**Annex 2**

# 2020/21 BCF Delivery Plan Priorities Summary

## 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.

1.2 Explore the increased application of assistive technology to support the independence of residents in the community.

1.3 Review the model of voluntary sector support for adults to improve options for social prescribing, including through provision of Personal Health Budgets.

1.4 Align the eight Neighbourhood Teams to the six Primary Care Networks (PCNs) across the borough.

1.5 Embed the integrated shielded and vulnerable person management function with all partners to ensure that applicable residents have one personalised care plan and one key worker across health, social care and the voluntary sector.

1.6 Develop an integrated response hub with a range of primary and community-based health and social care services that can respond within 2 hours to a person experiencing deterioration and at risk of an emergency hospital admission.

## Scheme 2: An integrated approach to supporting Carers.

2.1 Ensure that the identity of the Carers' lead in each GP Practice is clearly displayed.

2.2 Develop a guide for people who suddenly become Carers.

2.3 Develop and implement a strategy for addressing identified barriers to screening uptake amongst Carers and the people they are caring for.

2.4 Support access to primary care by piloting a darsi/farsi speaking interpreter in the south of the borough where there is greatest need.

2.5 Co-design information for children with learning difficulties and/or autism and their families, including Easy to Read guidance on accessing the health service appropriately.

## Scheme 3: Better care at end of life.

3.1 Improve access and co-ordination for end of life services, managed under an integrated management function.

3.2 Improve access to medication that can help patients coming towards the end of life if their condition deteriorates or symptoms suddenly occur.

3.3 Deliver family support, education and workforce development to enhance palliative care expertise across the Hillingdon health & care workforce and improve end of life support to Carers.

**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.

4.2 Establish a point of coordination within Hillingdon Hospital for hospital discharges.

4.3 Establish a point of coordination for access to community resources to build up suitable packages of care and support.

4.4 Develop and implement pathways with inclusion criteria that support the discharge of patients on pathway 2.

4.5 Develop and implement the standards for the triaging process, including the automation of data reporting.

4.6 Agree a simplified joint assessment for patients on all discharge pathways.

4.7 Review all specialist pathways to include Frailty, End of Life and Palliative Care to ensure these are aligned to the integrated discharge model.

4.8 Seek organisational sign-up to the CHC, shared care and section 117 memorandum of understanding.

4.9 Ensure availability of sufficient step-down/step-up provision (bedded and non-bedded) to meet winter demand surge requirements.

**Scheme 5: Improving care market management and development.**

5.1 Develop and deliver a provider engagement plan.

5.2 Secure agreement on long-term integrated brokerage arrangements.

5.3 Implement the Direct Enhanced Service (DES) contract for care homes.

5.4 Explore scope for extending the local Care Home and Extra Care Support Service to all supported living schemes.

5.5 Coordinate access to Covid-19 testing for care providers.

5.6 Coordinate response to Covid-19 outbreaks within care homes and supported living services.

5.7 Establish and implement lead commissioning arrangements to address care home placement requirements of local statutory agencies.

5.8 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.

**Scheme 6: Living well with dementia.**

6.1 Develop training and support for care homes in how to manage people with challenging behaviours.

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.

6.3 Restore dementia diagnosis rates to the national target of 67%

**Scheme 7: Integrated therapies for children and young people**

7.1 Implement the integrated therapies pathway model.

7.2 Develop Children and Adolescent Mental Health Services (CAMHS) early intervention model within all neighbourhood teams.

7.3 Develop provision to deliver more services in the community (Step-up/down) via new PATCH (Providing Assessment & Treatment for Children at Home) model of care.

**Scheme 8: Integrated care and support for people with learning disabilities and/or autism.**

8.1 Develop an agreed integrated model for a community team for people with learning disabilities.

8.2 Implement the 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.

8.3 Implement the action plan from reviews completed between health and social care under the Learning Disabilities Mortality Review Programme.