HILLINGDON
LONDON

Appendix 4

Health Impact Assessment Update

STEP A) Description of what is to be assessed and its relevance to health

What is being assessed? Please tick ✓

Review of a service ☐ Staff restructure ☐ Decommissioning a service ☐

Changing a policy ☐ Tendering for a new service ☐ A strategy or plan ✓

The Better Care Fund (BCF) Plan is a mechanism for providing better outcomes for residents and patients through closer integration between health and social care. This assessment updates that undertaken for the 2016/17 BCF plan, which was itself an update of the assessment undertaken for the original 2015/16 plan.

The focus of the 2017/19 BCF plan, as for the last two years, is the 65 and over population and there is a specific focus on:

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

The HIA that was undertaken for the 2016/17 plan still applies to the new plan and this assessment focuses on the changes for 2017/19. There are six schemes within the 2017/19 BCF plan and these are:

- ***Scheme 1*** - Early intervention and prevention.
- ***Scheme 2*** - An integrated approach to supporting Carers.
- ***Scheme 3*** - Better care at end of life.
- ***Scheme 4*** - Integrated hospital discharge.
- ***Scheme 5*** - Improving care market management and development.
- ***Scheme 6*** - Living well with dementia

Appendix 1 provides a summary of each of the schemes, but the key developments under the proposed plan are:

- ***The Council giving full consideration to its involvement in the Accountable Care Partnership (ACP)*** - Establishing the business case for the Council joining the ACP.

- ***Developing a single point of access for older people (scheme 1)*** - Bringing services together into a single service with a single point of access has proved successful for Carers in Hillingdon.

- ***An integrated approach to supporting Carers (scheme 2)*** - Implementing NHSE's integrated approach to assessing Carer health and wellbeing. The plan looks at identifying 'hidden' and 'young' Carers and the provision of support and break opportunities. It is also covers the development of self-help options such as self-assessment and improving support to Carers of people admitted to hospital.

- ***Getting hospital discharge right (scheme 4)*** - The plan is proposing to bring together the various services involved in facilitating discharge from hospital into the community, e.g. Homesafe, Rapid Response, Reablement, the Night Sitting Service and Prevention of Admission/Readmission to Hospital Service (PATH) into a single, integrated hospital discharge service delivered by a lead provider within the ACP.

- ***Exploring use of Disabled Facilities Grant flexibilities*** - Developing a business case to use flexibilities to address anticipated needs and support hospital discharge, e.g. home/garden clearance, home deep cleaning, home fumigation, furniture removals to set up micro-environment, etc;

- ***Joint market management and development approach (scheme 5)*** - With the objective of ensuring the supply of sufficient quality providers to meet demand, this area represents potential step-change for Hillingdon. It includes:
  - Development of all age, joint brokerage arrangements for homecare, short and long-term nursing home placements and Direct Payments and Personal Health Budgets as a pilot;
  - Commissioning of integrated homecare provision in 2017/18;
  - Commissioning of integrated palliative care at home provision in 2017/18;
  - Development of an integrated commissioning model for nursing home placements from 2019/20;
  - Supporting care homes - This links to the Improving health in care homes programme but also includes converting spot purchase arrangements into block contracts to guarantee capacity for local authority placements.

- ***Closer alignment between Adult Social Care and Care Connection Teams*** - Allocating social care staff to Care Connection Teams supporting extra care schemes.

- ***Development of specialist Dementia Resource Centre (DRC)*** - Maximising benefits from purpose-built DRC at Grassy Meadow Court extra care scheme.

What is the lead organisation for the service to be assessed? EG Hillingdon CCG or London Borough of Hillingdon

The plan is jointly led by HCCG and Hillingdon Council (LBH)

Who is accountable for the service? E.g. Head of Service or Corporate Director

Chief Operating Officer, HCCG
Corporate Director of Adults and Children and Young People's Services, LBH

Date assessment completed and approved by accountable person

Date assessment completed: 25th August 2017
Date assessment approved:

Names and job titles of people carrying out the assessment

Gary Collier - Health and Social Care Integration Manager, LBH/HCCG
Graham Hawkes - CEO, Hillingdon Healthwatch
Jane Walsh - Older People's Commissioner, HCCG

A.1) What are the main aims and intended benefits of what you are assessing?

