HM Government

NHS England

BCF narrative plan

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. Although the template is optional, we ask that BCF planning leads 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 25 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.

Cover

Health and Wellbeing Board(s).

London Borough of Hammersmith & Fulham

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

We have worked with partners within Hammersmith & Fulham Health and Care Partnership HFHCP (our borough-based partnership) to develop a plan built on shared outcomes and a commitment to build on learning from the last year. 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.

In Hammersmith & Fulham we have seen an increase in demand around discharges, particularly with increased demand for health and care services to enable residents to remain at home. Acuity of needs also means that we will need to seek further capacity to meet demand. Our Home Care and Independent Living service that went out to tender last year will be awarded this year with the new service starting in October 2023. It will focus on improve the quality of care for our residents by increasing the number of geographical patches from three to six smaller patches to improve punctuality and carer consistency. We have also explored the geographical patched aligning with the Primary Care Network boundaries as best as possible. Health-related tasks carried out by home care independent living workers with remain a key feature within the new service. The health-related tasks play a key role in helping to maintain our residents & patients' baseline, helping them to live longer in the community as well as prevent higher levels of hospital re-admissions. This is an area we think will require further investment

How have you gone about involving these stakeholders?

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 (ICHT), Chelsea & Westminster NHS Trust (ChelWest), Central London Community Healthcare NHS Trust (CLCH), West London Trust (WLT), Central and North West London NHS Foundation Trusts (CNWL) and LBHF. DFG and Housing leads have been involved in the BCF planning; the discussions around this has been at the H&F Adult Independent Living Steering group.

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

Agreed by the Adult Social Care Leadership Team

Signed off by the Chair of the H&F Health and Wellbeing Board on xxx.

Will be retrospectively signed-off at the next Health and Wellbeing Board in September 2023

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

The Plan has also been shared with HFHCP Operational Delivery Group whose representatives include:

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

Operational and/or BI teams from Imperial College NHS Trust (ICHT), Chelsea & Westminster NHS Trust (ChelWest), Central London Community Healthcare NHS Trust (CLCH), West London Trust (WLT), Central and North West London NHS Foundation Trusts (CNWL) have supported with completion of metrics tab, capacity and demand tab and the scheme outputs on the expenditure tab of the BCF Planning template.

Governance

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

Plan discussed and jointly agreed by the ICB and LA at monthly BCF review meetings.

Plan presented to the Health and Care Partnership Operational Group for review and comments.

Plan signed off by the Health and Care Partnership Executive Group.

Delegated sign off by the chair of the Health and Wellbeing Board prior to plan submission.

Formal sign off at the next Health and Wellbeing Board on 20th September 2023.

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

- "Doing with residents not to them" remains a key priority for H&F. This will mean local people are fully involved in the service design, delivery and evaluation, using a

"strength based" approach to health and social care. (Our Homecare and Independent Living Service tender involved a resident evaluator to ensure that resident voice was consistent through the evaluation process).

- Working with our housing department and Registered Providers to ensure that our vision for Independent Living is achieved across systems. We have developed a Housing for Independent Living Board, led by housing to ensure that there is governance around a systems approach to improving outcomes for residents. Workstream membership includes carer, parent carers, colleagues from health, employment, transitions to adulthood and social care.

- We remain committed to preventative and reablement services. We will ensure that people have improved outcomes and independence and are empowered to meet their own health and care needs through the use of a therapeutic model. We will maintain our investment in the Community Independence Service Model.

- Reduction in length of stay in hospital for residents who no longer require clinical support. Continued investment in step down facilities that support hospital discharge. Review of mental health community provision with health partners to assess what the are barriers to discharge from acute mental health beds and how community provision can support.

- Market sustainability. We have developed a Market Sustainability Plan which will ensure that the acute and primary healthcare sectors are adequately supported by the care market place. The key priorities of this plan are: improving the quality of care provision, ensuring an adequate supply of care, workforce development, strategic partnering and managing the rising demands of inflation.

- We support and value our local carers, including young carers. We have a commissioned Carers Hub for adult carers and a new young carers offer has been launched with a universal and enhanced offer to support varying need levels. We are coproducing a joint Carers Strategy that will align with our vision for Independent Living in Hammersmith and Fulham to ensure that there is parity and consistency across our services.

