10.6	10.8	10.8	10.4
65-69	11.7	11.2	11.1	11.2	11.4	11.8	12.2

Source: 2012 SNPP (National Statistics)

In Hillingdon, there is an increasing focus for our health and care services for older people to become more proactive in supporting people at risk of escalating need instead of being directed at acute interventions. Our planning and our services are also in the process of becoming more joined-up to support older residents in their homes and in their communities.

The case for change issues the BCF will be used to address in Hillingdon will include:-

- More than 39,000 older people live in Hillingdon in 2016, a figure that is likely to increase by approximately 7% by 2020 and 11% by 2022.
- 40% of our non-elective activity in 2014/15 and 39% during Quarters 1 to 3 2015/16 was attributed to the 65 and over population, this group accounted for 56% of the total health emergency admission spend (54% Q1 to 3 2015/16). In 2014/15 the 42% (39% Q1 to 3 2015/16) of emergency admission spend was on the 75 and over population, which accounted for 29% of admissions in 2014/15 (27% Q1 to 3 2015/16). We estimate that some 35% of emergency admission for the 75 and over population grou are avoidable or deferrable, which is based on the proportion of admissions resulting in a length of stay of between 0 and 2 days.
- 56% of the Council's gross spend on care for older people in 2014/15 was on care homes (residential and nursing). This made Hillingdon the 11th lowest in London (22 boroughs have a higher proportion spend than Hillingdon). However, the desired trajectory would be towards the 40% level. The lowest spend in 2014/15 was London's poorest borough, Tower Hamlets, which achieved 38%; in North West London Hammersmith and Fulham achieved the lowest spend on this type of care at 51%. The Council would like to eliminate the use of residential care for new

permanent placements completely for older people by the end of 2018.

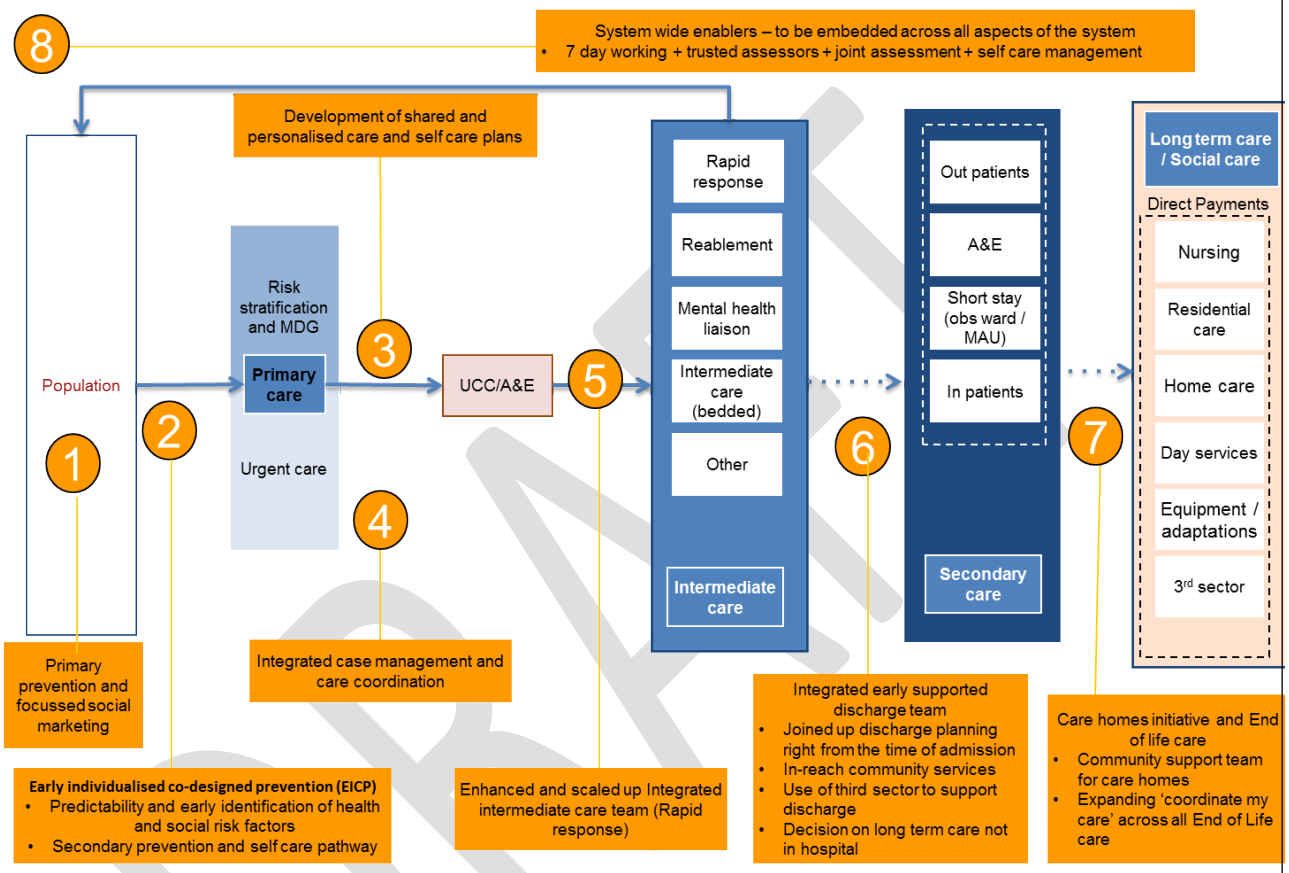
- 31% of all older people live on their own and could be at risk of being socially isolated.
- Overall, Hillingdon is expected to have the greatest increase in the proportion of older people with long term conditions compared to other London boroughs making the management of these conditions a significant priority.
- In 2013/14 there were 3,246 people who had been diagnosed with a stroke in NHS Hillingdon CCG. In the same period there were 310 admissions recorded on the Sentinel Stroke National Audit Programme. Atrial fibrillation is a known risk factor for stroke. The diagnosed prevalence in Hillingdon is 1.1% and the estimated prevalence is 2.0%. There could be an additional 2,500 people with undiagnosed atrial fibrillation in the CCG.
- Projections from Projecting Older People Population Information System (POPPI) suggest that the number of older people living with diabetes in Hillingdon will increase by 9.5% from 4,805 in 2015 to 5,307 by 2020. Similarly, predictions from Projecting Older People Population Information System (POPPI) suggest that the number of people living with dementia will increase by 13.5% from 2,711 in 2015 to 3,133 by 2020.
- Whilst there are discharges from Hillingdon Hospital taking place seven days a week the distribution across the week is uneven and there is considerable scope for making improvements following on from the work that has taken place during 2015/16.
- The structure of the current care home market for older people is not compatible with future needs of Hillingdon's ageing population and does not reflect the impact of the development of extra care sheltered schemes as realistic alternatives to residential care. Clearer messages need to be given to providers about future needs and requirements and suitable levels of support made available to ensure the availability of a sustainable, quality care home market in the borough.
- Expansion of supported living schemes to maximise the opportunities for residents to live fulfilling lives in the least restrictive care setting requires more integrated approaches to support providers, reduce demand on primary care and prevent avoidable hospital attendances and admissions.
- The 2011 census showed that 18% of unpaid carers were aged 65 and over. POPPI projections suggest that this number is likely to increase by 19% to 5,703 by 2020. The census also showed that approximately 10% of carers were aged under 25. Whilst the focus of the BCF in 2015/16 was on older carers, supporting young and younger carers is equally important.

