BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this template.

Cover

London Borough of Hammersmith and Fulham

Health and Wellbeing Board(s)

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

We have worked with partners to develop a plan built on shared outcomes and a commitment to build on learning from the last year across borough-based partnerships, 3rd sector, providers of Health and social care and residents. Pooled budgets have ensured that we work together not only to improve hospital discharge but to address health inequalities across the health and care system. The planning templates have been completed with input from the NWL local care team. NWL Local care team has engaged with system partners for completion of relevant sections of the template. For H&F, local system partners are: Imperial College NHS Trust, Chelsea & Westminster NHS Trust, Central London Community Healthcare NHS Trust, West London Trust, Central and North West London NHS Foundation Trusts and

How have you gone about involving these stakeholders?

This submission has been discussed at the H&F BCF Review meeting

Agreed by the Adult Social Care Leadership Team – lisa.redfern@lbhf.gov.uk

Retrospective sign-off by Health and Wellbeing Board in September 2022 lisa.redfern@lbhf.gov.uk

The H&F HCP executive leadership has reviewed and signed off the BCF plan. H&F HCP Executive group members are: CLCH NHS Trust Director, West London NHS Trust Director, LBHF Strategic Director, Primary Care Lead, PCN representative, NWL CCG Inner London cluster COO, NWL CCG H&F Borough Director.

HCP Operational Leads Group: Operational Lead representatives from
NHS Trusts: CLCH, ICHT, ChelWest, WLT
Primary Care: PCN CDs
Social care- adults and children's
Voluntary sector and patient reps- SOBUS, lay reps, HealthWatch
NWL ICB: H&F Primary care team and H&F Integration & Delivery team

Executive summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

Key Priorities

- Doing things with residents not to them. This will mean local people are fully involved in the service design, delivery and evaluation, using a “strength based” approach to health and care.
- Learning from Covid -19. Our plans being developed will consider the latest data and local intelligence to inform delivery so to reduce inequalities in our communities This has informed our approaches to vaccinations, we are also working with communities about health inequalities specifically how we build trust with Black communities
- We remain committed to preventative and reablement services. We will ensure people have improved outcomes and independence and are empowered to meet their own health and care needs through the use of a therapeutic model so need to increase or at least maintain investment in our Community Independence service model.
- Reduction of length of stay in hospital for residents who no longer require clinical support. Continued investment in step down facilities that support hospital discharges including step down for patients with Mental Health needs.
- Market sustainability. We will need to ensure the acute and primary healthcare sectors are adequately supported by the care marketplace, including appropriate skills to support the changing needs of residents
- We support and value our local carers, including young carers. The mental health and well-being need of local carers are met by recognising the impact of caring on people’s health and long-term care needs and that young carers are fully supported into adulthood.

Metrics

- No residents discharged from Hospital into residential care
- Reduction in number of people requiring home support following reablement
- Reduced length of stay of 14 days and 21 days
- Discharge to P3 bed within 48hrs of EDD
- Reducing avoidable admissions via A&E
- Increase Carers identified and supported

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

Send in draft plans by 18 August (this is optional, but strongly recommended)

Final, signed off plans by 26 September

Approval letters back by 30 November

S75s to all be signed by 31 December

Governance Steps and Timelines for 22-23 BCF Plan & Template Submission

Agreement of Consolidated 22-23 BCF Pooled Budgets

LA Director Approval & Sign-off SLT Management Meeting

HWBB Chair Approval & Sign-off CMB (Joint but LA Lead)

ICP Board Group Oversight & Sign-off (Joint but CCG Lead)

Following Submission

HWBB Meeting Retrospective Rubber stamping

Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.

How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

All the partners in our H&F ICP are committed to a shared purpose, building on the shared commitment to collaboration to meet the health and wellbeing needs of residents in Hammersmith and Fulham. We will do this by building a deep 'person centred' understanding of the health and care needs in each neighbourhood, co-producing with our residents and working together to improve services in the knowledge that we are better together than individually.

As a partnership we have also agreed to a set of shared principles:

Reducing inequalities and contributions to Population Health

Reducing Inequalities and using a Population Health Management (PHM) approach to underpin all decisions

Delivery of Vaccine programme, hesitancy and Post Covid care

Primary Care Networks (PCN) development and integration of neighbourhood teams

Development of PCNs and reducing variation in PC

Integrating and organising teams at neighbourhood level, to support complex care and frailty, having a strength-based approach to supporting individuals and families

Keeping people out of hospital, standardisation of services

Diabetes – achieving new specification to improve health

Community Mental Health – deliver new community model and NWL access standards

Dementia - improving our diagnosis rates in Hammersmith and Fulham as part of our co-produced Dementia Strategy

We have joint multi-disciplinary teams (MDT) with PCN's already in place for frailty, these have been happening throughout Covid and have provided a valuable communication and shared learning of each other's ways of working.