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, a personalisation of service provision and a collaborative approach between providers;
- Where there is systematic early identification of susceptibility to disease or exacerbation in the population, alongside integrated management of conditions and a consistent approach to care provision;
- Where better coordination of services are configured around Hillingdon's residents, including a much stronger focus on case management and prevention and integration of health and social care;
- Where residents and carers are actively involved in the planning of their care and recognised as expert partners in care;
- Enablement of self-care and preventative services and promotion of independence for as long as possible
- 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;
- The most effective use of health and care resources is made to achieve best

value for the Hillingdon £ by allowing for a flexible use of collective resources and reduction in transaction costs; and
- Enablers such as IT interoperability, development of a sustainable workforce and a vibrant market offering residents/patients quality choices.

The key benefits of the plan are:

a. A reduction in the number of non-elective admissions (NELs) attributed to the 65 and over population by 975 during 2017/18. This is a contribution to the overall CCG target for 2017/18;
b. A reduction in the number of permanent admissions of older people (65 + and over) to care homes, per 100,000 population;
c. Increase in the proportion of older people (65 + and over) who were still at home 91 days after discharge from hospital into reablement services;
d. Reduction in delayed transfers of care (delayed days) from hospital per 100,000 population (18 +).

A.2) Who are the service users or staff affected by what you are assessing?

The service users, residents and patients affected by the BCF Plan are Hillingdon's 65 and over population and their Carers. People affected would also include adults with learning disabilities and adults living with mental health conditions who are living in a supported living environment or who could benefit from this model.

There are some services included within the plan that are intended to address need irrespective of age, e.g. community equipment and homecare.

A.3) Who are the stakeholders in this assessment and what is their interest in it?

Stakeholders	Interest
Residents and patients	People directly affected by the Plan
Carers	People directly affected by the Plan
Hillingdon Health and Care Partners	Involved in delivery of the schemes
Third sector (voluntary and community)	Involved in delivery of the schemes

A.4) Which health-related issues are relevant to the assessment? ✓ in the box.

Employment or financial well-being	✓	Self-care	✓
Access to healthcare (primary, secondary, specialised)	✓	Social inclusion	✓
Environmental exposures (e.g. noise, air quality, green space)		Mental wellness	✓

Lifestyle (e.g. diet, physical activity, smoking, alcohol)	✓	Health inequalities	✓
Infectious disease	✓	Community Safety (eg crime, road safety, defensible space)	
Scope of health care services	✓	Other – please state	

STEP B) Consideration of information; data, research, consultation, engagement

B.1) Consideration of information and data - what have you got and what is it telling you?

Overview

The 65 + population accounted for 42% of all non-elective admissions in 2016/17 and 58% of the non-elective health spend. In 2016/17 34% of emergency admission spend was on the 80 and over population, which accounted for nearly 23% of admissions. It is estimated that 28% of admissions for the 80 and over population group were avoidable or deferrable, which is based on the proportion of admissions resulting in a length of stay of between 0 and 1 days.

Population 65 +

Hillingdon's Joint Strategic Needs Assessment (JSNA) shows that in 2017 there are a total of 40,355 people over the age of 65 in Hillingdon, out of which 40,355 (46%) are men, and 21,881 (54 %) are women. Older People's (65+) population is predicted to increase by 6% (2,470) by 2020 and 10% (4,440) by 2022.

Population 85 +

The projected overall increase in the population of persons aged 85+ is 8% in the next five years compared with 5% in Hillingdon's total population. Currently, the total number of people aged 85+ is 5,616, out of which 2,172 (39%) are men and 3,444 (61%) are women.

Population 65 + and Ethnicity

A key feature of Hillingdon's demography is that ethnic diversity is concentrated in the younger age groups. For each of the five year age bands for people aged 65 and over there is an increasing proportion of White British. It is expected that the lack of diversity within these older age groups will change over the coming decades as the younger age groups grow older.

