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A

Social Services, Housing and Public Health Policy Overview Committee

Date: **WEDNESDAY, 20 APRIL 2016**

Time: **7.00 PM**

Venue: **COMMITTEE ROOM 6 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

Meeting Details: Members of the Public and Press are welcome to attend this meeting

Councillors on the Committee

Wayne Bridges (Chairman)
Teji Barnes
Shehryar Ahmad-Wallana
Peter Davis
Beulah East (Labour Lead)
Becky Haggar
Manjit Khatra
June Nelson
Jane Palmer

Co-Opted Member
Mary O'Connor

Published: Tuesday, 12 April 2016

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Putting our residents first

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Head of Democratic Services
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SOCIAL SERVICES, HOUSING & PUBLIC HEALTH

To perform the policy overview role outlined above in relation to the following matters:

1. Adult Social Care
2. Older People's Services
3. Care and support for people with physical disabilities, mental health problems and learning difficulties
4. Asylum Seekers
5. Local Authority Public Health services
6. Encouraging a fit and healthy lifestyle
7. Health Control Unit, Heathrow
8. Encouraging home ownership
9. Social and supported housing provision for local residents
10. Homelessness and housing needs
11. Home energy conservation
12. National Welfare and Benefits changes

Agenda

CHAIRMAN'S ANNOUNCEMENTS

Minutes

SOCIAL SERVICES, HOUSING AND PUBLIC HEALTH POLICY OVERVIEW COMMITTEE

24 March 2016

Meeting held at Committee Rooms 6 - Civic Centre, High Street, Uxbridge, Middlesex UB8 1UW

	MEMBERS PRESENT: Councillors: Wayne Bridges (Chairman) Teji Barnes (Vice-Chairman) Shehryar Ahmad-Wallana Peter Davis Beulah East (Labour Lead) Tony Eginton Becky Haggar June Nelson Jane Palmer **Co-Opted Member** Mary O'Connor
	OFFICERS PRESENT: Shikha Sharma, Public Health Gary Collier, Better Care Fund Manager Charles Francis, Democratic Services
1.	**APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS** *(Agenda Item 1)* Apologies for absence were received from Councillor Khatra, substitute Councillor Eginton
2.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* None.
3.	**TO RECEIVE THE MINUTES OF THE MEETING HELD ON 23 FEBRUARY 2016** *(Agenda Item 3)* Were agreed as an accurate record.
4.	**TO CONFIRM THAT THE ITEMS OF BUSINESS MARKED IN PART I WILL BE CONSIDERED IN PUBLIC AND THAT THE ITEMS MARKED PART II WILL BE CONSIDERED IN PRIVATE** *(Agenda Item 4)* All items were considered in public.

6.	**SECOND REVIEW 2015/16 - SUPPORTING INFORMATION - TO FOLLOW** *(Agenda Item 5)* Shikha Sharma, Consultant in Public Health, provided a verbal report on stroke. The following points were noted: Strokes were defined as a 'brain attack' when the blood supply to part of the brain was cut off. Officers explained that blood carried essential nutrients and oxygen to the brain. Without such a blood supply, brain cells could be damaged or destroyed. The two main types of stroke were: 1) Ischaemic stroke, which was the most common type, caused by a blood clot in the brain and 2) a Haemorrhagic stroke caused by a bleed in the brain. A Transient Ischaemic Attack (TIA) was also known as a mini stroke and occurs when the brain'' blood supply is briefly interrupted. Stroke causes a greater range of disabilities than any other common condition. It can affect mobility, cognition, balance, bowel and bladder control, spatial awareness, weakness, clumsiness or paralysis; swallowing; speech and language; understanding; eyesight; recognising objects and knowing how to use them; concentration of paying attention and remembering; and difficulty in controlling emotions. In terms of those at higher risk, the following points were noted: **Age and gender:** • Men are at 25% higher risk and at a younger age than women. • Older men and women have more strokes. In the UK around 26% strokes happen in people aged under 65 and the rest 74% in people aged over 65. • Stroke occurs in a small number of children too. **Social Deprivation:** • Residents in economically deprived areas are twice as likely to suffer a stroke, have it at much younger age, and three times more likely to die from stroke **Ethnicity:** • Black people are twice as likely to suffer strokes (partly due to higher prevalence of high blood pressure, diabetes and sickle cell disease. • White people are more likely to have an irregular heartbeat, and higher prevalence of excessive alcohol use. • Bangladeshi and Pakistani men are more likely to smoke than the rest of the UK population. • South Asians are more likely to have strokes at significantly younger age than white people; and are more likely to have high blood pressure, high cholesterol and diabetes than white people. • Indian men, and Pakistani women are more than twice as likely to have to have diabetes type 2as compared to the average UK

