Appendix 3

NHS
Hillingdon
Clinical Commissioning Group

Better Care Fund Plan 2016/17

Annex 1

Detailed Scheme Descriptions

HILLINGDON
LONDON

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Better Care Fund Plan 2016/17
Annex 1: Detailed Scheme Descriptions
Contents

BCF Plan 2016/17
ANNEX 1 – Detailed Scheme Descriptions

Scheme One
a) Scheme Name
Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation
b) Scheme Strategic Objectives
This scheme seeks to manage demand arising from demographic pressures by reducing the movement of Hillingdon residents/patients from lower tiers of risk into higher tiers of risk through proactive early identification and facilitating access to preventative pathways.
c) Scheme Overview
This scheme builds on the work undertaken under Hillingdon's 2015/16 BCF plan to take forward the anticipatory model of care and apply a more preventative approach to addressing health and social care need. The scheme's focus is people whose current level of need is low and as a result their risk factors would not be identified through the risk stratification process being undertaken in primary care. See scheme 5: *Integrated Community-based Care and Support* for details of the utilisation of risk stratification as part of the delivery of better anticipatory care in Hillingdon. Identification of this cohort of people will enable early engagement in self-directed care and support and facilitate access to preventative pathways. People living with dementia, people susceptibility to falls and/or who are socially isolated are disproportionately represented in our non-elective admissions and admissions to long term residential care. In addition, stroke is one of the main causes of disability in the 55 and over population and one of the main causes of death in the 75 and over population. Susceptibility to stroke increases as people age and there are factors that can contribute to a person being particularly at risk. As stroke is a largely preventable condition, early identification of people at risk can help to prevent this life changing condition from occurring. There is a loss of opportunity in not being able to identify people with these conditions early on in their development and to intervene sooner. The potential impact on outcomes in the medium to long term could be significant. Key initiatives include: • *Promotion and further development of an online citizen portal* - Access to good information and advice is fundamental to people being able to self-manage their own health and wellbeing. The Connect to Support portal established in 2015/16 will be promoted further in 2016/17 to make it the go-to place for information and advice, including about activities and services to support the health and wellbeing of Hillingdon's residents.

- *Making every contact count (MECC)* - Training delivered to frontline staff in Q4 about how to identify people who may be at risk of dementia, falls and/or social isolation and how to respond will be evaluated. This will shape the content of any further training to staff who visit people in their own homes. The extent to which this is rolled out further will depend on the readiness of the response to issues raised following staff contact with residents at risk;

- *Delivering a system-wide response* - This entails setting out what to do when we identify people with these susceptibilities. It could include a referral to the pilot Hillingdon Health and Wellbeing Service provided by the third sector consortium H4All, which will provide support to older people with one or more long-term condition who need assistance to manage their condition. People referred to this service can also benefit from an assessment using the Patient Activation Measures (PAM). This assessment is intended to identify people needing support to engage more actively in the management of their own condition. People identified as needing support to engage with self-care plans are at greatest risk of increased health and care need and will receive a programme of direct support from the service. Other people will be advised about the options available to address their needs, including being sign-posted to services provided by third sector organisations.

- *Reviewing the falls strategy* - A centralised falls service (with multi-factorial assessment management), assisted discharge from hospital for people who have fallen and a community based falls prevention service were established prior to 2015/16 and have proved successful in preventing emergency admissions. Hillingdon's strategy for supporting people at risk of falling as well as those who have fallen will be reviewed in 2016/17. This will take a comprehensive view of the respective Council and CCG functions and funded services and how collectively with partners falls prevention can be supported.

- *Supporting and developing the role of the third sector* - The evaluation of the impact of the Health and Wellbeing Service pilot will include patterns of utilisation of services provided by Hillingdon's third sector. This will inform how best to target current third sector capacity funded by the Council and/or CCG in order to maximise the outcomes of supporting people to be independent in the community and preventing or delaying escalation and subsequent demand on statutory services. This will help inform commissioning decisions about the appropriate configuration of services to meet local need in the period up to 2020 as part of an integrated model community based care for older people, which links to scheme 5: *Integrated community-based Care and Support*.

- *Stroke prevention*: There are four components to a stroke prevention strategy and these are: increasing physical activity, addressing excess weight issues, smoking cessation and early detection. During the 2016/17 the following initiatives will be undertaken:

    - *Increasing physical activity* - There is an existing physical activity programme and targeting this at people aged 55 and over carrying excess weight is expected to have a beneficial outcome.

    - *Addressing excess weight issues* - In 2015/16 a weight management project

working with 200 residents has been piloted. The results of this will inform the development of a business cases for a tier 2 weight management service directed at obese or overweight people who need personal, time-limited interventions in the community to support them in managing lifestyle changes;

- *Smoking cessation* - The Council, through its public health function, already provides a successful smoking cessation service and this will continue. It will be reviewed during 2016/17 to explore how its effectiveness can be maximised;

- *Early detection* - A key method for detecting at an early stage susceptibility to stroke is through the NHS health check programme. We currently have an active programme but at 12% of the eligible population being targeted per annum the rates are lower than is ideal and aiming for 20% would be more effective in disease prevention. Hypertension and high cholesterol (both important in causing stroke) are already tested for in NHS health checks. Atrial fibrillation (AF), a disturbance of heart rhythm, is a major cause of stroke and is not tested as part of the health check programme. During 2016/17 options to increase the rate of health checks (as well as extending them to cover AF) will be explored.

- <u>*Delivering older people's wellbeing initiatives*</u> - The Council will implement the reorganisation of its Health Promotion and Sports Development Services into a Wellbeing Service, which will be able to develop more comprehensive initiatives in partnership with the third sector to improve health and wellbeing by helping to keep people active, both mentally and physically.

- <u>*Preventing dementia*</u> – The actions set out above to prevent stroke and promote the wellbeing of older people will also help to prevent or delay the onset of dementia. This links with scheme 8: *People living well with dementia*.

- <u>*Identification of carers*</u> - Many people who provide care for loved ones free of charge are not aware that they are carers. The work undertaken under this scheme provides an opportunity to identify carers and refer them to the Council for a carer's assessment and/or the third sector for information, advice and appropriate support. This links with scheme 7: *Supporting carers.*

- <u>*Making best use of assistive technology*</u> - The work undertaken under this scheme provides an opportunity to identify people who may benefit from assistive technology, e.g. telecare and telehealth, and to make referrals. This technology can help to provide the residents/patients and their families with greater confidence about them remaining in their own home.

d) The Delivery Chain

<u>Scheme Lead Role</u>

The Council will be the lead for this scheme.

<u>Scheme Delivery</u>

- The online resident portal, Connect to Support, is commissioned by the Council;
- A multi-agency, multi-disciplinary clinical working group (CWG) co-ordinates the development of falls and falls prevention services in Hillingdon. The current falls-specific prevention and treatment services are commissioned by the CCG and provided by CNWL, Age UK and THH;
- Support for people with dementia will come from a range of providers including GP Networks, NHS community services, direct Council provision, e.g. TeleCareLine, and the third sector;
- The current screening programme is undertaken in primary care;
- The new Wellbeing Team will work in partnership with the Library Service and the third sector to support older residents to become or remain mentally and physically active. This will help to prevent or delay the onset of dementia, as well as help to prevent stroke;
- The Council provides telecare through its in-house TeleCareLine Service, which includes a response service for those without a family responder or where the family responder is not contactable in the event of an emergency. Telecare equipment is supplied by a private provider.

e) The Evidence Base

Feedback from residents both nationally and locally identifies the importance of access to information and advice to be fundamental to people being able to self-manage their long-term conditions and also to having choice and control over how their needs are met.