Long-term Conditions

It is estimated that 2% of the most complex patients (all ages), e.g. people living with two or more long-term conditions, comprise 16.2% of CCG spend. 57% of these

complex patients are people aged 65 and over; 35% are aged 75 and over and 14% aged 85 and over. In 2016/17 the local health spend on people aged 65 and over living with multiple health conditions was £9.1m.

Within the next 5 years, there is a projected increase of 9% in the number of people aged 65 and over with a limiting long-term illness. This figure is slightly higher than the projections for Ealing and the London region, but close to the percentage increases projected for Hounslow and Harrow. Overall Hillingdon has the highest projected increase in relation to the London region and the forenamed neighbours.

The latest official data on dementia prevalence data (Joint Commissioning Panel for Mental Health, 2013) suggests that at mid-year 2014 there were 2,574 people in the borough living with dementia. This is projected to grow by 13.5% to 2,975 by 2021. The Projecting Older People's Population Information (POPPI) service developed by the Institute of Public Care (IPC) in partnership with Oxford Brookes University suggests that there are currently 2,670 people living with dementia and predicts an increase of 12% to 3,037 by 2020. The dementia diagnosis rate increased to 69.3% in Hillingdon at the end of 2016/17 compared to 41% in 2014/15.

The Royal Society of Psychiatrists' 2009 study *Dementia and People with Learning Disabilities: Guidance on the assessment, diagnosis, treatment and support of people learning disabilities who develop dementia* shows that there is an increased susceptibility amongst this population group to develop dementia once they reach the age of 50. The following figures suggest that the risk is up to four times greater than the general population:

- 1 in 10 of those aged 50 to 64
- 1 in 7 of those aged 65 to 74
- 1 in 4 of those aged 75 to 84
- Nearly three-quarters of those aged 85 or over.

Research undertaken in partnership with the Alzheimers' Society estimates that 1 in 10 people with a learning disability will go on to develop dementia between the ages of 50 and 65 and approximately 50% of those aged 85 and over. For people living with Down's syndrome 1 in 50 are estimated to develop dementia in their 30s and 50% of those aged 60 and over will develop it. The Projecting Adult Needs and Service Information (PANSI) suggests that there are currently 5,393 adults in Hillingdon with a learning disability and that this will increase by 6% to 5,749 in the period up to 2020. There are approximately 117 people who have Down's syndrome in Hillingdon.

POPPI projections suggest that the number of people aged 65 and over with a body mass index of 30 + was 10,094 in 2015 and that this will increase by 8% to 10,943 by 2020. The numbers of older people living with types 1 & 2 diabetes are projected to increase by nearly 10% from 4,805 in 2015 to 5,307 in 2020.

Stroke

In 2013/14 there were 3,246 people who had been diagnosed with a stroke in Hillingdon. 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 Hillingdon.

Falls and Fractures

The consequences of falls have a significant impact on both NHS and social care services. Falling can precipitate loss of confidence, the need for regular social care support at home, or even admission to a care home. Fractures of the hip require major surgery and inpatient care in acute and often rehabilitation settings, on-going recuperation and support at home from NHS community health and social care teams. In addition, hip fractures are the event that prompts entry to a care home in up to 10% of cases. Indeed, fractures of any kind frequently require a care package for older people to support them at home.

In the UK, 35% of over-65s experience one or more falls each year. About 45% of people aged over 80 who live in the community fall each year. Between 10% and 25% of such fallers will sustain a serious injury.

In 2016/17 there were 816 falls-related admissions to Hillingdon Hospital at a cost of £2.8m.

Life Expectancy

The latest data (2013-15) shows that a male child born in Hillingdon can expect to live for 80.4 years and females for 83.7 years, which is higher than the England average (79.5 years for males and 83.1 for females). Life expectancy in Hillingdon is estimated at 79.4 years for males and 83.5 years for females (data from 2008-12). This is similar to the averages for London and England & Wales. Men in Hillingdon aged 65 now can expect to live to the age of 84.3 years and females 86.4 years.