5.2 How integration will be used to improve issues identified

The need and potential for greater integration to result in more timely and effective interventions is recognised and accepted by both the Council and CCG and was reflected in the 2015/16. The diagram below maps the health and care system in Hillingdon as it was at the start of 2015/16 and which is largely still current.. It illustrates a series of

points for intervention across the system that were identified, through stakeholder engagement, where the best opportunities for improving the quality of life for Hillingdon's older residents are. Improvements have been made during 2015/16 and the proposed schemes for 2016/17 build on this work in order to deliver better outcomes for residentspatients and Hillingdon's health and care economy.

Current system map in Hillingdon and key points of intervention



The planned points of integration are:

1. **Population-wide prevention services -** These promote self-care and general well-being. This includes promotion of access to information and advice through an online citizen portal and the development of a third sector provided Wellbeing Service. It also includes the development of wellbeing initiatives to keep older people mentally and physically active. Through the Wellbeing Service assessments against Patient Activation Measures will determine the level of support required by a person to enable them to manage their own long-term condition.

2. **Specific self-care initiatives for older people** – This is designed around their conditions or infirmities. For example, self-management education for older people living with dementia and/or at risk of stroke or who have fallen or through provision of telecare assisted technology to provide monitoring and response services.

3. **Personalised care planning** – This is for people who have regular contact with primary or community health and/or social care. Their personalised care planning will

involve planned contact with a GP, a guided care nurse or care coordinator in general practice.

4. **Integrated case management** – This is a development of personalised care planning for people who need more intensive support to prevent a crisis in their health or care. It would revolve around GP planning and case management across primary, community and social care. This would include the further roll out of the Integrated Care Record that could be accessed by residents/patients online through the Care Information Exchange.

5. **Crisis Response and Intermediate care** – for people who despite all the above support have a care crisis or health exacerbation that causes them to access acute services. Intermediate services intervene here to provide appropriate support to return people to their homes without acute care. Having improved functional alignment during 2015/16 the next stage is to improve effectiveness and efficiency further by looking at structural integration options.

6. **Discharge support initiatives** – These help residents who have had to be admitted to an acute setting return home as soon as possible irrespective of what day of the week it is.

7. **Longer term residential interventions** – This supports people whose needs can only be met safely in a care home environment to prevent hospital admissions that are inappropriate and also to enable people to die in their care home where this is their preferred option.

8. **System-wide enablers** – The last intervention point is actually system-wide and represents a series of measures (including the BCF national conditions) that are catalysts to system improvement. It also includes IT interoperability.