During 2014/15 there were 871 emergency admissions as a result of falls at a total cost of £2.9m. During the period Q1 to Q3 2015/16 there were 578 falls-related emergency admissions, compared to 671 during the same period in 2014/15.The cost during the period Q1 to Q3 2015/16 was £1.7k compared with £2.1m during the same period in 2014/15. The target falls-related admissions ceiling for 2015/16 is 761 and activity from Q1 to Q3 suggests that on a straightline projection this may be slightly exceeded, although the performance will be improved upon that of the previous year.

However, the ageing population increases the necessity of addressing this area of risk both in terms of the loss of independence for older residents but also the additional costs to Adult Social Care and the NHS that may result from an admission to nursing care homes.

f) Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Health and Wellbeing Service	H4All	543	195	738

b) Connect to Support	Shop4Support	45	0	45
c) Online Services Coordinator	LBH	44	0	44
d) Atrial Fibrillation screening equipment	P & V	5	0	5
e) Older People Wellbeing initiatives	LBH	20	0	20
f) Falls Prevention Service	Age UK	0	140	140
	Primary Care	0	55	55
TOTALS		**657**	**390**	**1,047**

g) Contribution to BCF Metrics

This scheme will contribute to the following key BCF metric:

- Reduction in non-elective admissions

h) Other Success Measures

The following measures will be used to identify whether the scheme is working:

- Increase in utilisation rates for Connect to Support (new and repeat users) – Baseline to be established in Q4 2015/16.
- % of users of Adult Social Care who have found it easy or difficult to access information and advice about services and/or benefits (Test through the Adult Social Care Survey).
- Reduction in falls-related emergency admissions (83 admissions prevented).
- Proportion of residents/patients who have an improved PAM scoring where there is tangible improvement in engagement in self-directed support.
- Number of people assessed through the Health and Wellbeing Service receiving active support from a support coordinator.
- Number of people supported by the Health and Wellbeing Service who receive appropriate information or signposting to local groups through the service's triage assessment. This will require a separate survey of service users.
- Number of successful referrals to voluntary and community organisations from the H4A Service and the referral outcomes. This will require a system to be put in place to monitor user feedback and identify delivery of intended outcomes.
- Numbers of people aged 55 and over participating in stroke prevention activities. Activities that help to prevent stroke will also contribute to reducing the risk of dementia.

- % of people aged 55 and over participating in screening programmes.
- Evaluation of the training programme for frontline staff who visit residents in their own homes.

Scheme Two

a) Scheme name

Better care for people at the end of their life

b) Scheme Strategic Objectives

This scheme seeks to realign and better integrate the services provided to support people towards the end of their life in order to deliver the ethos of a 'good death.' This is intended to maximise the dignity of the person at end of life, ensure that they receive the right services at the right time and relieve as much as is possible the stress for them and their carers and/or family.

c) Scheme Overview

This scheme builds on the work undertaken in 2015/16. The main goals of the scheme are to ensure that people at end of life are able to be cared for and die in their preferred place and to ensure that people at end of life are only admitted to hospital where this is clinically necessary or where a hospital is their preferred place of care or death.

To achieve these goals the key initiatives under this scheme will include:

- *Identification of people at end of life* - The process for identifying people at end of life resulting from work undertaken in 2015/16 will be implemented. This will ensure that key professionals are supported in diagnosing people with advanced disease who are in the last months/year of life and who are in need of supportive and palliative care. This will support appropriate anticipatory planning being undertaken. This action links with scheme 8: *Living well with dementia*.

- *Delivering a communications plan for professionals* - The communications plan developed in 2015/16 setting out Hillingdon's end of life pathway, including the support available to residents/patients and their carers and/or families will be delivered. This will help to raise awareness of the support available to people at end of life whose preferred place of care is at home and help to prevent hospital admissions that are inappropriate in the context of expressed resident/patient wishes.

- *Increasing utilisation of multi-disciplinary care and support planning* – During 2016/17 partners will be increasing the utilisation of Co-ordinate My Care (CMC) as the advance care planning tool for people at end of life, which is in line with practice across London. This will include exploration of access to Adult Social Care staff and the provision of appropriate training to facilitate this. Increasing the utilisation of CMC

will link in to the expansion of the care information exchange (CIE) platform, subject to the success of the pilot which will be undertaken early in 2016/17.

- *Facilitating seamless care provision between health and social care* – The Council will bring its social care spend for people at end of life within the pooled budget to ensure that a disruption in care is not caused by a transition in funding responsibility between health and social care. The Council will also explore the feasibility of removing the potential charge for people diagnosed as likely to have only having six months to live whose needs are primarily social care. This would help to avoid the complexities and potential disputes that can arise when trying to determine at what point a person's care should be health funded.

- *Implementing results of market testing of end of life services* – In order to reduce the fragmentation of end of life services and avoid the disruption that can arise from a change of provider resulting from a person's needs transitioning from being primarily social care to health care at critical time, the Council and CCG will move towards single or lead provider arrangements.

- *Developing appropriate training for providers* - 'Difficult conversations' training will be delivered to health and social care providers to assist with planning for anticipatory care needs, which will help to avoid crisis situations leading to hospital attendances and admissions, especially where the latter is not the preferred place of care.

- *Implementing outcome of review of support for carers of people at end of life* – Any gaps in service provision to support carers of people at end of life will be considered as part of the work undertaken in scheme 7: *Supporting Carers*. Where additional funding is required appropriate business cases will be developed for consideration by the Council and/or CCG.

- *Reviewing available information* – Access to good, up to date information is critical to support residents/patients and their Carers and families. For residents/patients this will be promoted through the resident online portal Connect for Support. For professionals the additional route is the NHS Directory of Services. The range of services advertised and accuracy of the data will be monitored by the End of Life Forum.

d) The Delivery Chain

Scheme Lead Role

HCCG will lead on this scheme, the implementation of which will be overseen by the multi-agency End of Life Forum.

Scheme Delivery

The providers will be a combination of primary care, community NHS services, acute, social care, London Ambulance Service and voluntary and community sector providers.

e) The Evidence Base

The three main causes of death in Hillingdon and recorded on death certificates as

primary underlying causes were cardiovascular disease (29.0%), cancers (28.0%) and respiratory disease (14.5%). Respiratory causes of death rose to 34.3% if mentioned or recorded as 'contributory' to the cause of death. Alzheimer's and other forms of dementia accounted for about 12% and though it is the fourth cause of death, this is rising. In the last 3 years, deaths from cardiovascular disease, cancer and respiratory causes appear to be falling while the number and proportion of deaths from Alzheimer's and forms of dementia are rising. All these causes are considered demanding of end of life care.

The average number of deaths per year in Hillingdon for the period 2008 - 2012 was between 1800 and 1900.