- Bedding in our new joint equipment service which has only recently transitioned over to a new service provider remains a priority for us given the key role equipment has to play in enabling swift but safe hospital discharges and helping residents to live independently for as long as possible in the community whilst reducing the risk of re-admission.

Metrics

- No residents discharged from Hospital into residential care permanently
- Reduction in the number of residents in out-of-borough placements
- Reduction in number of people requiring home support following reablement

- Reduced length of stays of 14 days and 21 days
- Discharge to P3 bed within 48hours of EDD
- Reducing avoidable admissions via A&E
- Increase in number of carers identified and receiving support

National Condition 1: 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 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

All partners in our H&F Health and Care Partnership are committed to a collaborative approach to improving the health and wellbeing of residents in Hammersmith and Fulham. We have agreed six overarching, long-term priorities that we are working on as a partnership:

1. Supporting people to stay well as long as possible
2. Supporting people with mental health needs
3. Developing the partnership (including PCNs)
4. Supporting people who are living with an illness
5. Supporting people suffering with or recovering from Covid-19
6. Identifying and addressing health inequalities across our borough

As a partnership we have agreed to a set sub-priorities that will support delivery of the 6 overarching priorities:

- Frailty - improving our dementia diagnosis rates in Hammersmith & Fulham as part of a shared (health, local authority and third sector) Dementia Partnership Board (DPB) which oversees the delivery of the co-produced Dementia Strategy. The formation of the joint Dementia Diagnosis Working Group which reports into the DPB will improve awareness across the system of the pathways to diagnosis and improve rates.

- Tackling inequalities and using a Population Health Management (PHM) approach to underpin all decisions. A listening exercise in 2022 identified the following specific priority areas to address health inequalities: improving life expectancy for the 20% most deprived; increasing hypertension case finding; supporting mental health and wellbeing, post lockdown; reducing dental decay and improving oral health; ensuring fair access to services by equalities groups, refugees etc.

- Reducing variation between PCNs.

- Mental Health – delivering a new community model and NWL access standards. We have launched a join Mental Health Campaign that focusses on addressing the shared commitments set out in the NHS Long Term Plan.

- Keeping people out of hospital, including through a standardisation of services.

- Community-based specialist palliative care that aims to make sure people get the right care at the right time, by the right team in the right place. It also aims to ensure that patients with a life limiting illness, their families, carers and those important to them have equal access to high quality community-based specialist palliative and end of life care and support that is sustainable and coordinated, and which from diagnosis through to bereavement reflects their individual needs.

Additional areas of focus include:

In response to the Fuller report we have worked collaboratively with partners to strengthen multi-disciplinary teams (MDT) within PCNs for frailty with dedicated geriatricians and senior social workers now aligned to each PCN. Working with acute colleagues we meet weekly to reduce length of stay and overcome any blockages for discharge.

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.

In H&F, through a revamp Adult Independent Living steering group we continue to develop and oversee the improvements in the range of services and support available for young adults transitioning from Children's Services and for all adults with learning disabilities, with mental health issues and for those with autism. There are a number of key work stream that feed into this steering group, housing being a very important work stream. Work stream membership includes carer, parent carers, colleagues from health, employment, transitions to adulthood and social care.

The HCP has identified 3 key new priorities for 23-25:

- Access to health and care services – improve patient experience and satisfaction of access to health and care, support PCNs to develop at scale solutions to meet demand for same day care and manage patients with low complexity.

- Integrated Neighbourhood Teams –in response to the Fuller Report to support our complex patients, through proactive planning and delivery, enabling early intervention and prevention and reduction in escalation of need.

- Tackling health inequalities and implementing a population health management approach – identify priorities and campaigns, ensuring that reducing inequalities is at the centre of all we do, monitor the various inequalities initiatives within the borough, ensure use of data intelligence and PHM approach is embedded.