There are inequalities within the Borough at ward level. The gap in male life expectancy between Eastcote and East Ruislip and Botwell is 6.7 years and the gap in female life expectancy between Eastcote & East Ruislip and Botwell is 8.5 years.

Sedentary Lifestyle

Health Survey for England 2008 Volume 1 Physical activity and fitness shows that approximately 50% of Hillingdon's population aged 65 - 74 year olds spend 6 or more hours sedentary time per day during the week and over 50% at weekends. For the over 75s it is 62% for both week days and at weekends.

Older People Living Alone

The 2011 census identified that 31% of older people lived alone. Projections from the Projecting Older People Population Information System (POPPI) suggest that by 2020 36% (15,580) of the 65 and over population will be living on their own and 64% (9,980) of this number will comprise of people aged 75 and over.

The study *Preventing Suicide in England - a cross-governmental outcomes strategy*

to save lives (DH 2012) shows that living alone and becoming socially isolated and experiencing bereavement are contributory factors that can lead to suicide. Available figures show that the number of suicides amongst the 65 + age group in Hillingdon is small, e.g. 5 in 2010, 4 in 2011 and 3 in 2012, but they predominantly occur amongst men.

Extra Care Sheltered Housing

Two extra care sheltered housing schemes for the 55 and over population comprising of 95 self-contained flats for rent were opened in 2011 and 2012 respectively. These are Cottesmore House and Triscott House. Two further schemes comprising of a total of 148 self-contained flats are due to open in 2018. Two new schemes totalling an additional 148 self-contained flats, Grassy Meadow Court and Park View Court, are due to open in June and September 2018 respectively.

Consultation

B.2) Did you carry out any consultation or engagement as part of this assessment?

Please tick ✓ NO ☐ YES ✓

If Yes, what did you do or are planning to do? What were the outcomes?

The timescale for delivering the HIA did not permit consultation with a wide group of patients, residents and other stakeholders. However, the following stakeholders were invited to comment on the draft assessment:

- Kevin Byrne - *Head of Health Integration and Voluntary Sector Partnerships*
- Sally Chandler - *CEO, Hillingdon Carers*
- Claire Eves - *Operational Head of Hillingdon Health Care Partnership*
- Julian Lloyd - *CEO, Age UK Hillingdon*
- Jo Manley - *Hillingdon ACP Programme Director*
- Kam Rai - *Deputy Borough Director, CNWL*
- Shikha Sharma - *Consultant in Public Health*

B.3) Provide any other information to consider as part of the assessment

MTFF/QIPP context

The Council is required to find £15m of savings in 2017/18 and an equivalent amount in 2018/19.

HCCG's two year financial plan for 2017/19 identified a requirement to generate gross savings of £16.8m in 2017/18 with a further £11.2m in 2018/19.

National Policy Context

The Better Care Fund has been introduced as part of national policy as a tool to

implement the new general duty under the 2014 Care Act to integrate services between health and social care. The intention behind integration is to achieve efficiencies through better coordination and provide patients and residents with an improved experience of care and support. In the 2015 Autumn Statement the Government announced its intention that the BCF would be the mechanism to deliver full integration between health and social care by 2020.

A further objective is that there are timely and appropriate interventions by the statutory agencies working with primary care and the third sector to prevent non-elective attendances at A & E that are avoidable as well as avoidable hospital admissions. Integration through the BCF is also intended to be used as a mechanism for preventing escalation in the needs of older people that result in a loss of independence and the need for more expensive forms of intervention by health and social care.

Hillingdon's plan has been drafted in accordance with the requirements of the *Integration and Better Care Fund Policy Framework 2017/19* (DH March 2017) and the *Integration and Better Care Fund Planning Requirements for 2017/19* (NHSE July 2017)

Local Policy Context

The Better Care Fund plan is key to the delivery of the aspects of Hillingdon's Sustainability and Transformation Plan that are dependent on integration between health and social care or closer working between the NHS and the Council for delivery. It also contributes to the delivery of the statutory Joint Health and Wellbeing Strategy. It enables HCCG and the Council, as well as other statutory partners to meet integration requirements contained within the 2012 Health and Social Care Act.