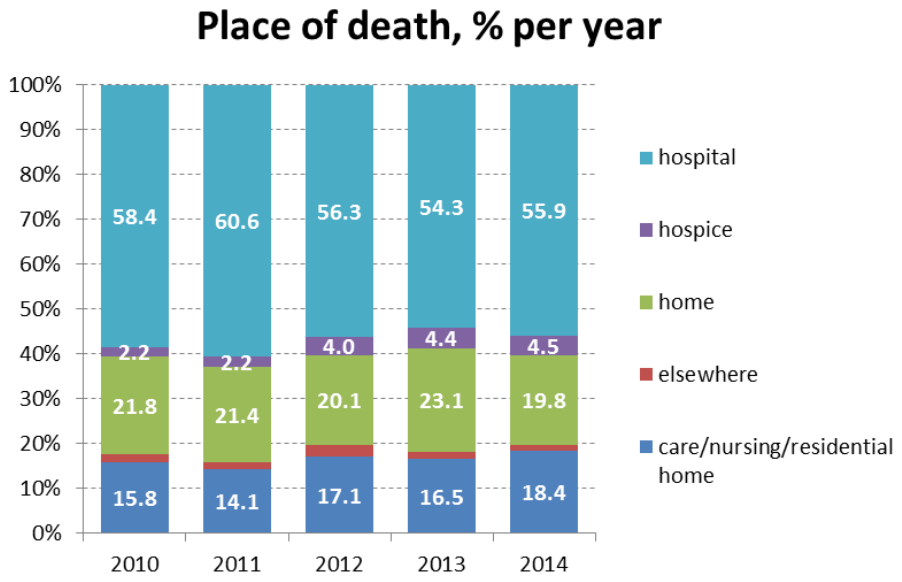
- People aged 65+ accounted for 85% of all deaths (88% in the North and 82% in the south)
- People aged 75+ accounted for 70% of all deaths (76% in the North and 65% in the south)
- Percentage of deaths in both those aged 75+ and 85+ are lower than national average but higher than London average though not significantly different
- More deaths in 75+ in Care homes based in the North than in the South (or more deaths in Hospital with residents in the South).

ONS, 2014MYE shows that over half (56.5%) of Hillingdon's 65 and over population live in the south of the borough, e.g. south of the A40. By 2020 the growth in the 65 and over population is estimated to be over 700 people per year broken down as follows:

- 85-89 by an extra 110 per year
- 75-84 by an extra 220 per year
- 65-74 by an extra 360 per year

There are more care home beds per 1000 population for 75+ based in the North (88/1000) than in the South (56/1000) and this helps to explain why there are proportionately more deaths in care homes in the north of the borough than in the south, where more people die in hospital.

The Primary Care Mortality Data there were 1,823 deaths in 2014. 51% (926) of these were female and 49% (897) male. The diagram below shows place of death between 2010 and 2014.



f) Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Specialist Palliative Personal Care Service	Third Sector	50	106	156
TOTALS		**50**	**106**	**156**

g) Contribution to BCF Metrics

This scheme will contribute to the following key BCF metric:

- Reduction in non-elective admissions

h) Other Success Measures

The following measures will be used to identify whether the scheme is working:

- To achieve 90% of people at end of life with an advanced care plan on CMC.
- >50% of people with an advanced care plan on CMC dying in their preferred place of care.
- Positive family/carer experience of the quality of care and support provided at end of life. Securing this information will require a separate survey to be undertaken the sensitive nature of which is likely to necessitate one to one support.

Scheme Three

a) Scheme name
Rapid Response and Integrated Intermediate Care
b) Scheme Strategic Objectives
Prevention of admission and readmission to acute care following an event or a health exacerbation and enabling recovery through intermediate care interventions with the aim of maximising the person's independence, ability to self-care and remain in their usual place of residence for as long as possible.
c) Scheme Overview
Existing crisis response services for adults (aged 18 years and above) with both health and mental health conditions are provided in the community and in-reach to the emergency department (ED) at The Hillingdon Hospital (THH). They also link with the Psychiatric Liaison Service in the ED. The Rapid Response service provides nursing, therapeutic and care needs for up to 10 days and has a fast track referral process to the LBH to establish packages of care or reablement. For people with more severe mental health conditions, including dementia, the Home Treatment Service is available for up to 14 weeks. There is also access to night carers for up to 3 nights and a service which will escort people home from the ED. This scheme is aligned with the early supported discharge HomeSafe Service, which is clinically led by Hillingdon Hospital through the Care of the Elderly Team (COTE). The service entails older people aged 65 and over who are admitted through the ED being screened for a comprehensive geriatric assessment (CGA). Patients who receive a CGA will be managed on the HomeSafe pathway. Health and care needs identified are met by community based providers for up to 10 days to facilitate clinically appropriate and timely discharge from acute care. Appropriate onward referrals to address on-going needs are then made. The intermediate care provision is made up of the 22 bed Hawthorn Intermediate Care Unit (HICU) on the Hillingdon Hospital site, the Community Rehabilitation Team, Reablement Team, community equipment, telecare services and Prevention and Admission to Hospital Service provided by Age UK for people with low social care needs. 5 step-down beds are provided at Franklin House Nursing Home for people who are medically stable and are a) on a rehabilitation pathway, need a bed-based service but unable to weight bear for 3 weeks or more; or b) are undergoing an assessment for continuing health care (CHC) which has not yet been completed. There is also a flat at the Cottesmore House extracare sheltered housing scheme that is used to meet step-up or step-down needs and supported by private sector care provider with in-reach support from the Reablement Team. During 2015/16 an integrated discharge team has been set up in the Acute Medical Unit (AMU) to identify adults with care needs as soon as they are admitted to hospital and to take a more proactive and joint approach between health and social care to discharge management. This will continue into 2016/17. Although there has been greater functional alignment between services during 2015/16

they still remain fragmented. During 2016/17 work will take place to explore integration options, including possible incentivisation of providers, that will deliver the following outcomes:

- Reduction in the number of hand-offs between different organisations.
- Resident/patient needs being addressed by the most suitably qualified professional first time.
- Reduction in the number of points of access.
- Reduction in length of stay in intermediate care services.
- Improved resident/patient experience of care.
- Value for money.

Service options development will also include consideration of procurement routes.

d) The Delivery Chain

Scheme Lead Role

HCCG will lead on this scheme, the implementation of which will be overseen by the Systems Resilience Group.

Scheme Delivery

Crisis response and home treatment services are provided by CNWL and commissioned by the CCG. They link with the Reablement Team which is provided by LBH. They also link into private sector provided homecare commissioned by LBH.

Telecare services are also provided by LBH and the ED and home from hospital (up to 6 weeks for people with low care needs) service is jointly commissioned by the CCG and LBH, as is the community equipment provision. The night carer service is provided by Harlington Hospice and commissioned by the CCG.

It is expected that delivery options during 2016/17 will be shaped by the emerging Accountable Care Partnership (ACP).

e) Evidence Base

A review of intermediate care and development of a new model of care was commissioned by the CCG from Libera partners, consulted on with partner organisations and reported on locally in January 2012. This recommended a number of changes to the way that intermediate care services were delivered, which led to a business case being agreed by the CCG in 2012/13 that led to changes in the provision and capacity of intermediate care and community-based crisis response services and to early supported discharge arrangements, e.g HomeSafe Service.