Approach to Joint/Collaborative Commissioning

H&F has commenced the re-procurement of our Home Care and Independent Living Services and the plan is for the new service to be mobilised by June 2024. As the new service will address joint objectives and help to relieve pressures on hospital discharge we plan to continue using the BCF to support this area. BCF funding ensures we maintain sufficient supply of home care with H&F to sustain rapid discharge from hospital back into the community. Our health colleagues also have a bridging service in place. Our Independent Living Workers are expected to carry out a range of health-related tasks, these include:

- Immunisation reminders and support to book these if necessary – Supporting Public Health messages around recommended vaccinations and support residents to engage with these.
- Assistance with eye drops / ear drops - Supporting self-administration and some assistance with administration, if needed and appropriate equipment is available.
- Support with taking Temperature and blood pressure
- 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

We have a range of Section 75 schemes that the local authority and ICB are collaboratively commissioning to support the health and care needs of the population of Hammersmith and Fulham:

- Jointly commissioned nursing and social care beds in two nursing homes
- Homelessness support services
- Mental health hospital liaison service
- Community Independence Service

- Stroke early supported discharge service

- Open Age “Steady & Stable” – Falls Prevention Service.

- British Red Cross Service supporting both discharge and prevention of admission

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:

- Jointly funded care package and placements for LD clients

- Jointly funded PFI care home beds

- Jointly funded PFI extra care scheme

- Jointly funded mental health placements

- Jointly funded direct payments and personalised health budget clients

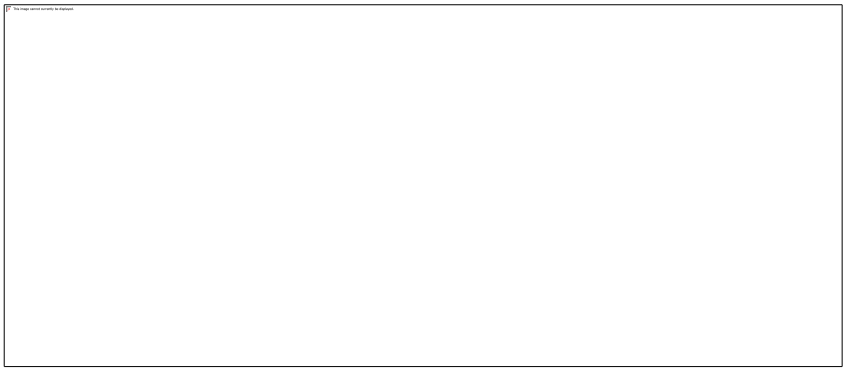
- Jointly funded community equipment contract

- Jointly funded Carer’s advice and support services

- Jointly funded safeguarding services

Ageing well

Ageing well funding was provided to deliver the broad objectives of the national programme, which related to improving and investing in NHS community services. The specific priorities below align to the objectives of the BCF providing admissions avoidance support and support to discharge. Systems also had flexibility to utilise funding beyond these categories in support of aligned services/priorities specific to individual boroughs



Safeguarding :

Safeguarding Children: Contribution to the BCF and is intended to protect the health, wellbeing and human rights of children and young people subject to, or at risk of, abuse.

Safeguarding Adult: Contributes to the BCF supports and is intended to protect adults at risk of abuse or neglect

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

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 using a therapeutic approach, wrap-a-round care which reables residents helps to avoid hospital re-admissions.

- Develop an independent living service, which gives people real choice through direct payments. Independent Living Worker are being encouraged to think in a reabling way.

- 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 the rapid response service enables a joint holistic person-centred assessment which informs joint care planning and delivery across community nursing and adult social care.

- 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,

    - Being 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 a Frailty Campaign in place which has the following key priorities:

1. Review and strengthen MDT Models
2. Integration of End of Life & Palliative Care Services
3. Further integration of mental health /social/physical interface in frailty
4. Data/Metrics (exploration of WSIC frailty dashboard and how it can inform areas of focus to improve patient care)

The expected impact from this campaign will be improved care of frail elderly in the community through improving integration between NHS Services & Local Authority services. There is particular focus on reducing duplication where there may be social care and health care visits to the same patient. In addition we are developing a service directory to improve

signposting to health, social care and voluntary sector services. There is a focus on dementia- , improving the awareness across the system of the pathways to dementia diagnosis and improve diagnosis rates and use data to inform areas of focus to improve patient care.