C) Assessment

What did you find in B1? Who is affected? Is there, or likely to be, an impact on certain groups?

C.1) Describe any **NEGATIVE** impacts (actual or potential):

Health-related issues	Impact on this issue and actions you need to take
Employment or financial wellbeing	The 2017 assessment review confirmed that there were no negative impacts on this health-related issue arising from the proposed 2017/19 plan. The potential negative impact on staff as a result of the development of further integration options (structural as well as functional) that apply under proposals contained within scheme 4: *Integrated hospital discharge* will be mitigated through the application of good employment practice procedures.

	The seven day working requirements under national condition 4: *Transfers of care* could also result in staff coming under pressure, real or perceived, to work extended hours to ensure that services are available. This issue was identified in the assessment of the 2016/17 plan and will continue to be mitigated, once again, through the application of good employment practice procedures.
Access to healthcare	Assessments of earlier iterations of the BCF plan considered whether the BCF Plan would lead to resources being diverted from other user groups. There has been no evidence of this in 2015/16 or 2016/17. In 2017/19, as in previous years, much of the investment going into the pooled budget is committed to existing contracts and this militates against this eventuality. Additional demands on health services could arise from the pro-active early identification work proposed to be undertaken as part of *scheme 1: Early intervention and prevention*. The compensation for this is the potential for avoiding or delaying increased costs as a result of a more anticipatory model of care. The assessment team identified a potential concern about clinical treatment decisions being influenced negatively by the early identification of a person as being within the last year of life. This is again militated by the benefits of early identification for enabling advanced planning to take place and therefore reducing the likelihood of crisis situations occurring that will inevitably be distressing for everyone involved. *Scheme 5: Improving care market management and development* - This includes the development of wrap-around services to support the independence of residents in supported living schemes, such as extra care sheltered for older people, could result in initial cost pressures. The scheme also includes a similar approach with care homes. It is expected that any financial outlay will be matched by reductions in A & E attendances and emergency admissions. The outcomes of the scheme both in terms of resource outlay and reductions in avoidable demand on hospital resources will be monitored and reported to Governing Body and the Health and Wellbeing Board. The Plan is aligned with the key integration enablers such as care and support planning being delivered by the GP Confederation, shifting to planning for anticipated needs with GPs as lead professional. This will result in more services being delivered from local GP practices and may create access issues for some people who might otherwise have gone to Hillingdon Hospital. However, the compensation is the probable increased access and convenience that there will be for others as a result of health services being delivered closer to home. For

	those for whom transport may be an issue this is being addressed through amendments to provider contracts to ensure that patient transport is provided where needed. The current issue with access to transport for people attending medical appointments should be addressed once the new contract starts.
Self-care	The assessment team acknowledged a point made during the assessment for the 2016/17 plan that people with capacity had the right to make 'bad' decisions and that a continuing objective of the plan was to ensure that people had access to information and support to enable them to make informed decisions. The assessment team did identify services provided to people as under discharge to assess (D2A) arrangements could create unrealistic expectations. This would be mitigated by the provision of improvements in the information made available post-admission to patients and their families. Addressing this issue is included in the Delayed Transfers of Care Action Plan (see **Annex 1** of the submission documents).
Social inclusion **Mental wellness** **Lifestyle** **Infectious disease**	No negative impacts were identified from the six schemes within the 2017/19 plan on these health-related issues by the assessing team. However, the importance of H4All Wellbeing Service and third sector consortium partners managing flow through services, including managing dependency and associated service capacity was acknowledged. This will be kept under review through the Wellbeing Service contract monitoring process.
Health inequalities	The assessment team noted that the basis for establishing the CCTs was on GP registered population rather than disease/condition prevalence, which could consequently lead to variable impact on the capacity of the teams dependent on geographical location. However, it was recognised that the CCTs were a new concept for Hillingdon and that their composition would be reviewed once data was available following full implementation in 2017/18 and into 2018/19.
Scope of healthcare services	The proactive approach to identification of need required under *schemes 1 and 2 - An integrated approach to supporting Carers,* may lead to the identification of health needs for which the appropriate services may not currently be in place and which may therefore have additional resource implications. 2016/17 has seen additional service requirements of a preventative nature being identified and both the H4All Wellbeing Service and Hillingdon Carers' Partnership have pursued innovative ways of addressing these both with the support of other H4All consortium members and through attracting external funding.