population.

Risk Factors:

High blood pressure: is one of the main contributory factors. 54% of strokes were caused by blood pressure, which affected 12.35% of the adult population in Hillingdon. In Hillingdon, GP registers showed there were over 37,000 'recorded' hypertension sufferers, which is just over 12.3% of population. Modelled estimates suggest that in fact around 22% adults suffer from hypertension in Hillingdon..

Atrial Fibrillation: is described as the 'irregularly irregular heartbeat which increases the risk of stroke by 5 fold. Around 3,500 people in Hillingdon are 'recorded as having this condition.
Obesity: increases the risk of stroke through many mechanisms including high blood pressure, high cholesterol, sleep aponoea and diabetes mellitus. In Hillingdon 63.4% carry excess weight, out of which 23% adults are estimated to be obese.

Diabetes type 1 and type 2 double the risk of stroke. There are over 14,700 types 2 diabetes sufferers in Hillingdon, recorded on GP registers. However, the actual estimated number is over 19,000 (modelled prevalence) with the rest of the affected people not being aware of the condition.
High blood cholesterol level.Excessive cholesterol level in blood can cause narrowing of arteries, which can cause heart attack or stroke.
NHS health check is a mandatory programme commissioned by local authorities for early detection of those who might have the illness but not aware of it. 7,189 residents (aged 40 to 74) were invited to receive Health Checks provided by the NHS, ending quarter 3 - end of December 2015

Prevention
With regard to preventative measures, the best way to prevent stokes is:

- healthy eating.
- being physically active
- smoking cessation
- keeping your weight down
- and sensible drinking.

Officers provided details of the action the Council was taking locally, as well as highlighting the national campaigns which were taking place.

In response to questions from Members, Officers advised that:

- Strokes were more prevalent in economically deprived areas due to several reasons like: greater numbers of residents from ethnic minorities who are at higher risk, higher concentration of risk factors like smoking prevalence, higher rates of high BP, AF and diabetes, poor detection, poorer housing conditions and a greater number of adverse life style choices.
- The current scale of Health checks was based on a historic offer from the PCT. However this would need to be verified by the appropriate Officer Team.
- In relation to salt reduction at Fast Food outlets, Officers confirmed, that Public Health worked in partnership with the Environmental

	Health Team to scope how salt usage in Hillingdon's fast food outlets could be reduced. • The Council was exploring options to provide additional blood pressure checks at Pharmacies and Public Libraries. At present 43 out of 48 GP surgeries provided blood pressure monitoring. • Officers agreed that educating people about the risks posed by being overweight, drinking and smoking were important and assured the Committee that national campaigns such as Stoptober were promoted locally. • There was an action plan to address physical activity, including the 'Let's Get Moving' exercise referral scheme where GPs could refer patients suffering from long term conditions like high blood pressure and diabetes . In terms of the work being conducted by Adult Social Care, it was noted that Proposals to implement evidence based early identification of people with a susceptibility to stroke were being considered as part of the 2016/17 Better Care Fund Plan, which would be considered by the Health and Wellbeing Board at its meeting on the 12th April 2016. The Committee would have the opportunity to look at these proposals, as well as the detail of the proposed BCF plan at its meeting on the 20th April. **Resolved -** **1. That the report be noted.** **2. That Officers be requested to provided further information on the Lets' Get Moving Programme.** **3. That Councillors Ahmad-Wallana, Barnes and East meet with stroke sufferers at a monthly social function on 18 April 2016 as part of the evidence gathering for the review.**
7.	**FORWARD PLAN** *(Agenda Item 6)* The Committee considered the latest version of the Forward Plan. **Resolved –** **1. That the report be noted.**
8.	**WORK PROGRAMME** *(Agenda Item 7)* Reference was made to the work programme and timetable of meetings. **Resolved -** 1. **The Committee noted the Work Programme 2015/16.**
	The meeting, which commenced at 7.00 pm, closed at 7.45 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Charles Francis on 01895 556454. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