Building on what was done last year the Frailty Campaign has:

- Transitioned frailty campaign to an operational group to ensure sustainability and embed the MDT way of working as BAU across all PCNs.
- Transferred geriatrician resource to all PCNs.
- Strengthened connections with adult social care.
- Used intelligence gathered from the palliative care public engagement work to identify areas for improvement and agree priorities for delivery at borough level.
- Co-produced the EoL/ palliative care engagement strategy with lay partners & HAFSON representatives.
- Completed phase one of the engagement exercise and gathered public views on what good looks like; what is currently working; where are the gaps area and how we can improve the current service.
- Established a subgroup to improve the dementia diagnosis rate across H&F.
- Engaged with all H&F GPs to correct the dementia coding on their system.
- Created a Dementia WSIC dashboard.
- Improved the Dementia diagnosis rate from 60.4% to 61.9% (pre change of methodology).

Personalised Care and Asset-Based Approaches

Enabling resident to live well, safe and independently within the community requires close working with them to understand what their individual and community strengths are and in some cases linking them up to these. All frontline staff are training and have adapted the culture of working with residents in a strength-based way, understanding that what outcome resident are trying to achieve in order for them to live fulfilled lives free to make wishes and choices that as we do.

Vision for Independent Living

Here in Hammersmith & Fulham we want everyone to have the best possible life. We want everyone to be included. No one should be left behind. Our vision for independent living is for Disabled people of all ages to have the same rights as everyone else to live in the community how they choose. Everyone should be able to be part of and contribute to their communities. We all gain when this happens. We are committed to doing things with residents not to residents. This way we find the best solutions together. Disabled people

should be involved in all the decisions that affect their lives. With this in mind, co-production of services and local care strategies is what we do, involving residents, provider and our vibrant voluntary organisation in service development and monitoring. We remain on a journey to keep building on this.

Delivery of joint Health and Care:

- We have multiagency joint MDT with PCN's already in place for frailty, providing a valuable communication route for all partners 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.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

The Avoidable Admission 22/23 Q1-Q4 plan was calculated by reducing 21/22 Q1-Q4 Actual Observed values by 1% and recalculating the Indicator Value based on this reduced

Observed value. Please note the 21/22 Q1-Q4 Actual Observed values and Indicator methodology was produced by the BCF Team.

We are continuing a focus as a sector on improving our discharge levels and are implementing measures to improve flow by local and sector partnership working and internal improvements within trusts and our integrated care hubs. Whilst we expect some improvements, we are not making significant changes in terms capacity in out of hospital immediately, though this remains our longer-term plan.

There are a number of programmes underway which will give us increased ability to hold more complex patients within the community and therefore potentially support reductions in admissions. This work is complex and as such we do not want to overstate the potential impact. The centrally led NW London work that could impact on admissions over the next six months is as follows:

- The development of our virtual wards programme
- Continued roll out of post covid syndrome clinics
- Go live of respiratory hub-lets
- Continued work roll out of virtual monitoring
- 111/999 Push pilots with urgent community response continue

The local schemes/initiatives supporting this metric are:

- HFHCP Diabetes campaign across primary, community and secondary care for timely monitoring, management and prevention of complications.

- Promotion of vaccination programmes to increase uptake and thereby reduce complications in people with chronic cardio-respiratory conditions.

- HFHCP Frailty campaign with focus on frailty pathway to better support frail adults with chronic conditions in the community

- Integrated Rapid response service in the community to reduce conveyances to hospitals

- Multiagency prevention of admission team at front end of local hospitals to support safe transfer into community

- Expansion of acute SDEC pathways supported by successful recruitment (Imperial)

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions

- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

Where possible most people should continue to live in their own home with the clinical wraparound they need and the social care support. Only when this is not possible, should nursing and residential care be offered. However, stepdown care in homes can be invaluable before discharging someone home.

We're continuing to redesign the social care front door so that most people have a period of reablement to prevent unnecessary admission into hospital and to facilitate a speedy discharge home. We have a health and social care - strategic sub-group - Support at Home, which reports into the Frailty campaign group of the ICP.