2014/15 there were 10,341 non-elective admissions of Hillingdon residents who were aged 65 and over at a cost of £25.8m. During 2014/15 46.5% of non-elective admissions of the 65 and over population had a length of stay of between 0 and 2 days, thereby suggesting these admissions were avoidable and this trend was repeated during the first half of 2015/16.

f) Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Rapid Response	CNWL	0	1,546	1,546
b) Hawthorn Intermediate Care Unit	CNWL	0	1,614	1,614
c) Community Rehab	CNWL	0	1,094	1,094
d) Prevention of Admission/Readmission to Hospital (PATH)	Age UK	29	91	120
e) Take Home & Settle	Age UK	0	63	63
f) Reablement Team	LBH	2,211	0	2,211
g) Reablement Physio	CNWL	51	0	51
e) Community Homesafe	CNWL	0	688	688
f) Spot purchased intermediate care beds	Various P & V	341	0	341
g) Step-down beds (Franklin House)	Care Uk	0	198	198
h) Support to step-down beds	CNWL	0	53	53
i) Cottesmore Reablement Flats	Paradigm Housing Group	38	0	38
j) Hospital Social Workers	LBH	210	0	210
k) Mental Health Nurse in Rapid Response	CNWL	40	0	40
TOTAL		**2,920**	**5,347**	**8,267**

g) Contribution to BCF Metrics

This scheme will impact on the following BCF metrics:

- Reduction in the number of non-elective admissions.
- Reduction in permanent admissions of older people aged 65 years and over to residential and nursing care homes, per 100,000 population from 2015/16 baseline.
- Increase in % of older people aged 65 years and over who are still at home 91 days post hospital discharge into reablement service from 2015/16 baseline.

h) Other Success Measures

The following measures will be used to identify whether the scheme is working:

- 7 admissions a day avoided following referral to Rapid Response by Hillingdon Hospital's Emergency Department and 1 admission per day avoided following referrals from other routes.
- Average number of discharges supported home from Hillingdon Hospital wards by HomeSafe per day.
- Reduction in admissions resulting in a length of stay (LOS) of between 0 and 2 days.
- 78 admissions avoided as a result of the availability of the Rapid Access Care of the Elderly (COTE) clinics.
- Average of 80 referrals to Reablement per month.
- % of new clients who received Reablement where no further request was made for

long-term support.
- Number of reablement cases closed within 6 weeks.
- Number of people readmitted to hospital whilst receiving reablement.

Qualitative feedback will be sought through surveys of residents/patients to capture their feedback about their experience.

Baselines will be established in Q4 2015/16 against which progress in 2016/17 can be measured.

Scheme Four

a) Scheme name

Seven Day Working

b) Scheme Strategic Objectives

To improve quality and patient safety through reducing inconsistent care provision by:-
- Enabling discharge from the acute trust seven days a week for people admitted for either planned or unplanned procedures;

- Enabling access to community services seven days a week thereby preventing unnecessary emergency department attendances and admission and reducing length of stay for people admitted to hospital for either planned or unplanned procedures;

Reducing the uneven rate of hospital discharge across the week.

c) Scheme Overview

This scheme is intended to deliver standard 9 of the 10 Seven Day Working Clinical Standards.

There are a number of interdependencies with other schemes that are critical to the delivery of standard 9 and these include:

- *Placements for people with challenging behaviour needs* - Securing suitable local placements for people with challenging behaviour needs is a key cause of delayed transfers of care and this piece of work falls within the remit of scheme 6: *Care Home and Supported Living Market Development;*

- *Seven day assessments in nursing homes* - The availability of suitably qualified staff in nursing homes to undertake assessments of people who have been admitted to hospital and are medically fit for discharge will contribute to delivering a more even spread of discharges across the week. This requirement will be included as a condition of the Dynamic Purchasing System (DPS) tender for care homes that the Council is undertaking with the West London Alliance (WLA) of local authorities. This piece of work falls within the remit of scheme 6: *Care Home and Supported Living Market Development.*

- *Palliative & hospice bed provision* - The ability of the Hospital to discharge people who are at end of life is impacted by available service provision and this will also be addressed under scheme 6: *Care Home and Supported Living Market Development.* This also links with scheme 2: *Better care at end of life*.

Improvements in managing the discharge process from Hillingdon Hospital introduced in 2015/16 will be carried forward into 2016/17. Essential components of this will be earlier planning and this will be assisted by the following:

- *Advanced discharge planning on wards* - Hospital wards will be set specific targets to facilitate advanced discharge planning to ensure that key enablers such as medication and transport are available. Opportunities for standardising the MDT process on wards on the Hillingdon Hospitals sites will be explored. The objective of this work will be to apply the most effective MDT model consistently to achieve a better experience of care for patients and expedite the discharge of people who no longer need to be in hospital.

- *Embedding earlier referrals to Hospital transport* - The Hospital has transport available 24/7 365 days a year but earlier planning will assist in enabling referrals to be made earlier in the day in order to avoid a glut of activity around 4pm. This will also help to improve the experience of care by preventing patients being taken back home late at night.

- *Developing the Integrated Discharge Team* (IDT) - The continuation of the IDT into 2016/17 is subject to the outcome of an evaluation into its effectiveness that will take place in Q4 2015/16. However, the practice of Adult Social Care proactively engaging with the wards to facilitate advanced discharge planning will continue in one form or another. Subject to the availability of accommodation on the Hospital site, there will be an increased social care presence to ensure a prompt response to addressing social care needs, which will contribute to a more even seven day flow out of the Hospital. This links into scheme 3: *Rapid Response and Integrated Intermediate Care*.

Other required components of the work to improve the discharge process will include:

- *Addressing needs of people with acute mental health needs* - Caring for people admitted to the Emergency Department with acute health needs in addition to severe mental health needs can be very resource intensive and this can impact on the delivery of a smooth discharge pathway for other patients. Through joint working between the CCG, Hillingdon Hospital, CNWL and the UK Border Agency the intention is to release acute mental health beds to ensure that people with acute mental health needs are cared for in the most appropriate setting to support their recovery.

- *Earlier referrals to Psychiatric Liaison Service* (PLS) - Changing practice to ensure early referral of patients showing signs of mental distress are referred to the PLS prior to discharge will also assist in preventing readmission that is avoidable.

- *Developing the role of the third sector* - Linking into scheme 3: *Rapid Response and*

Integrated Intermediate, the support from the third sector to people at the point of discharge and in the first few weeks after they have returned home will be considered. The purpose of this will be to ensure that maximum benefit can be obtained from the unique skills available from the third sector to support the independence of residents and prevent readmissions that are avoidable.

- *Developing a common functional assessment in hospitals in North West London (excluding Hillingdon Hospitals)* - Assessment of patient need and function occurs within the hospital and is carried out by the hospital Multi-disciplinary Team (MDT) however, decision-making about which community service(s) is most appropriate is undertaken by the community team. The development of a common tool for assessing a patient's needs and function in hospitals other than Hillingdon Hospital would assist in supporting the discharge process where Hillingdon residents are admitted to other hospitals in north west London.

d) The Delivery Chain

Scheme Lead Role

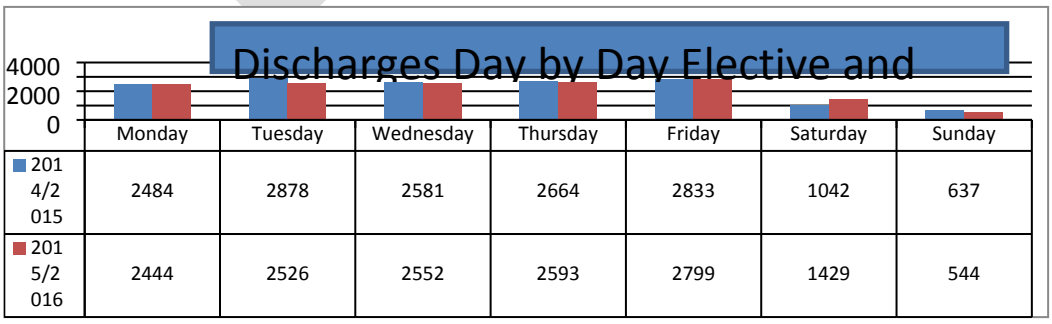
Hillingdon Hospital will continue as the lead for this scheme, which will be overseen by the System Resilience Group (SRG). The SRG has responsibility for monitoring delivery of all the clinical standards mandated by NHSE.