We have reviewed discharge pathways together with PCN, Social Care Trust and community health colleagues incl. commissioned providers of care. This has enabled safer quicker transfer of care for patients.

Working with acute Colleagues we meet weekly to reduce length of stay and overcome any blockages for discharge.

We have joint commissioning plans for step up and step-down beds to support hospital admission avoidance and reduce length of stay (LOS).

We are also looking at opportunities to co-commission services for people with learning disabilities (LD) and mental health (MH) patients support in a shared care environment, to enable people to be re-abled, and gain stability in their lives.

Hammersmith & Fulham (H&F) is going out to re-procure our Home Care and independent Living service in the Autumn of 2022 and providers carers are expected to carry out a range of health-related task around assistance with medication and low-level healthcare needs, including administrating and prompting. In addition to these, the following healthcare interventions may be required of a Home Care and Independent Living carer:

- Immunisation reminders and support to book these if necessary - Supporting Public Health messages around recommended vaccinations and supporting residents to engage with these.
- Assistance with eye drops / ear drops - Supporting self-administration and some assistance with administration - Support for residents if needed and appropriate equipment is available.
- Temperature and blood pressure taking support
- Medication assistance
- Topical application of medication - Supporting self-administration and some assistance with administration
- Pressure ulcer care (grade 1) and pressure area monitoring - Monitor skin integrity and escalate to relevant professionals as required
- Simple stoma care - Only with support from District Nursing
- Simple wound care - Only with support from District Nursing
- Eating and drinking therapy - As part of self-care programmes
- Blood glucose monitoring - Only with support from District Nursing
- Domiciliary foot care - As instructed by clinical teams

Extensive training will need to be made available by community health Service Providers prior to the implementation of any health task to ensure Home Care and Independent Living carers are skilled and confident to undertake the above.

The joint work also creates a new career structure for care workers and professionalises the work, which we envisage will reduce workforce shortages.

Given the joint objectives being achieved through the delivery of homecare in H&F we will be look for an increase in the BCF funding to support this.

Approach to Joint/Collaborative Commissioning

As in previous years we have a range of Section 75 schemes that the CCG and local authority are collaboratively commissioning to support meet the health and care needs of the population of Hammersmith and Fulham. These include the following schemes to facilitate timely discharge of patients from hospitals:

- Jointly commissioned nursing and social care beds in two nursing homes
- Homelessness support services
- Reablement services
- Mental Health hospital liaison service
- Community Independence service
- Stroke Early supported discharge service
- Open Age "Steady & Stable" - Falls Prevention Service.
- Red Cross Service

In addition to these schemes we have the following jointly commissioned schemes that promote the health and wellbeing of our residents, promote independence and support them to remain in their normal place of residence; thereby reducing the hospital attendances and length of stay in acute settings:

- Joint funded care package and placements for LD clients
- Joint funded mental health placements
- Joint funded direct payments and personalised health budget clients
- Jointly funded community equipment contract
- Carer's advice and support services
- Safeguarding services

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

Integrating Care Around the Person

H&F vision for health and care integration is to create a strong, sustainable, person-centred, and integrated health and care system, which improves outcomes for our residents. Our model of care is designed to:

- Deliver more care outside of hospital.
- Develop an independent living service, which gives people real choice through direct payments
- Provide integrated, personalised, and holistic services.
- Help residents, carers and professionals work hand in hand to maintain health, wellbeing and independence, for as long as possible.
- Person Centred Approaches: Promoting Choice, Maximising Independence
- Integrated approaches
- H&F integrated reablement working alongside and rapid response service has a joint holistic person-centred assessment which directs joint care planning and delivery across community nursing and adult social care.
- Promoting Personalisation, Choice and Independence
- H&F's model of integrated health and care is designed to offer more choice and personalised care planning via:
- Improving access to information and advice to all our diverse communities
- The delivery of improved person-centred care planning in neighbourhood teams,
- supported by a strong platform of social prescribing, including face to face support from local teams
- The home first philosophy, promoting maximum reablement opportunity at home
- The development of a Carers Strategy which acknowledges and values the role of informal carers
- Creation of step up and step-down opportunities as an alternative to hospital admissions
- Support to residents and their families at end of life
- Increased capacity for AMHP at A&E to speed up access when needed
- The use of Disabled Facilities Grant to promote independence and allow people to maintain family links where possible.
- Creative use of technology to enable people to remain at home and feel safe.
- Working with acute Colleagues we meet weekly to reduce length of stay and overcome any blockages for discharge.

