Annex 1

Integration Vision and BCF Scheme Summaries

A. Vision for Health and Social Care Integration

Hillingdon's vision for care and support within the geographical boundary of the borough is set out within our STP submission and this is:

Health & Wellbeing	• Working collaboratively across health, social care and public health we will improve outcomes and reduce inequalities for our population with a focus on those with both traditional Long-term Conditions (including both physical and mental health LTCs) and emergent categories of LTCs such as pain, frailty and social isolation. • Our coordinated programme of work will bring together our existing plans for the BCF and our Health & Wellbeing Strategy (HWBB) and engage our whole community to create a resilient population and assist people to remain independent with better quality of life for longer.
Care & Quality	• We will provide care that is safe, effective and delivered by experienced practitioners through collaborative working across health and social care services. • We will be able to share information that improves the quality of health and social care services and that enables our population to make informed choices. • We will deliver the best and highest quality care possible within the constraints of our local economy and the growth in demand that we are predicting.
Finance & Efficiency	• It is simply not viable to continue trying to respond to increasing demand for services, particularly at the expense of preventative action. We are committed to finding financial savings and ways to achieve better outcomes for individuals and their families through the better integration of services and by reducing demand through an increased focus on prevention and patient activation.

B. BCF Scheme Summaries

Scheme Number	Scheme Title	Scheme Aim (s)
1.	Early intervention and prevention.	To manage demand arising from demographic pressures by reducing the movement of Hillingdon residents/patients from lower tiers of risk into higher tiers of risk through proactive early identification and facilitating access to preventative pathways.
2.	An integrated approach to supporting Carers.	To maximise the amount of time that Carers are willing and able to undertake a caring role.

3.	Better care at end of life.	To realign and better integrate the services provided to support people towards the end of their life in order to deliver the ethos of a 'good death.' The main goals of the scheme are to: • Ensure that people at end of life are able to be cared for and die in their preferred place of care; and • To ensure that people at end of life are only admitted to hospital where this is clinically necessary or where a hospital is their preferred place of care or death.
4.	Covid-19 and hospital discharge	To maintain sufficient capacity within acute hospitals to provide care for people with Covid-19 who require hospitalisation and other residents with acute conditions and to achieve this by facilitating rapid discharge of people who are clinically suitable for discharge from hospitals but are unable to return to their usual place of residence or care setting.
4A.	Integrated hospital discharge and the intermediate tier.	This scheme seeks to prevent admission and readmission to acute care following an event or a health exacerbation and enabling recovery through intermediate care interventions with the aim of maximising the person's independence, ability to self-care and remain in their usual place of residence for as long as possible. A further objective of this scheme is to support discharge from mental health community beds in recognition of the impact of these delays on patient flow through Hillingdon Hospital.
5.	Improving care market management and development.	This scheme is intended to contribute to the STP 2020/21 outcomes of achieving: • A market capable of meeting the health and care needs of the local population within financial constraints; and • A diverse market of quality providers maximising choice for local people.

6.	Living well with dementia	The objective of this scheme is that people with dementia and their family carers are enabled to live well with dementia and are able to say: • *I was diagnosed in a timely way.* • *I know what I can do to help myself and who else can help me.* • *Those around me and looking after me are well supported.* • *I get the treatment and support, best for my dementia, and for my life.* • *I feel included as part of society.* • *I understand so I am able to make decisions.* • *I am treated with dignity and respect.* • *I am confident my end of life wishes will be respected. I can expect a good death.*
7.	Integrated therapies for children and young people.	This scheme seeks to: • Provide early intervention therapy services that offer early assessment and advice, support self-care and reduce dependence on services in future years. • Provide a robust integrated triage process that directs children and young people to the most appropriate therapy and support without delay. • Ensure that children and young people with physical, occupational and speech and language difficulties in the criminal justice system are offered an assessment in accordance with national guidance and good practice. • Ensure coordination between CCG, HHCP providers, education and social care in relation to Education, Health and Care Plans pathway (EHCP) and manage operational issues in relation to these plans for children and young people with highly complex needs.

8.	Care and support for people with learning disabilities and/or autism.	This scheme aims to: • To improve the quality of care for people with a learning disability and/or autism; • To improve quality of life for people with a learning disability and/or autism; • To support people with a learning disability and/or autism down pathways of care to the least restrictive setting; • To ensure that services are user focused and responsive to identified needs.