	The individual benefits of the schemes versus additional resource requirements will be kept under review as part of the BCF monitoring process.

C.2) Describe any **POSITIVE** impacts

The assessing team felt that the comments raised as part of the 2015/16 plan assessment were still valid. Additions have been made to those comments where the team felt that this was appropriate in view of the content of the 2016/17 proposed plan.

Health-related issues	**Impact on this issue and actions you need to take**
Employment or financial well-being.	Scheme 5 - The use of the Improved Better Care Fund Grant (IBCF) to fund a requirement that agencies on the homecare Dynamic Purchasing System (DPS) pay their workforce the equivalent of the London Living Wage will help to sustain the financial wellbeing of care workers. This will assist in ensuring market capacity and service quality that will have implications for admission avoidance as well as preventing delayed transfers of care attributed to the absence of a package of care reason. Most of all, it should improve the resident's experience of care. *Scheme 1* - Should lead to early identification of Carers who may be in employment and provision of timely support following a Carer's assessment may enable them to continue in employment for longer with the benefits as described above. *Schemes 1 and 6*: Living well with dementia - Early identification of people living with dementia and their Carers may help to ensure early access to appropriate treatments that may enable them to retain employment longer.
Access to healthcare	*Scheme 1* - As with the 2016/17 plan the early identification of people at risk of falls, dementia and/or social isolation will ensure timely access to appropriate healthcare as well as other care and support services. This will allow for more effective care planning where required and prevent deterioration in need that can lead to a loss of independence and more expensive healthcare interventions. The Care Connection Teams (CCTs) will have a critical role in delivering this at a GP surgery level. *Scheme 3: Better care at end of life* - This will support people to die in their preferred place of care, which is generally at home. As well as being a more comforting

	environment for the person in the last days of their life (as well as their family). The scheme will lead to a more effective coordination of the required services. *Scheme 1* - This should result in the health needs of residents being addressed at a more local level. Taken in conjunction with the other schemes within the BCF Plan and other integrated care system enablers such as improved care planning, care navigation and multi-disciplinary team working, the result should be a more efficient use of resources. *Scheme 5*: *Improving care market management and development* - The creation of a dedicated social care resource to support extra care and link in with the CCTs will help to ensure timely access to appropriate healthcare services. The wrap-around primary care service proposals also support this.
Self-care	*Schemes 1, 2, 3* and 4 promote self-care as a means of putting individuals more in control of managing their own health and care needs, thus preventing or delaying a escalation in their needs and the loss of independence that can arise from this. The H4All Wellbeing Service should have an increasingly significant impact in empowering people to take more control and navigate the health and care system in a better way.
Social inclusion	*Scheme 1* - The implementation of the CCTs across the borough creates an opportunity to identify people who are either socially isolated or at risk of social isolation and through the H4All Wellbeing Service present them with options to engage with their local communities. This could include opportunities to volunteer with third sector organisations.
Mental wellness	*Scheme 1* - Early identification of those living with dementia can help to ensure timely access to treatment that may arrest the progress of the condition. Access to advice about changes in lifestyle habits that may contribute to and/or accelerate progress of the condition could also have the same effect. Engaging with people who are socially isolated can help prevent adverse health impacts, such as depression, that can also lead to other physical health problems. *Scheme 2*: Better management of the end of life pathway should relieve some of the stress experienced both by the