MAJOR REVIEWS IN 2015/16 - STROKE PREVENTION IN HILLINGDON - WITNESS SESSION 2

Contact Officer: Charles Francis
Telephone: x 6454

REASON FOR ITEM

To enable the Committee to gather evidence as part of their Review into 'Stroke Prevention in Hillingdon'.'

OPTIONS AVAILABLE TO THE COMMITTEE

1. Question the witnesses
2. Highlight issues for further investigation.
3. To make a note of possible recommendations for the review.

BACKGROUND

At the Committee meeting on 20 January 2016, Members discussed a number of public health topics and requested officers to prepare a scoping report on *'Stroke Prevention in Hillingdon'.*

The first witness session on 24 March 2016, provided an understanding of what strokes are and placed their prevalence in a national and local context. It also established what Hillingdon's interventions were and what work Public Health was currently doing.

This witness session will consider evidence from the Stroke Association and external experts to see how Hillingdon's approach might be improved.

INFORMATION

To assist the Committee, the following witnesses will be attending the meeting:

Shikha Sharma - Consultant in Public Health, Residents Services
Gary Collier - Better Care Fund Programme Manager, Adult Social Care
Paul Richards - Head of Green Spaces, Sport and Culture
Claire Lynch - Wellbeing Service Manager, Residents Services
Jacqui Guyett - Stroke Association
NHS Hillingdon CCG - representative to be confirmed

SUPPORTING INFORMATION

The scoping report for the review is attached as a reference document.

HILLINGDON
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Policy Overview Committee
Review Scoping Report 2015/16

Stroke prevention in Hillingdon

Aim of review

This review aims to examine what is currently being done to prevent strokes in Hillingdon and investigate best practice from both other Local Authorities and stroke organisations.

To meet this aim the following Terms of Reference are proposed:

Terms of Reference

1. To gain a comprehensive understanding of what strokes are and to place its prevalence in a national and local context.
2. To establish what Hillingdon's interventions are and what work Public Health is currently doing.
3. To gather evidence from other Local Authority Public Health Teams about what work they are doing to inform Hillingdon's approach.
4. To receive and consider evidence from stroke organisations and experts to see how Hillingdon's approach might be improved.

Reasons for the review

As per the GP data in 2014/15 there were 3,336 patients in Hillingdon who had suffered stroke. The estimated average cost to the NHS of a stroke per patient is £10,000. Approximately a third of new care home admissions are for people with first strokes, which can cost £100,000 per year for as long as the person lives.

Raising awareness of stroke prevention and learning lessons from external organisations will contribute to the Council's preventative agenda, given the long term human and financial costs associated with aftermath of stroke.

This Committee's Terms of Reference state that some of its core areas of responsibility include: Adult Social Care, Older People's Services, care and support for people with physical disabilities, mental health problems and learning difficulties, Local Authority Public Health Services and encouraging a fit and healthy lifestyle. As will be seen from the information contained below, it is clear that the implementation of the prevention agenda touches upon many areas of the Committee's remit and, therefore, is an appropriate topic for its consideration.

INFORMATION AND ANALYSIS

What are strokes?