Several local schemes contribute to reducing unplanned admissions to hospital for chronic ambulatory care sensitive conditions and include:

- HFHCP Diabetes campaign across primary, community and secondary care for timely monitoring, management and prevention of complications.
- Promotion of vaccination programmes to increase uptake and thereby reduce complications in people with chronic cardio-respiratory conditions.
- HFHCP Frailty campaign with focus on frailty pathway to better support frail adults with chronic conditions in the community
- Integrated rapid response service in the community to reduce conveyances to hospitals
- Multiagency prevention of admission team at front end of local hospitals to support safe transfer into community
- Expansion of acute SDEC pathways supported by successful recruitment (Imperial)

In addition there are centrally led NWL programmes which give increased ability to hold more complex patients within the community and therefore potentially support reductions in admissions locally:

- The development of our virtual wards programme
- Continued roll out of post covid syndrome clinics
- Go live of respiratory hub-lets
- Continued work roll out of virtual monitoring
- 111/999 Push pilots with urgent community response continue

Included within BCF is the 52 week falls prevention pathway provided by CLCH and a third sector provider (Open age steady & stable). The service provides early falls prevention through provision of exercise classes, which are clinically proven to reduce the risk of falls. Through the open age steady & stable service there is an offer of further exercise / mobility classes after the falls prevention programme which includes tai chi; zumba; yoga; chair exercises and a specific men’s exercise group.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered 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, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

In H&F, we have put in place Rapid Response services that support patients and our local acute Trusts to implement the home first approach. People are visited by health care professionals at short notice and receive an assessment by a MDT, made up of nurses, therapists and care and support workers. The care plan will include rehabilitation goals, support for carers, and any equipment which may be needed along with self-help advice. Some people have complex needs and may require longer-term care. The team carries out robust assessments, before coming to a decision, with the person and their families, to determine their long term plan of care.

Additional discharge funding will be used to increase community capacity to support discharges. We will continue investment in the following areas:

- Additional domiciliary care
- Additional step down beds
- Additional assistive care technologies and equipment in the community
- Additional resources to increase capacity of reablement service by increasing operational hours of service
- Workforce recruitment and retention including therapy staff and social workers

Please see High Impact Changes assessment and summary for details on our progress with tackling delayed discharges from hospital. In addition, our investments in reablement services and intermediate care services are aimed at supporting people to regain independence and remain longer in the community following discharge (reducing re-admissions).

Through the above broader approach, we are tackling the mix of causes of delays throughout the system. This includes improving patient flow in hospitals by identifying and

tackling process issues within hospitals that may contribute to delays, and expanding the range of NHS and social care services available to support patients outside hospitals.

Mental Health

A Mental Health working together project which is focusing on the better understanding the mental health discharge pathway and the barriers that affect the swift discharge from mental health inpatient units across northwest London. In H&F we are working through gathering and analysing the mental health data before going on to compare it with other northwest London boroughs. The view is that once we have a regional and local picture we can then begin to improve the mental health discharge pathway.

The additional discharge funding is being used to fund additional homecare and reablement capacity Interim / stepdown placements, Equipment including Telecare, Hospital and community based staffing including Advanced Mental Health Practitioner, Occupational Therapists and Social workers. Care related costs, homecare and placements are only funded from the discharge funding for limited period before social care then picks up the cost. The breakdown of the spend demonstrates we are investing the discharge funding in supporting hospital discharges.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Data available to us at the time of completing the BCF plan indicates that for most of the intermediate care services in H&F, overall we have the right capacity to meet the demand. This is supported with the evidence that system partners have not flagged issues regarding patients waiting excessively for access to bedded or community based intermediate care services. Resources have been allocated to cater for the seasonal variation in demand for intermediate care services.

One of the key areas identified has been the lack of social care input to assess and facilitate step up into intermediate care in the community. We have remedied this, by allocating additional fund towards additional social workers.

The expectation is that this additional resource along with the development of Integrated Neighbourhood Teams will enhance the seamless access to intermediate care in the community; thereby reducing urgent & emergency care presentations.

The plan is that further work on intermediate care capacity, demand and access will be carried out as part of the North West London BCF review and standardisation of BCF across North West London.