Scheme Delivery

The services required to deliver a more even hospital discharge process across the week will be provided by a combination of the following providers: The Hillingdon Hospital Foundation Trust, Central North West London Community Health and Mental Health Services, Hillingdon's four GP networks, Adult Social Care, Hillingdon's third sector and the private sector.

e) The Evidence Base

This scheme is being rolled forward from 2015/16 in accordance with national policy requirements. The chart below illustrates the scope for improving the distribution of hospital discharges (planned and unplanned) over the week.



f) Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	

a) Mental Health Social Workers	LBH	100	0	100
TOTALS		**100**	**0**	**100**

g) Contribution to BCF Metrics

The scheme will impact on the following BCF metrics:

- Reduction in non-elective admissions through a reduction in readmissions
- % of people supported at home 91 days post discharge into reablement by reducing the number of readmissions related to the cause of the original admission.

h) Other Success Measures

The following measures will be used to identify whether the scheme is working:

- 35% of discharges should occur before midday 7/7.
- Weekend discharges are 80% of weekday rates.
- Number of people discharged at weekends.
- % of people supported at home 91 days post discharge into reablement.
- Reduction in differential mortality rates between weekdays and weekends.
- Reduction in readmissions within 30 days.
- Resident/patient feedback
- Carer feedback

With the exception of the last two measures, this data is collected automatically. The last two qualitative measures will require new surveys to be undertaken of patients and carers.

Scheme Five

a) Scheme Name

Integrated Community-based Care and Support

b) Scheme Strategic Objectives

To ensure that community based care and support works as effectively and as efficiently as possible and is aligned across primary care and community services to deliver anticipatory care in community settings that achieves the best outcomes for patients/residents and delivers value for money.

c) Scheme Overview

There has been a review and improvement in efficiency of a range of community health services to ensure that value for money from existing services is being achieved. An integrated model of care for older people will be extended where integrated care and support planning approaches facilitate closer integration between health, social care and third sector providers and delivers improved outcomes.

This scheme will contribute to this through the following actions:

- *Expanding the use of risk stratification tools* - The Metrohealth GP network in the north of the borough has been using a combination of multi-provider risk stratification tools, informed GP practice intelligence and informed provider intelligence to detect early signs of frailty to trigger earlier support. During 2016/17 risk stratification tools will be refined and this learning will be rolled out across the borough to all practices.

- *Mainstreaming personalised care planning* - Care planning processes and outcomes have been reviewed in 2015/16. This will enable work the undertaken in 2015/16 and linked to the application of risk stratification tools to be fully embedded in GP networks across the borough to support a reduction in avoidable emergency admissions to hospital. This will be supported by the development of the co-produced Integrated Care and Support Record (ICSR) and, subject to the outcome of the pilot, the further scale up of the care information exchange (CIE) platform.

- *Embed a multi-disciplinary team (MDT) approach to addressing the needs of residents/patients with complex needs* - GP networks will be supported to embed the MDT approach as a cost effective tool for maximising the health and wellbeing of residents/patients living with long-term conditions. This will include training for MDT chairs as well as practical support for the administration of meetings.

- *Scaling up the integrated model of care for older people across the borough* - Building on integrated care planning in primary care, an enhanced model of integrated care provision for older people is currently being piloted with Metrohealth GP network in the north of the borough. This will inform commissioning a system wide integrated model of care for older people in shadow form in 2016/17 and will enable the involvement of other networks as maturity builds. This approach requires new contractual relationships with primary care, community health, acute and the third sector and the development of enablers to drive better outcomes.

- *Raise awareness within primary care of community service provision and access routes* - Training will be provided to staff within primary care about the range of services provided by the Council to support the health and wellbeing of residents/patients in their own homes, including the provision of Disabled Facilities Grants (DFGs). Training will include promotion of the online resident portal Connect to Support and how to access information about the range of services provided by the voluntary and community sector.

- *Deliver an integrated community equipment service* - Community equipment is critical to supporting people with physical disabilities and/or sensory impairments in their own home. People of all ages often have a variety of equipment needs, ranging from daily living equipment such as bath board, hoists, electric beds, etc, to more medical equipment, e.g. pressure relieving mattresses and/or oxygen. To avoid the coordination difficulties posed by having different providers delivering different types of equipment, the community equipment service will be retendered in 2016/17 under a model that brings together as many types of equipment as possible to improve efficiency in meeting the equipment needs of residents/patients. This provision will apply to all adults and children.

- *Relaunch the retail model for community equipment* - The purpose of the retail model is to give residents greater choice by enabling them to access more personalised equipment than is available from the standard catalogue available to the Council and the NHS. Under this model they can pay a top-up if the cost of the equipment item is greater than the equipment prescription value.

- *Develop an integrated approach to home care market development and management* - This will bring together health and social care to ensure better management of medication in the community. A key intended outcome would be to prevent residents/patients needing to change provider to address their respective health or social care needs unless this was necessary for clinical reasons. Another outcome would be to ensure service availability to support people who had care needs but who did not meet the national eligibility criteria for social care. As part of the joint approach to the management of the homecare market is ensuring the availability of provision to support people in the community living with dementia, which links with scheme 8: *People living well with dementia*.

- *Expansion of Personal Health Budgets (PHB)* – A local offer for PHBs will be developed for residents/patients living with one or more long-term conditions and also children with special educational needs. The PHB offer will not be restricted to people who are eligible for NHS funded Continuing Healthcare. During 2016/17 a three year plan to expand the take-up of PHBs will be developed and this will include joint PHBs and Direct Payments where an adult meets the national eligibility criteria for a financial contribution from the local authority to meet their social care needs. The plan will also address market development issues.

d) The Delivery Chain

Scheme Lead Role

HCCG will lead for this scheme, which will be overseen by the multi-agency Integrated Care Steering Group.

Scheme Delivery

An Accountable Care Partnership (ACP) is HCCG's preferred model of delivery for integrated care. An ACP is where a group of providers agree to take responsibility for providing all care for a given population for a defined period of time under a contractual arrangement with a commissioner. Under this model providers are held accountable for achieving a set of pre-agreed quality outcomes within a given budget or expenditure target. In Hillingdon the ACP comprises of The Hillingdon Hospitals Foundation Trust, Central North West London Foundation Trust (CNWL), Metrohealth GP network and the H4All third sector consortium.

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. This is not expected to occur in 2016/17, which will be a shadow year before the ACP becomes fully operational in 2017/18. The ACP will deliver services under the current contracts held by its constituent organisations and a shadow capitated budget will be developed in 2016/17. A capitated budget is a sum of money

based on the estimated needs of a population group and for 2016/17 this will initially be older people with long-term conditions. Both the CCG and the ACP will monitor the cost of the model of care and outcomes in readiness for moving to a full capitated model after April 2017.