Strokes are defined as a 'brain attack' when the blood supply to part of the brain is cut off. Blood carries essential nutrients and oxygen to the brain. Without such a blood supply, brain cells can be damaged or destroyed.

The two main types of stroke are:

1) Ischaemic stroke, which is the most common type, caused by a blood clot in the brain and
2) a Haemorrhagic stroke caused by a bleed in the brain.

A Transient Ischaemic Attack (TIA) is also known as a mini stroke and occurs when the brain'' blood supply is briefly interrupted.

Common problems after a stroke include problems of weakness, clumsiness or paralysis; swallowing; speech and language; understanding; eyesight; recognising objects and knowing how to use them; concentration of paying attention and remembering; and difficulty in controlling emotions.

What action is the Council currently taking?

Prevention: The best way to prevent stroke is healthy eating, being physically active, smoking cessation, keeping your weight down and sensible drinking.

(Local Action)

> **Healthy Eating:** Public awareness and targeted action to reduce intake of fat and salt in diets prevents risk factors like high blood pressure and high cholesterol. Hillingdon Council is implementing a project where fast food restaurants will be encouraged to reduce salt and fat in food they serve.

Smoking: Hillingdon Stop Smoking Service provides support for smokers to quit. Smoking significantly increases an individual's risk of having a stroke. Helping more smokers to quit smoking is likely to decrease the population level risk.

Exercise: Hillingdon Council's Leisure Services provides a comprehensive programme of activities to encourage people to increase their fitness levels. For most people, at least 150 minutes (2 hours and 30 minutes) of moderate-intensity aerobic activity, such as cycling or fast walking, every week is recommended. After suffering a stroke, rehabilitation and gradually increasing activity level (as per medical advice) is recommended.

Alcohol: The Council has an array of initiatives to encourage sensible drinking in the borough from licensing, support and treatment via commissioned Drugs and Alcohol services and an A&E liaison specialist. Excessive alcohol consumption can lead to high blood pressure and trigger irregular heartbeat (atrial fibrillation), both of which can increase the risk of having a stroke. Alcohol being high in calories also contributes to excess weight hence increases the risk in many ways.

Weight loss: Hillingdon Council is currently piloting weight loss services to support local residents because currently 63.4% of Hillingdon's adult population carries excess weight; and 23.3% are classified as clinically obese. Excess weight increases your risk of developing high blood pressure, high cholesterol and the risk of vascular diseases including stroke. With the majority of the adult population in the overweight bracket, effective and adequate provision for people to achieve weightloss is important for reducing the risk of cerebro-vascular disease.

(National Action)

Awareness Raising: Nationally, FAST campaign has been a hugely effective tool to raise awareness of stroke. Public Health England's (PHE) evaluation of the campaign saw a 70% rise in the number of emergency calls for stroke, meaning that 40, 000 more people got to hospital within 3 hours of their stroke symptoms starting and nearly 4,500 fewer people became disabled as a result. Figures showed that although the campaign cost £12.5m it provided a return on investment of £332.9m including a decrease in care costs and benefit to the state. Therefore, raising awareness of symptoms at population level saves lives and is cost effective.

NHS Healthchecks and Identification of risk factors: Hillingdon Council commissions the NHS Health checks programme via local pharmacists and GPs. It is aimed at the population group aged 40-74 years for identifying the risk of vascular diseases including strokes. One of the earlier studies found that NHS healthchecks averted 1800 strokes per year in England. Since then, the programme has been rolled out nationally and identifying AF (Atrial fibrillation - one of the risk factors for stroke) has been added to the programme. Checking adequate numbers of residents is likely to increase our capacity to prevent more strokes.

Regulations made in 2013 set out legal duties for local authorities to make arrangements for NHS Health Checks to be offered to each eligible person aged

40–74 years once every 5 years and for each person to be recalled every 5 years if they remain eligible so that the risk assessment includes specific tests and measurements, as well as to ensure the person having their health check is told their cardiovascular risk score and their other results.