The BCF review will take into consideration where consistency with other boroughs within North West London is appropriate whilst ensuring that the specific needs of H&F's residents are addressed.

Intermediate Care Services

Please see attached Capacity & Demand template for details on H&F's intermediate care capacity and demand plans. A significant proportion of H&F's Intermediate Care spend is on 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. Most 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

Extra Care

We are also exploring the use of extra care services to support stepdown from hospital into community settings.

Reablement

Reablement as a therapeutic approach to meeting needs and preventing the escalation of needs means we remain compliant with Care Act 2014. The interface between this service and our Home Care and Independent Living service ensures that the right residents end up with the right size care package after their time in reablement.

Community Equipment

Our joint community equipment service ensures that discharge form hospital is not delayed and that residents have the right equipment in place as they are discharge to an appropriate setting.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

Reablement

Continued BCF funding for our community independence service (reablement) will ensure that we are able to offer a reabling service to every resident who is discharged from hospital with a view supporting to live independently back at their usual place of residence. Where this is not possible a right-sized homecare package is put in place to support residents and avoid hospital re-admissions.

Community provision

Where return or admission to a care home become necessary we work as one system to ensure efficient discharge back to usual place of resident with a package of care that supports residents and aims to prevent readmission to hospital. Commissioned provider as

seen as a critical part of the system, so we continue to work with providers with a few to steering the market towards supporting safe but rapid discharges from hospital setting.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

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. A new digital solution – Optica is being rolled out at Local Acute trust to introduce new digital solution to monitor daily discharge tasks across organisations. This will be accessible to local authority, community teams etc. to provide a live position of discharge status across the Local Acute trust.

- 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.

There is a monthly Tri borough discharge steering group which identifies and tackles specific pathway issues and workflows

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: Mature

Pathways for discharging residents are mature and business as usual and 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. Continuing Healthcare checklists and decision support tools are no longer completed in hospital.

There is a Home First service in place that covers the three inner London boroughs (Hammersmith & Fulham, RBKC and Westminster). Home First teams communicate daily on capacity with the acute teams and work is underway to try to make the coordination of home first

We are participating in NWL wide Discharge system peer reviews to establish consistent sets of standards and expectations across NWL - we expect recommendations on Discharge Hub workflows and discharge to assess to be a product of this.

Discharge peer reviews are underway and run to July 2023 across the 9 NW London hospital sites to undertake a holistic review of how discharge services are delivered.

In preparation for the surge in demand for hospital beds this winter, we have commenced work on developing the local operational model for a **Bridging Service**. This service will be set up on the following principles:

Timeframe: The goal is to deliver up to 5 days of care to patients ready for discharge, with a maximum of 12 hours from the point of readiness.

Care Capacity: Each day, a predetermined amount of care capacity will be available to accommodate patients ready for discharge, streamlining the process.

Assessment at Home: Patients will be assessed at home post-discharge to determine the most suitable care plan, which may include reablement, longer-term care packages, or care home placement if required.

Integration with Existing Services: The Bridging Service will seamlessly integrate with existing reablement home first services and local authority teams, promoting collaboration and coordination between care providers.

Same Day Clinical Assessment: Clinical assessments will be conducted on the same day as discharge to address patients' therapy needs promptly.

Coordination and Leadership: Effective coordination, overseen by dedicated therapy leadership, will ensure smooth transitions and continuity of care. Daily multidisciplinary team (MDT) calls have already begun to discuss patient progress and make collaborative decisions.

This bridging service would impact on pathway 1 but also avoid patients deteriorating in hospital, having complications and becoming pathway 3 patients needing complex care in care home settings later down the line.

- Seven-day service: Established

All organisations involved in discharge run a 7-day discharge service. However, we continue to see a significant drop off of weekend discharges as a NWL system.

- 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 to continue to look for way of reducing LoS.

- 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. NWL framework form discharge and choice is in final stages of sign off. Acute trusts have been implementing choice policies as per national guidance

- 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 significant amount in 23/24 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.

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

The BCF support the running of a variety of jointly commissioned services that ensures H&F continues to deliver its duties under the Care Act 2014. Notable services that supported by the better care fund are:

- Reablement
- Homecare
- Equipment
- Carers Hub – planning and support post discharge
- Care home beds
- LD placement-

Attached is a detailed table of BCF schemes that support the delivery of our duties under the Care Act 2014.