The Council will commission care and support provision in extra care schemes from an independent sector provider and the CCG will commission community health services either from the existing community provider or an independent sector provider following a procurement process. Primary care services will be co-commissioned between the CCG and NHSE from the appropriate GP networks.

Community equipment is commissioned by the Council on its own behalf and that of the CCG and the service is provided by a private company. Hillingdon is part of a consortium comprising of 16 London boroughs and CCGs that is led by Hammersmith and Fulham. The success of the retail model for community equipment is dependent on ther being a range of approved providers. There are currently 16 participating pharmacists and expanding this coverage will be a task for 2016/17.

Both the Council and the CCG commission homecare providers from a range of private and independent sector companies.

Individual residents/patients will commission services directly from a range of third sector or private sector providers.

e) The Evidence Base

This scheme has been developed following a multi-agency evaluation of the schemes under the 2015/16 BCF plan.

f) Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Community equipment contract	Medequip Assistive Technology LTD	763	703	1,466
b) Pressure relieving mattresses	DHS	0	200	200
c) Telecare	Tunstall/LBH	262	0	262
d) Continence service	CNWL	0	529	529
e) Community matrons	CNWL	0	677	677
f) District Nursing	CNWL	0	3,287	3,287
g) Twilight	CNWL	0	167	167

Service				
h) Tissue Viability	CNWL	0	386	386
i) Disabled Facilities Grants	LBH	3,457	0	3,457
j) Packages of care: maintaining eligibility criteria	Various P & V	655	0	655
k) Medication Administration Record (MAR chart) provision	Pharmacists	0	8	8
l) Medication administration training	Opus	0	16	16
m) Homecare provider care standards training	Independent Sector	15	0	15
n) Adult Safeguarding	LBH	260	0	260
TOTALS		**5,412**	**5,973**	**11,385**

g) Contribution to BCF Metrics

This scheme will impact on the following BCF metrics:

- Reduction in non-elective admissions
- Reduction in permanent admissions to care homes of 65 + population.
- Reduction in delayed transfers of care.
- Social care quality of life.

h) Other Success Measures

The following measures will be used to identify whether the scheme is working:

- Proportion of residents identified as in need of preventative care who have been offered a care plan.
- Proportion of patients who have care planning where there is a tangible improvement in quality of life and level of independence.
- Proportion of patients who have achieved jointly agreed goals in 6 months or have shown a very positive progression towards achievement of their goals.
- Improved patient experience tested by part of patient survey.
- Number of people in receipt of a Personal Health Budget

Scheme Six

a) Scheme Name

Care Home and Supported Living Market Development

b) Scheme Strategic Objectives

Through market reshaping secure:

a. A vibrant, quality care home market that meets current and future local need; and

b. An appropriate mix of supported living provision that provides people with a realistic alternative to care home admission.

c) Scheme Overview

This scheme is focused on two areas:

a) The care home (residential and nursing) primarily for older people but also for younger adults with physical disabilities; and
b) The supported living markets for all adults and not just older people.

The scheme will include the following actions:

- *Launch of market position statements (MPSs)* - Through MPSs developers and providers of care homes for older people and other population groups and developers and providers of supported living schemes for older people and other population groups will be advised of LBH/HCCG needs over the next 3 - 5 years to address health and care needs of the population;

- *Securing suitable care home provision for people with challenging behaviour needs* - Securing suitable local placements for people with challenging behaviour needs, including those associated with dementias, is a key cause of delayed transfers of care. This will be accomplished through providing appropriate wrap-around support for care homes that includes access to medical and clinical expertise to existing providers as well as facilitating new supply, where appropriate. This links with scheme 4: *Seven day working;*

- *Palliative & hospice bed provision* - A review of bed based services will consider the need for additional palliative and bed-based hospice provision. Delivery of the outcomes of the review will start in 2016/17 but any new locally based services may take up to two years to come on stream. This links with scheme 2: *Better care at end of life* and scheme 4: *Seven day working*;

- *Monitoring quality of service provision*: A jointly agreed process for encouraging and monitoring quality of provision within the care home and supported living markets will be embedded;

- *Managing business failure* - A jointly agreed process for identifying and responding to provider business failure that will ensure continuity of service provision will be embedded;

- *Agreed price for care tool implementation* - Implementing an agreed tool for establishing a fair price for care will provide a transparent basis for determining care home fees that allow for market stability and are affordable and provide value for money for commissioners;

- *Securing agreement on integrated brokerage options* – Options for integration of nursing care home brokerage placements following work undertaken in 2015/16 will be considered jointly by the Council and CCG alongside options for joint contracting arrangements;

- *Implementing preferred contracting options for care homes* - Development of a joint care home specification that employs appropriate contractual levers to implement national policy priorities, e.g. seven day working. This will also include partnership working with the West London Alliance (WLA) of local authorities to tender for a Dynamic Purchasing System (DPS) for care homes. A DPS is a fully-electronic process used by public sector bodies to award contracts for works or services and it ensures that the end-to-end procurement process is competitive, fair and transparent.

- *Development of a menu of in-reach support for care homes and supported living schemes* - This would include medical and other clinical advice that will prevent hospital admissions that are avoidable;

- *Developing the model of care and support for extra care* - The development of wrap-around services to ensure that the health and care needs of older people in existing extra care sheltered schemes, Cottesmore House and Triscott House, are met as well as those in two new schemes (Grassy Meadow and Parkview) to be opened in 2018. The intention will be to minimise the circumstances where it is necessary for people living in these schemes to be admitted to care homes to address their needs.

d) The Delivery Chain

Scheme Lead Role

The Council will lead on this scheme and will be supported by a multi-agency task and finish group.

Scheme Delivery

The Council and CCG currently commission care home placements separately and often from the same private providers. The need for care home provision will be met by the private or independent sector market and through this scheme different commissioning options will be considered, including lead commissioning arrangements.

In-reach support from community matrons to care homes is commissioned by the CCG from CNWL. Any enhancement to this service to include other clinical and medical support and also to include supported living schemes would be subject to approval of proposed business cases and could be further developed within the emerging ACP.

The Council currently commissions a private provider to deliver care to the tenants of two existing extra care schemes, Cottesmore House and Triscott House. Housing-related support is provided directly to tenants by the Council. The Council will continue to be the lead commissioner for the service provided to tenants at these schemes and the new ones due to open in 2018. It is expected that core care and support hours, e.g. the level of care required for the safe running of the schemes, will be delivered by a private or independent sector

e) The Evidence Base

There are 58 care homes in Hillingdon of which 17 are registered nursing homes and 41 residential homes without nursing. 29 cater for the 65 and over population and 29 for people aged under 65. The total bed capacity is 1,390 but 1,195 of these are for older people. Hillingdon has the seventh largest supply of older people's care homes in

London and the fifteenth largest supply of care homes for people aged under 65.