Support Services

Rehabilitation and Community Support: Local authorities are responsible for providing care services to stroke patients and to work with NHS to prevent the risk of further harm, including risk of stroke. These services range from rehabilitation, overcoming communication difficulties, sensory loss and physical difficulties and psychosocial support. Effective rehabilitation can significantly limit disabilities.

The Committee will hear evidence on the current prevalence of stroke, prevention services and the challenges being faced. This will offer an opportunity for the Committee to consider best practice and learning from outside bodies which will contribute to ensuring that the Council is in an improved position to reduce instances of stroke and support those residents afflicted by this life-threatening medical condition.

EVIDENCE & ENQUIRY

Witnesses and timeframes

This is a two meeting review meaning that it will base its recommendations on the findings of two witness sessions. It is considered that an informal meeting taking place between a few Members of the Committee with stroke sufferers would be a useful tool to add insight and for the review. The timeline set out below will ensure that the Committee's report will be considered by Cabinet in July 2016.

The suggested witnesses for these sessions and the suggested dates are set out below:

Session Information	Suggested Witnesses
Agree Scoping Report *(23 February 2016)*	The Director of Public Health / Deputy Director Residents Services will be present at the meeting to present the scoping report
Witness Session 1 *(24 March 2016)*	▪ Representative of the Public Health Team ▪ Representative from a best practice Authority
Witness Session 2 *20 April 2016)*	▪ Representative from the Stroke Association ▪ GP Representative
Consideration of Draft Final Report *(23 June 2016)*	The draft final report will be presented by the Democratic Services Officer.
Report to Cabinet (*21 July 2016)*	

Risk Assessment

Relevant officers have been advised that this review is proposed and are aware of the possible implications on their workload.

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BETTER CARE FUND - UPDATE

Contact Officer: Charles Francis
Telephone: 6454

Appendix A: Better Care Fund Performance Report (Oct-Dec 2015)
Appendix B: Draft Better Care Fund Plan 2016-17

REASON FOR ITEM

This report is intended to establish whether the Social Services, Housing and Public Health Policy Overview Committee has any comments in relation to the Better Care Fund Plan 2016-17 and what this means for residents, the Council and its partnership with the local NHS.

OPTIONS AVAILABLE TO THE COMMITTEE

1. To note the contents of the report and the appendices.
2. To question officers on the content.
3. To make comment on the draft Better Care Fund Plan 2016-17.

INFORMATION

Background

1. The Better Care Fund (BCF) is a national initiative intended to deliver integration between health and social care in order to improve outcomes for residents. The key objectives of this initiative are that:

- Individuals with care needs receive more joined up care;
- That the independence of residents is maximised or maintained through better prevention and early intervention;
- Scarce resources are used more effectively; and
- There are joint plans with agreed priorities to achieve a greater positive impact for local people.

2. The BCF is a mechanism that is being used by the Government to implement the new integration duty under the 2014 Care Act, which came into effect on 1 April 2015. The BCF does not provide new money for Hillingdon; it is about creating efficiencies through integration to ensure that existing funding is used more effectively.

3. The Hillingdon Health and Wellbeing Board will consider the draft Better Care Fund Performance Report (Appendix A) and the Better Care Fund Plan 2016/2017 (Appendix B) at its meeting on 12 April 2016. The Social Services, Housing and Public Health Policy Overview Committee is being asked to comment on the proposed Plan.