HF%20s75%20BCF%20Schemes%20from9

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 commissions the Carers Network (a third sector organisations) to provide a Carers Hub offer, to ensure we provide carers assessment to all identified unpaid carers and provide them with financial support to prevent carer breakdown.

Hammersmith and Fulham Carers Network provides the following services to adult carers caring for another adult:

- Carers assessments, support plans and indicative personal budgets
- Information, advice and guidance on a range of topics
- Signposting to other services where appropriate.
- Forging partnerships with local charities and businesses to enhance the offer to carers (including support groups and coffee mornings)
- Support grants, when applicable
- Education, employment and training advice (including workshops and activities)
- Raising awareness & outreach to maximise the number of carers identified
- Support Carers to take action and improve their wellbeing (running a quarterly Carers Forum)

We are coproducing a joint Carers Strategy that will align with our vision for Independent Living in Hammersmith and Fulham to ensure that there is parity and consistency across our services. We will work closely with third sector partners and residents to deliver this, including those not currently in the scope for adult carers services, for example those who care for children with physical disabilities, learning disabilities and/or autism. The delivery of the recommendations will benefit from our improved joint working with housing, as early engagement has shown that this is an area of focus for carers particularly for those in social housing.

We are implementing the Dementia Strategy and activities that support people who care for people with dementia. There are four key priorities areas which we will work jointly with health to achieve:

Priority 1: To obtain early and accurate diagnosis within clearly understood timeframes

Priority 2: Clear and accessible information about how to get services and support

Priority 3 :Services must meet the evidenced needs of people with dementia and their carers and families as opposed to assumed needs

Priority 4: Hammersmith and Fulham to be a Dementia Friendly Community

Day centres in the borough provide support for unpaid carers not only providing day respite for carers but also through distinct projects for carers. The newly launched 'Time Out for Carers' is an online and in person self-care programme for carers. This is in partnership with Dementia Action Alliance, H&F and Nubian Life

A new young carers offer has been launched with a universal and enhanced offer to support varying need levels. There is an extensive respite offer for young carers.

H&F's commitment to free homecare offer supports with allowing carers to take breaks in addition to the offer of respite provided through the Carers Hub.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

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 2023 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.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Click or tap here to enter text.

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

Click or tap here to enter text.

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

We have made progress to improve the way we commission service to reduce health inequalities. The Core20PLUS which focuses on the most deprived 20% of a population, the ICS-identified group 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.

Working 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.
- Building trust with BAME communities to understand their lived experiences.

To address these priority areas we have set up the following campaigns:

- Mental Health Campaign
- Diabetes Campaign
- Frailty Campaign
- Dementia Partnership Board
- Building Trust Project – tackling health inequalities through a series of community led listening projects. The projects this summer are being led by the following: Nubian Life (Older People), Age UK (Older People), Eritrean Community, MACWO (Somali)AFND/ H&F Young People, Sobus (Third Sector Infrastructure Organisation), Ase, Sickle Cell Society, Faith Group, AFND/ H&F Young People, Homeless People / Mental Health (TBC).

As a Health Care Partnership in H&F, we have agreed the following as areas of focus to address inequalities:

1) Variation in access, experience of and quality of existing health and care services; Core 20 plus 5
2) Variable support provided to improve health behaviours and enable people to live healthier lives, including effective care and support for people with long term conditions
3) Variation in wider social determinants of health and wellbeing

For all existing and newly identified relevant BCF schemes, we have adopted the following methodology to address health inequalities:

- Improvement methodology combining co-creation with our communities and continuous improvement approach
- Find areas of inequalities using quantitative data (Population Health analytics). At a minimum explore disparities in constitutional standards based on deprivation, sex, age & ethnicity.
- Qualitative data to enhance our knowledge about the problems & its causes. Open conversations with those communities & cohorts that are experiencing those inequalities.
- Collaborate with a mix of stakeholders to generate ideas about potential problems identified.
- Unite a co-design group around small subset of ideas.

Study the impact of tested ideas – both quantitative and qualitative