Delivery of joint Health and Care :

- We have joint MDT with PCN's already in place for frailty, these have been happening throughout Covid and have provided a valuable communication and shared learning of each other's ways of working.
- We have reviewed discharge pathways together with PCN, Social Care, Trust and community health colleagues including commissioned providers of care. This has enabled safer quicker transfer of care for patients.
- Working with acute colleagues (Imperial & Chelwest) we meet x3 per week to reduce length of stay and overcome any blockages for discharge.
- We have joint commissioning plans for step up and step-down beds to support hospital admission avoidance and reduce LOS.
- We are also looking at opportunities to co-commission services for people with LD and MH patients support in a shared care environment, to enable people to be re-abled, and gain stability in their lives.

High Impact Change Model self-assessment:

- **Early discharge planning: Established**

Local acute trusts have implemented choice policy of which step 1 includes all patients to have EDD on admission, recorded on patient record system and information provided to patient/carer. Discharge hubs in place to support discharge planning and facilitate timely transfers out of acute settings.

- **Systems to monitor patient flow: Established**

A&E Delivery board framework and urgent care working group well established. H&F LA are developing AI and dashboards which will further enhance the local ability to monitor patient flow in real time. Local Acute trust to introduce new digital solution to monitor real time bed state, Red/Green and ELoS patients to improve management of patient flow.

- **Multi-disciplinary/Multi-agency discharge teams: Mature**

This has remained a multi borough approach within inner London cluster through well-established discharge hubs. The discharge hubs include VCS (British Red Cross, Hospital to Home Service), Social Care, Acute and community services. Hospital social work services work 7 days a week which contribute to the MDT discharge processes. H&F commission British Red Cross to support discharge of patients from hospital to home.

At a North West London level, a NWL Discharge Steering Group with membership from all trusts, Local Authorities and wider partners meets fortnightly to review progress against plans, with a monthly focus on operational performance including LoS, delays etc.
Ageing Well funding has been allocated to bolster the staffing levels and leadership of the integrated discharge hubs (one per acute site), including working 7 day working. These discharge hubs include clinicians which provide the "check and challenge" around discharge pathways - ensuring the patient is on the right discharge pathway.
There are also weekly DASS meetings and NWL meetings to look at all matters relating to hospital discharges.

- **Discharge to assess: Mature**

Discharge to Assess (D2A) Pathways are mature and business as usual. D2A implemented to ensure, where possible, patients are discharged home, with support, for assessment of their long-term needs. The expectation is that discharges home will be the default for the majority of patients and there will be less reliance on interim placements and a reduction in residential placements. It also supports the ongoing work programme to reduce the number of DSTs being completed in hospital through the Discharge to Assess Care pathways.

There is a Home First service in place that covers the three inner London boroughs (Hammersmith & Fulham, RBKC and Westminster). At a local level, working with acute colleagues (Imperial & Chelwest) we meet x 3 per week to reduce length of stay and overcome any blockages for discharge
We have reviewed discharge pathways together with PCN, Social Care, Trust and community health colleagues including commissioned providers of care. This has enabled safer quicker transfer of care for patients.

It is also vital to note that there in noticeable increase in the need for double handed care package for patients being discharged from hospital settings. This is linked to increased demand and patient acuity.

- **Seven-day service: Established**

Hospital social work services work 7 days a week to support discharges. Seven-day service already happens for discharges and some step-up services. Further work is underway through the ICP to identify support at PCN levels.

- **Trusted Assessors: Established**

Trusted assessor within block contract interim beds rolled out to reduce LoS. More work required with OT's/ acute and community and residential and nursing homes

- **Focus on choice: Established**

Local system acknowledges that D2A must be resident/ patient led for it to be successful. Principles of coproduction embedded within all service developments in H&F at both design and delivery phases. Direct payments and Home care are a major focus. Local acute trust due to implement choice policy.