The Council makes 12% fewer placements of older people per head of population than the London average but ranks 8th highest out of London's 33 boroughs for placements for people with learning disabilities of working age. 45% of the older people's care home supply is utilised by self-funders compared with a London average of 41%. In accordance with national and local policy the Council will be making less residential care home placements in coming years. To create real alternatives to residential care that will promote independent living two new extra care schemes for people aged 65 and over will open in early 2018 and these are Grassy Meadow, which will have 88 self-contained flats and an onsite dementia resource centre and Parkview, which have 66 self-contained flats. A 14 flat supported living scheme for people with learning disabilities is also scheduled to open during 2018 in Ruislip and a 12 flat scheme for adults with functional mental health needs in Uxbridge.

The older adult market is quite diverse with 40% of beds being owned by large national providers, e.g. those owning 40 or more homes elsewhere in England. The Council is largest provider of care home beds for younger adults and only 11% are owned by large providers.

In 2014/15 there were 885 emergency admissions to Hillingdon Hospital from care homes in the borough at a total cost of £2.2m. 71% (632) of these admissions were of the 65 and over care home population at a cost of £1.8m. During the first half of 2015/16 this trend was replicated with a total of 447 emergency admissions of which 70% (314) were of the 65 and over care home population. This shows that initiatives during 2015/16 have prevented an increase in the level of emergency admissions from care homes rather than improving it.

f) Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Quality Assurance Team	LBH	150	0	150
b) Care Home Prescriber	HCCG	0	32	32
TOTAL		**150**	**32**	**182**

g) Contribution to BCF Metrics

This scheme will impact on the following BCF metrics:

- Reduction in non-elective admissions
- Reduction in permanent admissions to care homes of 65 + population.
- Reduction in delayed transfers of care (mental health).
- Social care quality of life.

h) Other Success Measures

The following measures will be used to identify whether the scheme is working:

- Reduction in non-elective admissions from care homes.
- Reduction in non-elective admissions from supported living schemes, including extra

care.
- Reduction in number of people aged 65 + dying in hospital within seven, fourteen and twenty-one days of admission from a care home where the hospital is not their preferred place of care. This links to scheme 2: *Better care at end of life*.

Scheme Seven

a) Scheme Name

Supporting Carers

b) Scheme Strategic Objective

This strategic objective of this scheme is that carers are 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"

c) Scheme Overvew

The 2014 Care Act increased the responsibilities of local authorities towards adult carers. The Act changed the definition of who is a carer so that any adult providing unpaid care to another adult is legally regarded as a carer whether or not they regard themselves as such. Any carer within this definition has a right to a carer's assessment and also to have their own care and support needs identified from the assessment met by the local authority. This scheme seeks to support the health and wellbeing of carers, both adults and young carers and this will be achieved through the following actions:

- *Deliver a communications campaign to increase awareness and take up of carers' support/services* - The campaign will include identifying "hidden", e.g. people who do not necessarily identify themselves as carers. It will also include a *'What would you do? Where would you go?*' initiative to raise awareness for all residents who could become carers at any time.

- *Reviewing assessment capacity across the borough to provide additional support to carers* - The expectation is that as the population ages the number of carers will increase and there consequently needs to be sufficient capacity within the system to permit timely carers' assessments to take place. Some demand may be absorbed by the online self-assessment facility through Connect to Support but the Council will ensure sufficient capacity through its contracts with the third sector. From the autumn of 2016 this flexible response to demand for carers' assessments would come within the carers' hub contract.

- *Implement the carers' hub contract* - Following a tender for an integrated support service for carers in 2015/16 the new contract will be implemented in the autumn of 2016.

- *Deliver GP annual health checks and flu jab programmes for carers* - GP practices will be supported by the Communications Team to proactively identify carers and to register them as carers. Where feasible each practice will identify someone as a carers' champion and the definition of this role will be agreed in consultation with teh GP networks. A mechanism for referring carers for a health check following a carer's assessment will also be developed.

- *Deliver options to extend services for carers -* e.g. weekend carers cafes, more activities in winter months and condition specific cafes e.g. dementia, MH, autism and provide access to appropriate and improved 7 day health care services

- *Delivery of an integrated engagement framework for carers* - This is being developed in 2015/16 and is intended to enhance the voice of carers in service planning and delivery, across all providers. It will include use of technology to enable carers to give their views online in a way that is least disruptive to them. Subject to the outcome of a feasibility study, it may also include establishing a Carers' Assembly.

- *Support for carers of people at end of life* – The results of the review of the needs of carers of people at end of life undertaken as part of the work of the End of Life Forum under scheme 2: *Better care at end of life*, will be implemented. Where additional funding is required appropriate business cases will be developed for consideration by the Council and/or CCG.

d) The Delivery Chain

Scheme Lead Role

The Council will lead on this scheme and will be support by the multi-agency Carers Strategy Group.

Scheme Delivery

Carers' assessments are undertaken by the Council with additional capacity commissioned from Hillingdon Carers by the borough. This will continue during 2016/17.

Information and advice for carers is commissioned by the Council from a range of third sector providers and these include Hillingdon Carers, Rethink and the Alzheimers' Society. It is intended that the new carers' hub service being tendered during 2015/16 will be delivered by a third sector organisation and provide a single point of access to services for carers. This will include information and advice to young carers and a range of support services, including some therapeutic services.

The Council has commissioned the Carers' Trust to provide a sitting service for carers of people who do not meet eligibility criteria. This enables carers to take a break of four hours a week. A carers' assessment is not required for them to be able to access this service and any carer requiring more support may be able to receive this following an assessment. This service will be part of the new Carers' Hub Service that will operational from 1st October 2016.

Local GP networks are responsible for delivering health checks for carers. Where appropriate, Personal Health Budgets will be made available during 2016/17 to address the specific healthcare needs of carers identified from the health check process. See scheme 5: *Integrated Community-based Care and Support*.

e) The Evidence Base

The 2011 census shows that there were at least 25,702 Carers in Hillingdon; in fact, this figure was and is probably much higher when taking into consideration the fact that some people who are providing care to their partner or other relatives do not identify themselves as Carers. These 'hidden Carers' may not be accessing the support and advice that is available to them.
The table below provides a breakdown of the age of Carers as identified by the 2011 census.

Age Breakdown of Carers in Hillingdon	
Carer Age Group	**Number**
0 - 24	2,450
25 - 64	18,609
65 +	4,643
TOTAL	**25,702**

The census also showed that 36% of the Carers aged 65 and above were providing 50 hours a week or more unpaid care and of those 17% identified themselves as having bad or very bad health.

According to estimates within the Institute of Public Care's 2009 *Estimating the prevalence of severe learning disability in adults* - working paper 1, there should currently be approximately 400 people living with parents and this should rise to approximately 440 in 2020. Of the 220 people with learning disabilities currently being supported by the Council who live with parents or other relatives who are identified as their main Carers. 77 of these Carers are aged 65 and over and of these 11 are aged 75 and over. This illustrates both the importance of supporting older Carers and the need to plan for a time when they will be unable to continue their caring role because of the effects of old age.

f) Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Carers' hub, assessments and review	Third sector	600	0	600
b) Services to carers (inc respite)	Various P & V	209	0	209

c) Support to Hillingdon Social Care Direct	LBH	70	0	70
d) Training	Third sector	20	0	20
TOTALS		**899**	**0**	**899**

g) Contribution to BCF Metrics

This scheme will impact on the following BCF metrics:

- Reduction in non-elective admissions.
- Reduction in permanent admissions to care homes of 65 + population.

h) Other Success Measures

The following measures will be used to identify whether the scheme is working:

- Number of carers' assessments completed.
- Number of carers receiving respite or a carer specific service following an assessment.
- Through the national carers' survey:
  - Proportion of Carers who have found it easy or difficult to find information and advice about support services or benefits
  - Carer quality of life questions about:
    - Getting enough sleep and eating well
    - Having sufficient social contact
    - Receiving encouragement and support.
- Number of carers on GP Carers' Registers.
- Number of Carers in receipt of a Personal Health Budget. Links with scheme 5: *Integrated Community-based Care and Support*.