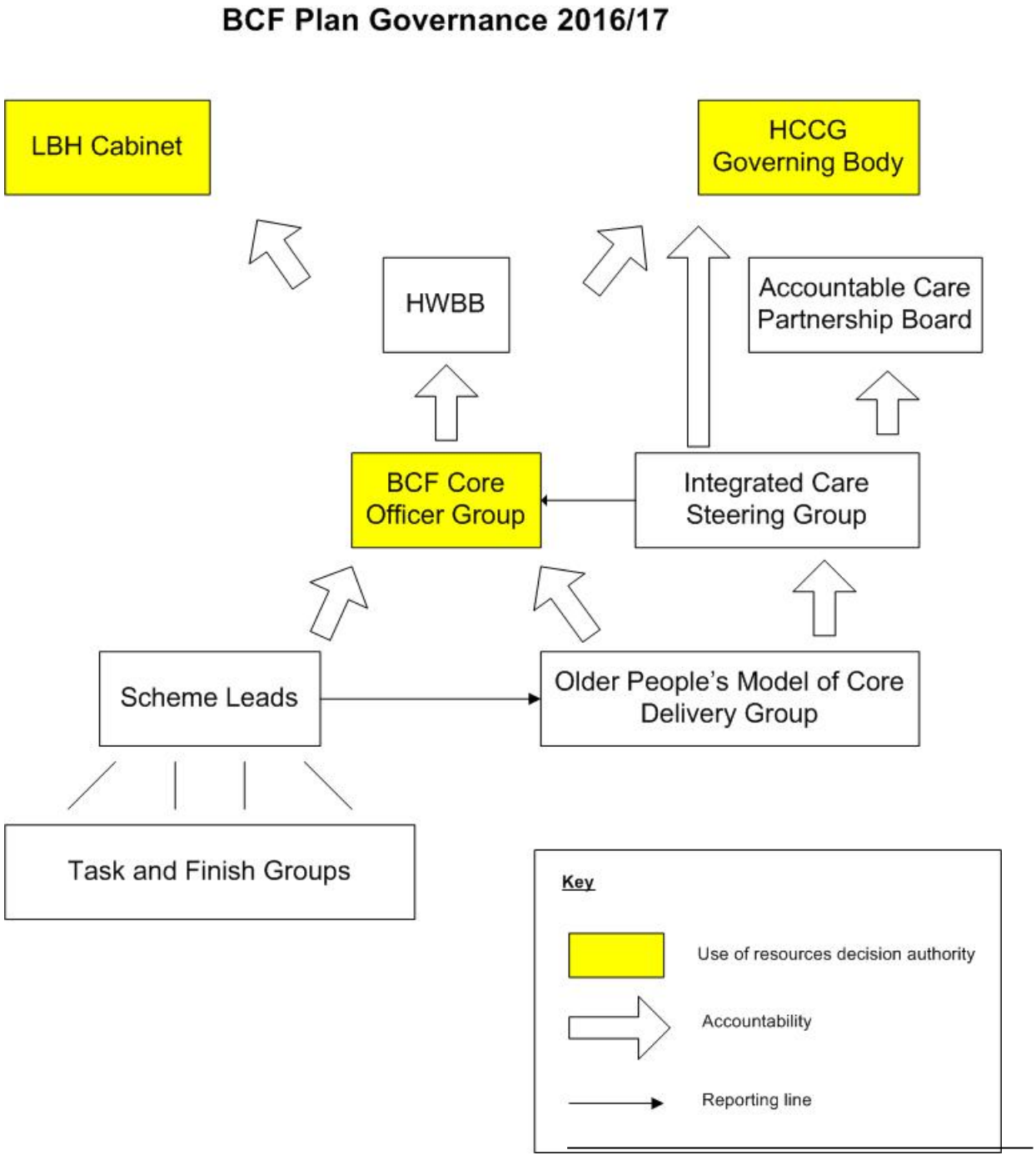
6. COORDINATED AND INTEGRATED PLAN OF ACTION FOR DELIVERING CHANGE

6.1 What will the governance arrangements look like?

The governance arrangements for the 2015/16 BCF plan have enabled delivery of improvements for residents and it is proposed that these will be replicated in 2016/17 with some modifications.

The legal agreement between the Council and the CCG established under Section 75 (s.75) of the National Health Service Act, 2006, for the 2015/16 plan will be updated new financial arrangements and modified governance arrangements. The terms of the updated agreement will be agreed during Q4 for formal sign-off in May 2016 by both the Council's Cabinet and the CCG's Governing Body.

The governance arrangements are summarised in the diagram below.



The **Hillingdon Health and Wellbeing Board** (HHWBB) provides leadership in developing a strategic approach for health and wellbeing in Hillingdon and is responsible for holding partner agencies to account for performance on agreed priorities. It is also responsible for collaborative working to develop social care and health related commissioning plans to improve the health and wellbeing of residents of the Borough and monitor implementation and performance. The board therefore takes strategic oversight for health and care systems in the Borough and has been involved from the outset in the planning for BCF. It is responsible for final sign off of plans and reports on behalf of partners and is the overarching leadership and governing body but does not, however, have authority to take investment decisions on behalf of its members. Individual

partners, therefore, need to be satisfied with the proposals going to the Board and, as necessary, to agree them in advance. This applies to the **HCCG Governing Body** and to **Hillingdon Council's Cabinet**.

Healthwatch Hillingdon, as the local "consumer champion" and full member of the Board needs to be satisfied that plans reflect its understanding of what residents and patients say they need.

A **Core Officer Group** comprising of senior officers from the CCG, Adult Social Care, LBH and CCG Finance and the LBH Corporate Policy team has been established to progress work on the BCF and to have operational responsibility for the management of the s.75 pooled budget. This group meets fortnightly and is jointly chaired by the Director of Adult Social Care and the CCG's Chief Operating Officer. It provides oversight of the programme and also considers opportunities for integrated working and/or joint commissioning for recommendation to the Health and Wellbeing Board as well as the Council's Cabinet and CCG Governing Body for decision about use of resources.

An **Older People's Model of Care Delivery Group is** accountable for the delivery of the model of care for older people in Hillingdon and is a mechanism to enable partner input into the successful delivery of integration priorities including the Better Care Fund plan. It has oversight and creates alignment of the existing plans, strategies and work steams for older people and identifies opportunities for increasing efficiency and effectiveness of service models. Its final function is to make recommendations regarding the strategic development of older people's services in Hillingdon, which will go the Health and Wellbeing Board and the **Integrated Care Steering Group**.

The **Integrated Care Steering Group** will ensure a programme of work is developed which will deliver the integrated model of care for both older people and adults with long-term conditions as well as ssociated system enablers, e.g. IT interoperability, outcome based commissioning, workforce development and the development of an Accountable Care Partnership (ACP). As shown in more detail in section 6: *Alignment*, this work is closely aligned to the BCF plan for 2016/17 with the intention of delivering our shared vision for older peple and the long-term sustainability of Hillingdon's health and care system. The Steering Group reports to HCCG's Governing Body and Accountable Care Partnership Board (see section 5). The Steering Group links with the Health and Wellbeing Board through its formal reporting to HCCG's Governing Body and its informal links with the BCF Core Officer Group.

Each of the eight BCF schemes is led by an identified **scheme lead** who is a senior manager within one of the partner organisations. They are supported by task and finish groups. A single seven day working task and finish group oversees the delivery of the four priority clinical standards as well as the out of hospital standard that is included within the BCF plan. This also reports into Hillingdon's Systems Resilience Group (SRG), which is mandated by NHSE under its 2012 Health and Social Care Act powers to oversee local implementation of the priority seven day working clinical standards.

This structure takes into account the sovereign nature of partners' decision making processes that require each partner to report through their own internal governance, as appropriate, on developments. Where necessary bilateral senior meetings have been arranged, for example, between the CCG Governing Body Chairman and the Leader of the Council, to consider any remedial actions required to resolve issues.

6.2 Details of the management and oversight of the delivery of the Better Care Fund plan, including management of remedial actions.

The practice in 2015/16 has been for the Core Group to receive performance updates on a monthly basis and this will continue in 2016/17. Where there are performance delivery issues escalation to the Core Group enables blockages to be identified and mitigation actions agreed. This group will continue to have operational responsibility for managing the s.75, including the risk share arrangements that are described in section 5: *Risk Share Arrangements*, and will therefore receive financial reports and will also monitor the risk register.

BCF schemes are also integral to achievement of Hillingdon's Health and Wellbeing objectives and this will be reflected in the annual revision of the Health and Wellbeing Strategy. Delivery against key metrics will therefore be reported quarterly to the Health and Wellbeing Board. Separate BCF performance reports to the Health and Wellbeing Board will enable the Board to get a broader understanding of plan delivery and impact on residents and Hillingdon's health and care system.

