Appendix 4

Draft Better Care Fund Plan 2019/20 Delivery Plan			v5 15.08.19	
Task	**Task Description**	**Lead Organisation**	**Start Date**	**End Date**
Scheme 1: Early intervention and prevention.				
1.1	Establish a single online information system as the directory of services across Health and Care Partners in Hillingdon.	LBH	Q1	Q4
1.2	Establish named Adult Social Care contacts for each of the emerging Neighbourhood Teams.	LBH	Q1	Q2
1.3	Explore the increased application of assistive technology to support the independence of residents in the community.	LBH	Q1	Q4
1.4	Review the model of voluntary sector support for adults to improve options for social prescribing, including through provision of Personal Health Budgets.	LBH/HCCG	Q3	Q4
1.5	Establish the eight Neighbourhood Teams aligned to the Primary Care Networks across the borough	HCCG	Q1	Q4
1.6	Provide opportunities for older people to participate in sport and physical activity.	LBH	Q1	Q4
Scheme 2: An integrated approach to supporting Carers.				
2.1	Ensure the identification of a Carer's Champion in all GP practices	HCCG	Q1	Q4
2.2	Review and develop the Carer Assessment Tools to simplify the assessment process.	LBH	Q2	Q4
2.3	Support schools and colleges in identifying and recognising the role of Young Carers.	LBH	Q2	Q4
2.4	Review and develop *'first point of contact'* arrangements for Carers in emergency situations outside of working hours, including for adults with mental health needs.	LBH	Q2	Q4
2.5	Ensure Carer identification markers are included in the development of information sharing platforms.	GP Confed	Q2	Q4
2.6	Coordinate the design and development of an 'App' for Young Carers.	HCP	Q3	Q1 20/21

Scheme 3: Better care at end of life.				
3.1	Clarify the end of life model of care for people who wish to die at home. Links to schemes 4 and 5.	HHCP	Q2	Q3
Scheme 4: Integrated hospital discharge and the intermediate tier.				
4.1	Complete the roll out of criteria-led discharge to all wards within Hillingdon Hospital.	THH	Q1	Q4
4.2	Establish a point of coordination within Hillingdon Hospital for hospital discharges.	HHCP	Q1	Q4
4.3	Establish a point of coordination for access to community resources to build up suitable packages of care and support.	HHCP	Q1	Q4
4.4	Develop a service specification for the integrated discharge service.	HHCP	Q1	Q4
4.5	Develop and implement pathways with inclusion criteria that support the discharge of patients on pathway 2.	HHCP	Q1	Q3
4.6	Develop and implement the standards for the triaging process, including the automation of data reporting.	HHCP	Q1	Q3
4.7	Agree a simplified joint assessment for patients on all discharge pathways.	HHCP	Q1	Q3
4.8	Review all specialist pathways to include Frailty, End of Life and Palliative Care to ensure these are aligned to the integrated discharge model.	HHCP	Q1	Q3
4.9	Review the Hospital Discharge Grant pilot and implement the result.	LBH	Q2	Q2
4.10	Seek organisational sign-up to the CHC, shared care and section 117 memorandum of understanding.	LBH	Q1	Q3
4.11	Review liaison and referral arrangements between Housing and both Hillingdon Hospital and CNWL.	LBH	Q1	Q2
4.12	Review the Hillingdon Hospital discharge policy that includes the Choice policy.	THH	Q3	Q4
Scheme 5: Improving care market management and development.				
	Cross Cutting			
5.1	Develop and deliver a provider engagement plan.	LBH	Q3	Q4

	Integrated Brokerage			
5.2	Secure agreement on long-term integrated brokerage arrangements.	LBH/HCCG	Q2	Q3
	Integrated Homecare			
5.3	Undertake a competitive tender for new model of integrated homecare provision.	LBH	Q2	Q3
5.4	Explore the feasibility of rapid access care provision to prevent admissions that are avoidable.	GP Confed	Q2	Q3
	Care Homes			
5.5	Implement Enhanced Support for Care Homes and Extra Care Service	HCCG	Q1	Q3
5.6	Develop a lead commissioning pilot for nursing care home provision by the Council on behalf of the CCG.	LBH	Q3	Q4
5.7	Embed training programme for care home staff on range of issues, including falls management, tissue viability, nutrition, medication and leadership for managers and/or aspiring managers.	HCCG	Q1	Q4
5.8	Explore feasibility of extending *'Red Bag'* scheme to extra care.	LBH	Q2	Q4
	Extra Care			
5.9	Open Park View Court and manage implementation of fill strategy in partnership with GP practices.	LBH	Q2	Q4
5.10	Continue to explore with partners opportunities to maximise the benefits of available resources at Grassy Meadow and Park View. Links to scheme 1.	LBH	Q2	Q4
Scheme 6: Living well with dementia.				
6.1	Develop training for care homes in how to manage people with challenging behaviours. Links to scheme 5.	LBH	Q3	Q4
6.2	Enable people living with dementia to continue to live independently in our community and feel supported and knowledgeable about where to access advice and help when required.	LBH	Q1	Q4
6.3	Develop a dementia befriending service.	H4All	Q1	Q4
Scheme 7: Integrated therapies for children and young people				

7.1	Implement the integrated therapies pathway model.	LBH	Q2	Q4
Scheme 8: Integrated care and support for people with learning disabilities and/or autism.				
8.1	Regularise current operational case management arrangements.	LBH	Q1	Q3
8.2	Deliver a model of care and support for people with learning disabilities and/or autism who are in a supported living setting that maximises their independence and supports their health and wellbeing.	LBH	Q1	Q2 20/21
8.3	Implement the action plan from reviews completed between health and social care under the Learning Disabilities Mortality Review Programme.	HCCG/LBH	Q1	Q4
8.4	Agree *'to be'* integration model.	LBH	Q3	Q4