Scheme Eight

a) Scheme Name

People living well with Dementia

b) Scheme Strategic Objective

The objective of this scheme is that people with dementia and their family carers are enabled to live well with dementia.

c) Scheme Overview

Hillingdon's ageing population means that dementia, a condition primarily associated with old age, is going to have a significant impact on the local health and care economy for the foreseeable future. Through more integrated working across health and social care it is intended that this scheme will contribute to people affected by dementia being able to say:

- I was diagnosed in a timely way.
- I know what I can do to help myself and who else can help me.
- Those around me and looking after me are well supported.
- I get the treatment and support, best for my dementia, and for my life.
- I feel included as part of society.
- I understand so I am able to make decisions.
- I am treated with dignity and respect.
- I am confident my end of life wishes will be respected. I can expect a good death.

To achieve this the following actions will be taken:

- *Preventing or delaying the onset of dementia* - This action links in with the work being undertaken under scheme 1: *Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation*, as the actions intended to prevent stroke will also assist in preventing or delaying the onset of dementia, e.g. promoting physical activity, nutrition guidance, smoking cessation and early detection of conditions such as hypertension and high cholesterol.

- *Implementing a single point of access (SPA) for crisis care* - Building on a single point of access to urgent and crisis care in 2015/16, the service will be developed in 2016/17 so that people with urgent mental health needs, including dementia, are able to receive multi-disciplinary assessments of need and onward referral as appropriate. It is envisaged that referrals into the SPA would come from professionals and voluntary and community organisations as well as residents themselves and/or their carers.

- *Completion of Integrated Multi-disciplinary Team business case* - Following modelling work undertaken in 2015/16, a business case will be developed in 2016/17 for a multi-disciplinary service model encompassing Memory Assessment, older people mental health beds and community home treatment services to provide a more integrated service for older people with dementia requiring diagnosis and post-diagnosis support. This will include case management approaches for people living with dementia and other long-term physical health needs. This links into existing integrated care planning for older people and specifically with scheme 5: *Integrated Community-based Care and Support.*

- *Developing a local dementia resource centre model* - A dementia resource centre will be included in the 88 flat Grassy Meadow extra care scheme due to open in early 2018. This resource is primarily intended to meet the social care needs of people living with dementia in the community with family carers, but during 2016/17 health and social care partners will work together to identify how the maximum benefit can be obtained from this facility.

- *Developing standardised training for providers* - The multi-agency Dementia Working Group will develop a training framework for health and social care staff that will address the following three tiers:

  - Tier 1: Dementia Awareness ('Essential information') that highlights the basic, essential competencies relevant to all sections of workforce and society.

  - Tier 2: 'Enhanced' builds on tier 1 and highlights competencies needed for those working in general health or social care settings and for those working with people with dementia.

  - Tier 3: 'Specialist' builds on tiers 1 & 2 and is relevant to those working in a more specialist and intensive way with people with dementia.

  It is envisaged that tier 1 and 2 would be available as an e-learning modules.

- *Securing care home provision for people living with dementia with challenging behaviours* – The current limited availability of this provision is the cause of people with dementia staying in inappropriate care settings for longer than is desirable and can contribute to delayed transfers of care. The work being undertaken under scheme 6: *Care Home and Supported Living Market Development* is intended to address this gap in provision.

- *Securing care provision for people living with dementia at end of life* – The work being undertaken under scheme 5: *Integrated Community-based Care and Support* and scheme 6: *Care Home and Supported Living Market Development* will ensure that appropriate service provision is available to address need at this particularly sensitive time.

d) The Delivery Chain

Scheme Lead Role

HCCG will lead on this scheme, which will be overseen by the multi-agency Dementia Working Group task and finish project group.

Scheme Delivery

Information and advice about dementia is commissioned by the Council from the Alzheimer's Society, who also provide an advice centre at the Templeton Centre in Northwood. The CCG commissions CNWL to provide a memory assessment service which is based at the Woodland Centre on the main Hillingdon Hospital site. In-patient provision is also based at the Woodland Centre, which is commissioned by the CCG. Both the Council and the CCG commission CNWL to provide an Admiral Nurse service, which supports carers of people living with dementia.

There are 29 care homes in Hillingdon that support older people and 26 of these are registered to support people with dementia. The direction for national and local policy is to support people living with dementia in their own homes or in as least restrictive environment as possible for as long as possible, which is one of the reasons for the

development of extra care schemes. The commissioning of care homes and care and support provision is addressed within scheme 6: *Care Home and Supported Living Market Development.* This includes provision to address the needs of people living with dementia with challenging behaviours.

Both the Council and the CCG commission homecare provision from private and independent sector providers to support people in their own homes with their personal care and health needs. The availability of a service to address the care needs of people living with dementia will be addressed under scheme 5: *Integrated Community-based Care and Support.*

The Council's Wellbeing Team, in partnership with the Libraries Service, provides a range of activities to keep people living with dementia mentally and physically active. This links with scheme 1: *Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.*

e) The Evidence Base

Hillingdon's Joint Strategic Needs Assessment (JSNA) estimates that in 2015 2,750 people in the borough are living with dementia that this will rise to 3,120 in 2020. This is a projected increase of around 13%. For those aged over 85 it is estimated that in 2015 there are 1,250 people in Hillingdon living with dementia and that this figure is likely to rise to 1,500 by 2020, an estimated increase of 19%. These estimates are based on information from the Projecting Older People Population Information service (POPPI) using data from Dementia UK: A report into the prevalence and cost of dementia prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society, 2007.

Research suggests that dementia may be more common in older adults with intellectual disability than in the general population. Incidence of dementia in older people with intellectual disabilities have been found to be up to five times higher than older adults in the general population. (source: Strydom *et al*. 2013, Research in Developmental Disabilities)

The number of people with learning disabilities living into old age is increasing and it is predicted that there will be an increase of around 10% of people over 65 with learning disabilities in Hillingdon between 2015 and 2020. This is in line with the average for all London boroughs (source: POPPI data March 2015).

This scheme is compatible with the *National Dementia Strategy* (DH 2009), the required actions identified in *Dementia: A state of the nation* (DH 2013) and *Dementia today and tomorrow: A new deal for people with dementia and their carers*, produced by the Deloitte Centre for the Alzheimer's Society in February 2015.

f) Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
Wren Centre	LBH	300	0	300

Staff & provider training	Third sector	5	0	5
	Totals	**305**	**0**	**305**

g) Contribution to BCF Metrics

This scheme will impact on the following BCF metrics:

- Reduction in permanent admissions to care homes of 65 + population.
- Social care quality of life.
- .

h) Feedback Loop

The following measures will be used to identify whether the scheme is working:

- Diagnosis rate as a percentage of projected prevalence of dementia within the Hillingdon population.
- Proportion of residents identified as in need of preventative care who have been offered a care plan.
- Number of people in receipt of a Personal Health Budget.
- Evaluation of training delivered to providers.