The whole programme is overseen by a programme manager, who reports to the Core Group and the Older People's Model of Care Delivery Group.

6.3 List of 2016/17 BCF schemes

The individual projects or changes planned as part of the BCF are listed below. **Annex 1** contains detailed descriptions for each of these schemes.

Ref no.	Scheme
1	*Scheme 1* - Early identification of people susceptible to falls, dementia, stroke and/or social isolation
2	*Scheme 2* - Better care for people at the end of life
3	*Scheme 3* - Rapid Response and integrated intermediate care
4	*Scheme 4* - Seven day working
5	*Scheme 5* -. Integrated Community-based Care and Support
6	*Scheme 6* - Care Home and Supported Living Market Development
7	*Scheme 7* - Supporting Carers
8	*Scheme 8* - Living well with dementia

6.4 Key milestones associated with the delivery of the 2016/17 plan

The following reflect some of the key milestones associated with the delivery of the 2016/17 plan:

Quarter 1

- Revision of plan to reflect feedback from Regional Assurance Team.
- Approval of plan by Health and Wellbeing Board and HCCG Governing Body
- Final plan submission.
- Task and finish group meetings and sign-off of detailed scheme action plans for 2016/17.
- Engagement with health and social care staff on content of 2016/17 plan.
- Third sector provided Wellbeing Service becomes operational.
- Stakeholder consultation on Sustainability and Transformation Plan and role of BCF in its delivery.
- Approval of section 75 agreement by Council's Cabinet and HCCG Governing Body.
- Single palliative personal care service operational.
- 2015/16 BCF outturn report considered by HWB/Governing Body.
- Arrangements in place with care homes to support people with challenging behaviours.

Quarter 2

- Joint nursing home brokerage pilot operational.
- Q1 BCF performance report to HWB/Governing Body.
- Decision about scope of 2017 - 2020 BCF plan.
- Training sessions for primary care about community service access provision, including DFGs, and referral routes.
- Joint hospital discharge protocol agreed.

Quarter 3

- Decision on integration and delivery model for intermediate care services.
- Review of Health and Wellbeing Service.
- Q2 BCF performance report to HWB/Governing Body.
- Review results of AF pilot with pharmacists.
- Consultation on proposed 2017 - 2020 BCF plan.
- Appointment of new joint community equipment provider.
- Joint care home market position statement published.

Quarter 4

- Q3 BCF performance report to HWB/Governing Body.
- 2017 - 2020 BCF plan approved by HWB and HCCG Governing Body.
- 2017 2020 BCF plan section 75 agreement approved by Council's Cabinet and HCCG Governing Body.

6.5 A full populated and comprehensive risk log

The risk log is set out in **Annex 2**.

7. RISK SHARE ARRANGEMENTS

7.1 Contingency planning and risk share arrangements that are in place.

Management of the BCF risk register and is addressed in section 6: *Coordinated and Integrated Plan of Action for Delivering Change.*

During 2015/16 the Council and CCG agreed to manage their own risks. It is intended to take a similar approach in 2016/17 but to apply specific risk share arrangements in respect of the following:

- **Specialist palliative personal care service** - With the palliative personal care service the risks associated with under or over-performance will be shared proporotionate to each organisation's financial contribution.

- **Community Equipment** - The risks share on the community equipment contract in respect of under and over- performance will be shared proporotionate to each organisation's financial contribution.

The intention is to develop a risk share agreement early in 2016/17 that can then be run in shadow form in order to inform arrangements to be included in the 2017/18 to 2019/20 BCF plan. It is intended that this would also include hospital discharge and delayed transfers of care and potentially involve providers such as Hillngdon Hospital and CNWL.

8. NATIONAL CONDITIONS

A brief description of how the plan meets each of the national conditions for the BCF.

8.1 Protecting social care services

a) Outline of local definition of protecting adult social care services (not funding)

As in 2015/16, protecting social care services within the London Borough of Hillingdon means that those identified as being in need of social care support, reablement or community equipment continue to receive the services and care they require to promote effective outcomes.

The national eligibility criteria came into effect on 1st April 2015 and this is equivalent to substantial under the previous critieria. In addition, it is intended that disabled facilities capital grants will continue at the pre-BCF level as part of the protection of social care.

The proposals within this plan protect Adult Social Care Services through managing demographic pressures, which may otherwise impact on the level of support that the Council is able to provide to residents with social care needs. The funding provided will also enable the eligibility criteria to be retained at moderate for community equipment,

which recognises the preventative nature of this service.

b) How local schemes and spending plans will support the commitment to protect social care

The 2016/17 plan builds on the work undertaken during 2015/16 to manage the financial pressures arising from demographic growth through earlier identification of older people at risk of escalating need. Through more joined-up and increasingly integrated approaches to early intervention this will help to maximise the independence of older people in their own homes and thereby reduce pressure on Social Care services and budgets, which will in turn reduce pressure on secondary care in Hillingdon.

c) The total amount from the BCF that has been allocated for the protection of adult social care services and confirmation that at least the local proportion of the £138m has been identified for the implementation of the new Care Act duties.

The CCG will be passporting £6,190k for protecting adult social care and the £899k allocation for the implementation of new Care Act. This compares to £4,771k and £838k respectively for 2015/16 and reflects the level required. This funding will contribute to the stability of the local social and health care system as a whole. Achieving stability and sustainability within the local market place is a key objective of the Hillingdon's BCF plan and is reflected in the construction of the schemes for 2016/17.

d) The level of resource that will be dedicated to carer-specific support

Hillingdon's plan for 2016/17 includes a dedicated 'Supporting Carers' scheme with a remit that includes carers of all ages. This scheme will deliver Hillingdon's Joint Carers' Strategy, 2015 - 2018, which was developed by the multi-agency Carers' Strategy Group and approved by both the Council and the CCG in 2015. The agreed vision for the strategy is that we want our carers to be able to say:

- *"I am physically and mentally well and treated with dignity"*
- *"I am not forced into financial hardship by my caring role"*
- *"I enjoy a life outside of caring"*
- *"I am recognised, supported and listened to as an experienced carer"*

There are four areas identified within the strategy that attention is focused on and this is on the basis that addressing these areas will 23aximize the amount of time a carer is prepared to undertake their caring role, which in turn influence key outcomes such as non-elective admissions, delayed transfers of care and permanent admissions to care homes. The four priority areas are:

- Health and wellbeing
- Financial circumstances, including access to information and advice
- A life outside of caring
- Recognition of the caring role

The investment in this scheme for 2016/17 to support delivery of the strategy and contribute to the delivery of key outcomes is approximately £1.4m. This comprises of £771k from the Care Act implementation fund carers' assessments and reviews as well as the provision of respite and other carer support services to address assessed social

care needs. In addition to this is included a further £630k from the Council for the Carers' Hub service provided by the third sector. This service delivers a range of preventative support services to carers, including access to information and advice. A further £18k is invested by the CCG for support provided by the third sector.