	person at the end of their life and also their family. The study *Preventing Suicide in England - a cross-governmental outcomes strategy to save lives* (DH 2012) shows that living alone and becoming socially isolated and also bereavement are contributory factors in leading to suicides. Living with a long-term condition is also a contributory risk factor. Available figures show that the number of suicides amongst the 65 + age group is small, e.g. 5 in 2010, 4 in 2011 and 3 in 2012, and these predominantly occur amongst men. *Schemes 1, 2* and *8* in particular would seek to address some of the issues that can lead to suicide.
Lifestyle	*Schemes 1, 2 and 4* will identify particular lifestyle issues, e.g. diet, smoking, alcohol abuse, through visits to patients' homes. The result will be referrals to appropriate professionals and/or third sector organisations to provide advice and support.
Infectious disease	Key objectives of the BCF Plan are to prevent non-elective admissions and to reduce Length of Stay (LOS) in the event of an admission. Achieving this will help to prevent the risk of hospital acquired infections. *Scheme 5* - Support provided to care homes should help to improve standards and reduce the number of care home acquired infections acquired by residents that can lead to hospital admission and a rapid deterioration in mental wellbeing as well as physical health. It was also noted that the DPS homecare specification jointly developed between health and social care and contained much more explicit provisions concerning infection control that reflected the content of the pan-London NHS any qualified provider (AQP) domiciliary care specification.
Health inequalities	The BCF Plan seeks to address health inequalities faced by Hillingdon's more vulnerable older population. However, given the disparity in social and economic wellbeing between older people in the north of the borough and those in the relatively more deprived, more culturally diverse wards in the south, particular consideration will have to be given as to how communities will be accessed. It is envisaged that this will be accomplished by close working with faith and other community-based groups. The provision of Personal Health budgets for people meeting Continuing Health Care (CHC) thresholds and Personal Budgets for people meeting the National Adult

	Social Care eligibility criteria provides opportunities for a more personalised approach to addressing need that would reflect cultural and religious diversity. Promotion of Personal Health Budgets is addressed within *scheme 5* of the plan. Proposals within *scheme 6* of the plan to provide wrap-around support for supported living schemes will also help to address health inequalities experienced by people with learning disabilities and people living with mental health conditions as well as maximising their independence within the least restrictive care setting.

D) Conclusions

The assessment has shown that the health implications of the 2017/19 BCF Plan are overwhelmingly positive for the residents of Hillingdon, which should consequently result in financial benefits for the local health and social care economy.

The assessment also identified that there may be access issues for some residents, as more health services are delivered locally from GP practices. The conclusion was that more people were likely to benefit from local provision and that individual solutions would need to be identified to address the needs of those who are disadvantaged. Transport-related access issues identified as part of the 2016/17 assessment are still current but should be addressed once the new NHS transport contract is implemented.

Key areas that need further consideration are:

- The impact of any functional or structural changes arising from the integrated hospital discharge proposals on staff, including seven day working, will be managed through the application of good employment practices.
- The suitability of existing services to meet the needs of people identified from the more proactive case finding approach set out in *scheme 1*.
- Patient expectations regarding service provision as a result of the D2A model, which can be managed through appropriate information provision.
- Impact of the CCTs being established on the basis of registered population rather than disease/condition prevalence, which will be reviewed when data becomes available as the teams become more established.

The impact of all of the schemes will be monitored as part of the governance process for the BCF Plan.

Signed and dated:……..

Name and position:……

Appendix 1

BCF Scheme Summaries

Scheme Number	Scheme Title	Scheme Aim(s)
1.	Early intervention and prevention.	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.
2.	An integrated approach to supporting Carers.	To maximise the amount of time that Carers are willing and able to undertake a caring role.
3.	Better care at end of life.	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.' 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 of care; 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.
4.	Integrated hospital discharge.	This scheme seeks to prevent 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. A further objective of this scheme is to support discharge from mental health community beds in recognition of the impact of these delays on patient flow through Hillingdon Hospital.
5.	Improving care market management and development.	This scheme is intended to contribute to the STP 2020/21 outcomes of achieving:

		• A market capable of meeting the health and care needs of the local population within financial constraints; and • A diverse market of quality providers maximising choice for local people.
6.	Living well with dementia	The objective of this scheme is that people with dementia and their family carers are enabled to live well with dementia and are 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.*