- **Intermediate Care Services**

Please see attached Capacity & Demand template for details on H&F's intermediate care capacity and demand plans. In summary, we have invested over £6.2 million in 22/23 on intermediate care services in H&F.
More than half of this funds the Community Independence Service (CIS) which is an intermediate care service providing advanced short- term nursing care, occupational therapy, physiotherapy and social care to people with immediate health or functional needs, who would otherwise require an admission to hospital. The service aims to offer safe care at home which enables people to avoid unplanned hospital admissions.

CIS consists of four teams:

Rapid Response: For urgent same day response within 0-2 hours for people with immediate health or functional needs who would otherwise require an admission to hospital (input for up to five days).

Home First: Working with acute hospitals to facilitate supported discharge for medically stable patients into the community. People can be assessed in their own home on the same day. (Input for up to 72 hours)

Rehabilitation: The rehab pathway helps people maintain or regain their independence at home to enable people to live well in their own homes, completing roles and tasks that are important to them with as much independence as possible. The majority of people will be seen within 48hours, with non-urgent referrals assessed within 14 days. (Input for up to six weeks)

Reablement: Services are provided in the home to help a person gain confidence and re-learn skills to carry out daily activities and practical tasks. (Input for up to six weeks)

The other intermediate care services that we commission are:

Community Neuro rehabilitation
Intermediate care beds at two units (Alexandra and Athlone)
Beds in Nursing home with funded nursing care contribution and reablement support
Intermediate care spot placements

Supporting unpaid carers.

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

H&F has a statutory obligation to offer a Care Act 2014 Carers Assessment to any adult carer with needs that arise as a consequence of providing necessary care to an adult, which result in deterioration in the carers physical or mental health, where the carer is 'unable' to achieve any of the key outcome defined the care act and as a consequence, there is or is likely to be a significant impact on the carer's wellbeing.

H&F is working in partnership with The carers Network, a third sector organisation, to ensure we provide carers assessment to all identified unpaid carers and provide them with financial support to prevent carer breakdown.

H&F also make provision for carers breaks to support as an outcome to carers assessments.

We are in the process of developing a joint carers strategy as part of the Better Care Fund.

Disabled Facilities Grant (DFG) and wider services

DFG will continue to support adaptations in a timely manner to support residents' discharge. Significant work continues across the Council to secure Occupational Therapists to work in aids and adaptations.

There is an ongoing programme to log all adapted properties and ensure that they are used to their maximum potential.

Development of extra care Housing scheme in white city in 2022 will release units for step down reablement flats, this will support people with complex needs to be assessed in an out of hospital provision, before decisions are made as to their next move. In addition, these flats will have digital equipment to support residents in maintaining their Health & wellbeing.

For residents pending discharge who require micro living arrangements and equipment we have used the DGF to be able to put in place temporary solutions including smart tech to facilitate the discharge.

We continue to work with housing colleagues to identify opportunities to develop step down facilities, an example of this is voids in extra care have been adapted with DFG and technology to support people to step down from Hospital. These are available for this winter

We have a specialist Housing board which has nominated partners attending to identify the needs and demands of adapted properties and plans for whole lifetime housing options for people 16 years and above.

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

We look to revamp a specialist housing board comprising key stakeholders that can help take a fresh look at how to best use our collective housing stock in alleviating pressures faced by our all organisations in our partnership and focus on using housing to improve the quality of life and wellbeing of our residents.

Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

We need to change the way we commission and provide services, with a renewed focus on reducing health inequalities at the centre of everything we do; addressing inequalities under Core20PLUS5, which focuses on the most deprived 20% of a population, the ICS-identified groups in each area that experience poorer than average access and five additional areas of focus. This includes:

• Proportionally targeting our resources to match the needs of individuals and communities to reduce the gap in life expectancy and to increase the quality of life, ensuring resources and delivery are in line with need, which may result for example in increasing resources for providers in more deprived areas in comparison to less deprived areas;

• Having robust mechanisms to reach, hear from and better understand people and communities' experiences.

To work with individuals and communities to reduce the effect of the cost-of-living crisis, especially on people who are already have physical and mental health needs

• Ensuring services are informed by both peoples' and communities' needs and assets.

• Connecting our knowledge of local health inequalities with front-line service delivery,

• Acting for people from pre-conception to after-death. Starting well and ageing well.

The focus in our BCF for 22-23 will be greater emphasis on improving peoples home environment, through DFG, equipment, technology.

Greater support for people who have mental health needs, either to prevent discharge, ensuring resident voices are heard during discharge and as part of support planning. We are also looking at step down opportunities for people.

Increasing the knowledge and skills of staff in relation to cultural competence and how to ensure MDT's are person centred, especially when looking at length of stay and delivery of personal care.