8.2 Seven day services to support discharge

a) Local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

A task and finish group has been established that will oversee implementation of the four priority seven day working standards and also standard 9, the out of hospital standard that is a dedicated scheme within Hillingdon's BCF plan for 2016/17. This group will report to the Systems Resilience Group as mandated by NHSE and other accountabilities will be as described in section 4 of this document: *Governance Arrangements*.

Improved discharge planning processes introduced in 2015/16 together with improvements in consultant cover, medication dispensing availability and a change in practice for referrals to hospital transport should result in changes to the discharge distribution across the week during 2016/17. Addressing the needs of people admitted to the Emergency Department at Hillingdon Hospital with acute mental health needs to ensure that they are supported in the most appropriate care setting will be a key piece of work in 2016/17, as will be working with the third sector to ensure that older residents with lower needs receive appropriate levels of support at the point of discharge. Basing the social work team at the main Hillingdon Hospital site, subject to the availability of suitable accommodation, will support clinical hospital staff and contribute to the proactive discharge planning referred to earlier.

Actions contained within other schemes will also contribute to the delivery of this national standard, e.g. ensuring the availability of care home provision for older people with challenging behaviours and ensuring the availability of appropriate local palliative and hospice bed provision .

Many of the actions that will facilitate seven day working will also contribute to a reduction in delayed transfers of care.

b) Evidence of progress towards implementation of four key seven day standards.

Hillingdon Hospital is one of the acute trusts within the North West London sector that has accepted the opportunity to be a national First Wave Delivery Site for the seven day services programme. As part of this programme, the Hospital has agreed to achieve delivery of the four prioritised standards by April 2017(Standard 2: *Time to consultant review*; Standard 5: *Access to diagnostics*; Standard 6: *Access to consultant-directed interventions*; and Standard 8: *On-going review*). The following provides examples of progress:

- The radiology department is close to hitting 70% of the agreed target of reporting scans within 24 hours;
- CCR, MRI and X-ray are all close to meeting targets;

- Modified Early Warning Scores (MEWS) are now in place;
- Consultation is currently in progress with lead clinicians regarding the need for a new model of inpatient care to deliver Standards 2 and 8;
- Procurement for the Radiology Deep Dive is in progress.

c) How local partners will work together to ensure that NHS providers meet the milestones for inclusion of Clinical Standards in 2016/17.

The key deliverables for 2016/17 are:

- Implementaing an inpatient model of care that achieves the first and on-going consultant reviews (Standards 2 & 8);
- Radiology: imaging inpatients within 24 hours of request, developing pathways for readiological diagnostics and interventions and establishing a formalised network across the North West London sector for specialised reporting (Standard 5);
- Establishing robust pathways for inpatient access to consultant interventions 24 hours a day, 7 days a week (Standard 6).

Project groups have been established across the sector to deliver the four priority standards and their is a local, Hillingdon Hospital based group. The Hillingdon 7-day task and finish group referred to above is intended to pull together the Hillingdon-based activity across partner organisations.

d) Risks relating to the move to seven day services.

The following risks and challenges have been identified in respect of the four priority standards as well as the out of hospital standard (9):

- Lack of understanding about funding available for service delivery, e.g. additional clinical posts, could impact on delivery of 4 priority standards;
- Uncertainty about NHSE funding has slowed down progress on Stanards 6 and 8;
- Time it takes to deliver cultural change;
- Robustness of the local care market and corresponding ability to adjust to different ways of working.

8.3 Data sharing

a) The local plans in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Health Providers

The NHS number is already used as the primary identifier in correspondence amongst health providers.

Local Authority

The NHS number is recorded on the Council's social care system, Protocol, and is utilised as the common identifier in accordance with requirements under section 251A of the Health and Social Care Act, 2012.

As at 31st December 2015 up to 95% of all active adult social care records had a confirmed NHS number.

The Council has been progressing realtime verification through identification of the appropriate link to the NHS spine through the N3 connector. The Council is exploring use of the Personal Demographic Servce (PDS) to facilitate a more automated service.

The NHS number is not currently used on correspondence but the intention is to develop standard letters on the Council's adult social care database system called Protocol that will be able to draw through the NHS number. This will be undertaken during 2016/17.

Third Sector

It is a contractual requirement for the third sector provided Health and Wellbeing Service to use the NHS number of patients/residents being supported by the service in any correspondence with other partners. This practise will be put in place by the five constituent organisations that form H4All (the Wellbeing Service provider) over the next six months as part of the process of standardisation.

b) The approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Health Providers

There are a range of systems in place amongst health providers that facilitate the sharing of information and the following are examples:

- All of Hillingdon's 46 GP practices now use a single system called EMIS Web and this enables them to share information between practices and GP networks where there are common services and care pathways.

- Hillingdon GPs are able to submit orders electronically for diagnostic tests (pathology and radiology) at The Hillingdon Hospital (THH), and see the results in their EMIS Web system, using a system called Sunquest ICE. ICE also allows GPs to view tests requested internally at THH. This capability is being extended to tests performed at other hospitals. In addition, ICE is being implemented for selected clinicians in community and mental health care at CNWL.

- At the end of an episode of hospital care at THH, summary letters are sent electronically to GPs.

- GP patient records from EMIS Web are visible across the clinical specialties at THH via the Medical Interoperability Gateway (MIG) and the THH clinical portal. This is especially useful to the Acute Medical Unit (AMU). It is also used in A & E and the Hospital Pharmacy, along with the national NHS Summary Care Record.

- GP patient records have also been made available to the Urgent Care Centre and to

the GP Out of Hours and 111 services operated by Care UK via the MIG.

- Referrals can be sent electronically from Hillingdon GPs to THH via the NHS E-referrals system, which will be extended to CNWL.

- The national Electronic Prescribing System sends prescriptions from GPs to community pharmacies.

16 GP practices in the north of the borough, as well as the Rapid Access Clinics, hospital-based Homesafe Service and Ambulatory Care Clinics within Hillingdon Hospital, CNWL and third sector organisations via H4All are participating in the Care Information Exchange (CIE) pilot as a means of enabling each other to share integrated care plans electronically. This information will also be available online to patients.

Local Authority

The Council is committed to adopting systems that have APIs and Open Standards. standards. The Council is currently participating in the CIE pilot referred to above which, if successful, would see direct links being established between the Council's case management database and that of the CIE provider. In the event that the CIE pilot is unsuccessful will pursue direct linkages to the GP EMIS system through the Medical Interoperability Gateway and it will be apparent during 2016/17 whether this is the route that needs to be pursued with the expectation that delivery would take place during 2017/18.

The Council is also currently working with Hillingdon Hospital to enable the electronic transfer of assessment and discharge notices to take place and funding options are being explored to address the supplier charges being levied.

Third Sector

Plans are in place for identified staff employed by the H4All Health and Wellbeing Service to be authorised to have read and write access to EMIS web via the H4All's IT system to enable them to update patient records to reflect the details of their intervention.

c) The approach for ensuring that the appropriate IG Controls will be in place. These will cover NHS Standard Contract requirements, IG Toolkit requirements and professional clinical practice and in particular the requirements set out in Caldicott 2.

Strategic Oversight

The Pan-Hillingdon Joint IT Project Group oversees the delivery of IT integration in Hillingdon and provides an opportunity to share good practice and advise on new developments, including new legislative requirements. This group includes representatives from Hillingdon Hospital, CNWL, the Royal Brompton and Harefield Hospital, Care UK and also from adult social care and the corporate IT team within the local authority. The group is chaired by a local GP, who is the clinical lead for IT development and integration and is also a member of the CCG's Governing Body.

Health Providers

All GPs and local healthcare providers meet IGT requirements and have signed up to the North West London Information Sharing Protocal (ISP), which commits them to meet NHS standards for information governance and embodies the Caldicott 2 principles and the broader requirements of relevant legislation, common law and professional standards. The ISP governs a number of specific Information Sharing Agreements that cover the data sharing set out above.

Local Authority

The Council has completed the self-assessment for the Information Governance Statement of Compliance (IGSOC) standards and has achieved an 85% scoring by the Health and Social Care Information Centre (HSCIC), which puts Hillingdon in the top quartile for local authorities. The Council's organisational code is 727 should more detail be required.

A bi-monthly Information Assurance Group (HIAG) meeting chaired by our Senior Information Risk Owner (SIRO) has been in place for a number of years and is attended by senior members of the Council's leadership team, including the Corporate Director of Adults' and Children and Young People's Services in his capacity as the Council's Caldicott Guardian. This group has a yearly workplan to ensure the policies, process and guidance are in place to support the local IG Protocols and agreements. The Caldicott workplan feeds in to the overall HIAG workplan

For all Social work staff Data Protection and Information Governance e-learning training is mandatory prior to receiving logon details to the social care systems.

Council-wide data protection and e-learning takes place annually. For employees new to the council they are required to take the full training course. For existing staff they are invited to take a shorter course with the understanding if they do not achieve 85% or above they are required to take the full course.

All potential software suppliers must satisfy the requirements to ensure the correct controls are in place through a series of questions.

The Council has signed-up to the information sharing protocol based on the template developed by NWL CCGs and local authorities.

Third Sector

H4All is currently at level 1 of the IGSOC standards and the plan is get to level 2 by the end of Q1 2016/17.

8.4 Joint assessment and accountable lead professional for high risk populations

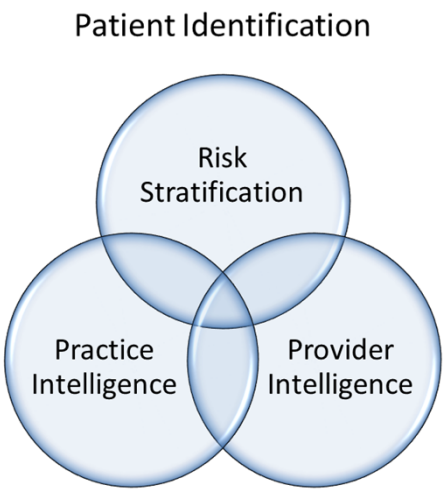
i) The proportion of the adult population that will be receiving case management and a named care coordinator.

Patient/Resident Identification

a) Health Providers

In order to ensure that patients can be identified by all care providers in a variety of settings in the local care economy, Hillingdon has devised a pathway which allows for a network-based collation and weighting of lists.

Patients will be selected by using a combination of multi-provider risk stratification tools, informed practice intelligence and informed provider intelligence. This is illustrated below:



In primary care patients wil be identified from a combination of practice intelligence, the use of the NHSE approved stratification tool QAdmissions and/or clinical judgement. From this information a list of patients for care planning will be developed at practice level.

Hillingdon Hospitals will use the risk stratification tool Parr 30 in order to identify those patients most at risk of readmission and this will be inputted into the information already available at a primary care level.

b) Local Authority

The Council has developed a risk stratification tool for determining the priority of existing service users for a review of their support plans and the extent to which their support plan is meeting their needs. Support plans are generally reviewed within eight weeks of implementation and then within one year thereafter if there is no change of circumstances in the intervening period; this is in accordance with the requirements of the 2014 Care Act. The risk stratification tool will identify people whose circumstances suggest that their review should be undertaken at an earlier stage. It will also help to identify the level of intensity of the review, e.g. whether this could be undertaken by telephone with the consent of the service user or if the complexity of their needs and circumstances requires that this be undertaken face to face.

c) General

A Hillingdon frailty screening tool is in development that will be available to all partner

organisations that come into contact with older residents in their own homes and will to identify whether a referral should be made either to the third sector provided Health and Wellbeing Service or to primary care.

Case Management and Named Care Coordinator

Hillingdon's model of care for older people is being implemented in the north of the borough and led by the Metrohealth GP network; it is intended that this will start to be rolled out to the rest of the borough during 2016/17. The model of care is based on the principle that the GP will remain the lead professional, although other professionals will often lead the coordination of care.

The process of risk stratification will identify people with high needs and those with potentially complex needs who are currently stable and will refer them for case management and care coordination. Care coordination is for both stable and escalated care needs. It is anticipated that escalated level care coordination will be carried out by a member of the Care Connection Team (CCT) as a key worker. Based on initial modelling by the Metro Health care connection team pilot , it is assuming 50 people per 1,000 will require escalated care then the total number requiring this level of support is approximately 770 (370 in the north of the borough and 400 in the south). The escalated care model is also being piloted in the north of the borough as a proof of concept.

The CCT comprises of a Guided Care Nurse, who works closely with patients, physicians and others to ensure coordinated, patient-centred care is provided for people at the greatest risk of hospital admission, and a care co-ordinator working with the GPs over 2 practices. The GPs, Guided Care Nurse and care co-ordinator are further supported by dedicated care of the elderly consultants available on the phone for advice and support and also by H4All. Where a patient is identified as being very high risk they are referred to the Rapid Access Clinics (RACE) provided by the Care of the Elderly Team at Hillingdon Hospital for a comprehensive geriatric assessment (CGA).

The CCT is linked into Adult Social Care to ensure appropriate local authority involvement to address eligible social care needs. Where an individual is already known to Adult Social Care and there is an allocated social worker, then they will continue to undertake a care coordination role in liaison with the CCT.
People with stable needs, e.g. those requiring less than a monthly intervention from a health care professional, will be supported by the care coordinator within the CCT, who will undertake a monitoring role, liaise with other members of the CCT and partners and ensure that care plans are updated.

Multi-disciplinary team (MDTs) meetings are being held in all GP networks across Hillingdon that involve all partner organisations to look at the most complex cases to identify the most effective ways of maximising patient independence and wellbeing and reducing demand on statutory services that is avoidable. MDTs are needs and outcome focused but their effectiveness is currently at different levels across the borough. Support will continue to be provided to ensure that these are an effective tool for managing complex needs.

MDTs are being supplemented in GP practices in the north of the borough by daily 'planning huddles' that involve some of the same professionals as at the MDTs to consider the very high risk patients. The activities that can occur within a huddle include:

- Discussion of the patient's wishes so that solutions can be modified to reflect their preferences, priorites and intentions;
- Communicating case management assessment findings to those that need to know;
- Establish treatment goals that meet the patient's health care and social needs as well as the referral source's requirepments;
- Medication review;
- Discussion of referrals to other community based services; and
- Discussion about laboratory, consultant and diagnostic reports.

ii) The proportions of the adult population that will be receiving self-management help.

Escalated Care Model

A principle supporting the escalated care model is that patients should be empowered and enabled through appropriate information, advice and support to manage their own conditions to the extent that they are able. It is in this context that assessments include, where possible, utilisation of the Patient Activation Measures (PAM), which help to determine the extent to which an individual is motivated to self-manage their own long-term condition (s).

People with Stable or Lower Level Needs

A single gateway to services provided by a range of voluntary and community groups is being managed by the third sector consortium, H4All. This is called the Health and Wellbeing Service. The service will:

- Take direct referrals from health and social care professionals to support people with low to moderate social care needs;
- Attend MDTs to ensure appropriate access and support to those whose needs can best be met from the third sector;
- Identify residents who are isolated, anxious and de-motivated.

The model for the Wellbeing Service has been developed to use the PAM tool to set a baseline on which to evaluate intervention and as a measure to target support and resources to people who require it. The service will work with residents to raise their participation and motivation in self-management.

A key to people being able to manage their own long-term conditions is access to information and advice and a range of services funded by the Council through Public Health money and provided by third sector organisations are in place. An online directory of services called Connect to Support is being developed and promoted as the key electronic source of information for borough residents, including links to the 111

service and NHS Choices and the Directory of NHS services. See scheme 1 in **Annex 1**: *Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation* for more detail.

8.5 Investment in NHS commissioned out-of-hospital services

2016/17 BCF plan includes an investment by the CCG of £10.6m in out of hospital services that are included within the BCF. This includes:

- Early supported discharge (Community Homesafe)
- Rapid Response
- Community Rehabilitation
- District Nursing Service
- Community matrons
- Hawthorn Intermediate Care Service
- Franklin House step-down beds
- Community equipment (including pressure mattresses)
- Falls Services (Hillingdon Hospital, CNWL and Age UK)
- Prevention of Admission to Hospital (PATH) Service

This reflects an increase of £1.9m of investment in out of hospital services that were contained within the BCF in 2015/16.

8.6 Agreement on local action plan to reduce delayed transfers of care, including a risk share agreement.

The number of delayed days in Hillingdon is low in comparison with other London boroughs and our BCF plan is designed to reduce this further and the detail is set out in **Annex 1** (see schemes 3: *Rapid Response and Integrated Intermediate Care*, scheme 4: *Seven Day Working,* scheme 5*: Integrated Community-based Care and Support* and scheme 6: *Care Home and Supported Living Market Development* . The key components of our approach are:

- Proactive discharge planning in Hillingdon Hospital supported by the Integrated Discharge Team and social work staff being permanently based on the main hospital site.
- Development of a consistent approach to MDTs within the acute hospital and mental health to ensure a common process and outcomes.
- Range of out of hospital services funded by the CCG to expedite discharge and prevent admission, including Hawthorne Intermediate Care Unit and step-down beds.
- Early support discharge services in the form of Community Homesafe Service provided by CNWL and Age UK for people with lower levels of need.
- Council provided Reablement Service to expedite discharge and prevent admission for residents who do not require health professional intervention.
- Developing a more integrated approach to support a stable local homecare market.
- Development of in-reach support services to encourage existing care homes to accept people with challenging behaviours as well as working with providers to ensure suitable local supply to meet future demand.
- Creation of a Social Care and Housing Board to identify solutions where access to suitable accommodation is likely to result in a delayed discharge.

The level of DTOCS in Hillingdon is such that the partners do not consider a risk share agreement in this area to be necessary.

8.7 Agreement on consequential impact of changes on providers

a) Impact of local plans have been agreed with relevant health and social care providers

i) Implications for acute providers

Our BCF plans have been developed with both acute and community providers and represents a local progression from the 2015/16 plan.

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.

A provider commentary is provided by THH is available in **Annex 3**.

ii) Primary care providers

Metrohealth primary care network has been engaged in the development of the plan as a result of the alignment of the BCF with the pioneer integration pilot. Engagement with other networks will be undertaken during Q1 2016/17 with a view to informing the development of the 2017/18 to 2019/20 plan. A provider commentary provided by Metrohealth is available in **Annex 3**.

iii) Social care providers and providers from the voluntary and community sector

Social Care Providers

The content of the plan reflects engagement with private providers, such as care homes and there will be engagement with other providers commissioned by the Council to inform the development of the 2017/18 to 2019/20 plan, e.g. home care providers.

Third Sector Providers

The third sector consortium H4All (Age UK, DASH, Harlington Hospice, Hillingdon Carers and Hillingdon Mind) has been engaged in the development of the plan through its alignment with the pioneer integration pilot. The pooled budget for 2016/17 includes the Council's core funding to four out of the five organisations within H4All. A provider commentary provided by H4All is available in **Annex 3**.

Iv) Implications for acute providers

Our BCF plans have been developed with both acute and community providers and represents a local progression from the 2015/16 plan.

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.

A provider commentary is provided by THH is available in **Annex 3**.

8.8 Better integration between mental and physical health

The links between mental health and physical health are reflected in the construction of the 2016/17 plan. This can be seen in the strongly prevention focused scheme 1: *Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.* Specific actions have been taken to increase integration between the two areas of need, as can be seen with the creation of the Registered Mental Nurse post in Rapid Response (see scheme 3: *Rapid Response and integrated intermediate care*). The creation of a specifc scheme on supporting people living dementia (scheme 8) is also intended to achieve greater integration to deliver better outcomes both for people living with dementia and their Carers.

9. NATIONAL METRICS

9.1 Non-elective admissions (General and Acute)

a) Explanation for how the target has been reached.

The target for non-elective admissions to be avoided in 2016/17, which is contained is reflected in the CCG's Operating Plan is 2,691 (1,280 in 2015/16). The contribution of the BCF plan to the achievement of this target is 714 admissions avoided. The target for 2016/17 has been based on consideration of 2015/16 activity and taking into consideration improvements that will be delivered in 2016/17.

b) Analysis of previous performance and assessment of impact of 2016/17 plan.

Performance in 2015/16 suggests that the falls-reduction ceiling will be slightly exceeded but will still be lower than the outturn for 2014/15. Emergency admissions from care homes was maintained at 2014/15 levels. However, embedding the new model of care for older people and the proposals contained within the detailed scheme descriptions set out in **Annex 1** should deliver improved performance in 2016/17 and the table below identifies the source for the contribution to the Operating Plan NEA target.

Scheme	Service Area	Hillingdon Hospital-related Reductions	London North-west-related Reductions
1	Falls	70	13
1	Health & Wellbeing Service	85	0

3	Intermediate Care	153	29
5	Integrated Care Planning	115	21
5	Rapid Access to Care of the Elderly Team clinics (RACE)	88	13
6	Care home-related admissions	64	12
	TOTAL	**575**	**88**
TOTAL NEA REDUCTION BCF TARGET		**663**	

9.2 Permanent admissions to residential and nursing care homes.

a) Explanation for how the target has been reached.

The target of 150 permanent admissions reflects the demographics of the borough and the lack of realistic alternatives to residential care pending the delivery of two extra care schemes comprising of 148 self-contained flats in 2018.

b) Analysis of previous performance and assessment of impact of 2016/17 plan.

The 2015/16 ceiling (104) was adjusted with the approval of the HWB to reflect the fact that the assumption made in 2014/15 in setting the ceiling that a 50 flat extra care scheme would be delivered in-year was not going to come to fruition. Increasing the effectivenss of Reablement to give more focus on people with reablement potential and the promotion of Disabled Facilities Grants (DFGs) are examples of specific actions that will be taken to help curtail the growth in the number of permanent admissions to care homes. However, the scope for the 2016/17 plan to significantly reduce the number of permanent placements is limited by the fact that the two new extra care schemes referred to above will not be delivered until late 2017/18. Work being undertaken as part of scheme 6 (see **Annex 1**): *Care Home and Supported Living Market Development,* will help to support older people within existing extra care schemes more effectively and for longer, but this will not take effect until early in 2017/18. A key objective of this work will also be to reduce the impact on primary care and avoidable emergency admissions.

9.3 Effectiveness of reablement

a) Explanation for how the target has been reached.

During 2015/16 the number of people entering the Reablement Service increased by 38%. The target for 2016/17 (93.8%) has been arrived at on the basis of 960 people being seen by the service during the year but with greater focus on people with reablement potential and therefore a 1.8% increase in the number of people still at home after 91 days following the hospital discharge.

b) Analysis of previous performance and assessment of impact of 2016/17 plan.

The practice during 2015/16 has been for the majority of service users being discharged via Hillingdon Hospital and for all new referrals from the community to be referred to the Reablement Service. This has proved not to be an efficient use of resources and following a review a restructure is proposed that provide more focus on people with reablement potential, which means that a significant increase in the target for people to be seen by the service would not be appropriate or deliverable.

9.4 Delayed transfers of care

a) Explanation for how the target has been reached.

The ceiling agreed for 2016/17 assumes an outturn for 2015/16 of 4,334 delayed days based on a straightline projection using year to date data to the end of January 2016. The 5% reduction target (or 217 delayed days) is based on how quickly it will be possible to address the key causes of the delay, 70% of which are due to issues in securing appropriate placements for people with challenging behaviours.

b) Assessment of impact of 2016/17 plan.

The 16/17 plan will deliver the key actions that will impact on reducing DTOCs and this includes: • Ensuring a common understanding of the definition of a DTOC. • Establishing an agreed discharge protocol and procedure. • Improving advanced discharge planning on acute wards. • Establishing common practices across acute and non-acute. • Improving liaison between acute and mental health professionals • Addressing supply of suitable, local care setting provision for people with behaviours that challenge. • Establishing seven day assessments in nursing homes. • Establishing a secure homecare market. More detail is provided in the individual scheme descriptions in **Annex 1**. See schemes 3, 4, 5 and 6.