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BETTER CARE FUND: PERFORMANCE REPORT (OCT - DEC 2015)

Relevant Board Member(s)	Councillor Ray Puddifoot MBE Councillor Philip Corthorne Dr Ian Goodman
Organisation	London Borough of Hillingdon
Report author	Paul Whaymand, Finance Tony Zaman, Adult Social Care Kevin Byrne, Policy and Partnerships
Papers with report	Appendix 1) BCF Monitoring report - Month 7 - 9: Oct - Dec 2015 Appendix 2) BCF Metrics Scorecard Appendix 3) 2015/16 Better Care Fund Plan Evaluation Appendix 4) Hillingdon Hospital Discharges Day by Day (April - December 2014/15 and 2015/16)

HEADLINE INFORMATION

Summary	This report provides the Board with the third update on the delivery of Hillingdon's 2015/16 Better Care Fund.
Contribution to plans and strategies	The Better Care Fund is a key part of Hillingdon's Joint Health and Wellbeing Strategy and meets certain requirements of the Health and Social Care Act 2012.
Financial Cost	This report sets out the budget monitoring position of the BCF pooled fund of £17,991k for 2015/16 as at Month 9.
Ward(s) affected	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

a. **notes the contents of the report.**
b. **agrees that a report on the draft digital roadmap across health and care partners in Hillingdon be brought to the July Board meeting for consideration.**

INFORMATION

1. This is the third performance report to the HWBB on the delivery of Hillingdon's Better Care Fund (BCF) Plan for 2015/16 and the management of the pooled budget hosted by the Council. The plan and its financial arrangements are set out in an agreement established under section 75 of the National Health Service Act, 2006 and approved in March 2015 by both Cabinet and Hillingdon Clinical Commissioning Group's (HCCG) Governing Body.

2. **Appendix 1** of this report describes progress against the agreed plan, including expenditure. **Appendix 2** is the BCF performance dashboard which provides the Board with a progress update against those of the six key performance indicators (KPIs) for which data is available.

3. The key headlines from the monitoring report are:

- The month 9 budget monitoring for the BCF has been undertaken jointly by the partners in accordance with the requirements set out in the s75 for the management of the pooled funds. This shows a forecast pressure of £553k against the pooled budget of £17,991k.

- There were 2,560 emergency (also known as non-elective) admissions in Q3 against a ceiling of 2,717 for the quarter, which supports the trend from Q2 and suggests that admissions prevention initiatives are having a positive effect.

- Delayed transfers of care - There were 1,369 delayed days during Q3 against a ceiling of 1,058. However, the total performance for Q1 to Q3 was 2,909 delayed days against a ceiling of 3,376. As the overall ceiling for 2015/16 is 4,790 delayed days this suggests that performance is following the desired trajectory.

- There were 25 permanent admissions of older people to care homes in Q3, which on a straightline projection would result in a total of 145 placements in 2015/16 against a ceiling of 150.

- Performance against the people aged 65 and over still at home 91 days after discharge from hospital to reablement suggests that there will be an improvement on the 2014/15 results but that the 2015/16 target may not be achieved.

- From 1st April (launch) to 31st December 2015, over 5,000 individuals have accessed Connect to Support and completed 7,900 sessions reviewing the information & advice pages and/or details of available services and support.

- In Q3 26 people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs).

- Between 1st April and 31st December 2015 343 carers' assessments were completed. On a straight line projection, this would suggest a total of 457 assessments for 2015/16, which would be 130 (40%) more than in 2014/15.

2015/16 Plan Evaluation

4. An evaluation of the 2015/16 plan using an adapted tool developed by NHSE took place on the 22nd December and included representatives from Hillingdon Hospital, CNWL, Adult Social Care, the third sector and Public Health. The results of this exercise were then tested with a broader range of stakeholders on the 9th January 2016. The general conclusion was that the plan had provided a catalyst for change by improving relationships between professions across health, social care and third sector partners and also between services. This endorses the view of officers reported to the Board's December meeting.

5. The detailed findings of the evaluation exercise are set out in **Appendix 3**, including suggestions as to how the individual schemes could be adapted to produce better outcomes for residents. Some of the key points are summarised in Table 1 below:

Table 1: 2015/16 BCF Plan Evaluation: Summary of Key Findings
What has worked well
• Commitment to work together and the acknowledgement of the importance to do so. • Closer working between health (including GPs), social care and teh voluntary sector. • Voluntary sector involvement across all schemes. • Creation of the third sector consortium, H4All (Age UK, Disablement Association Hillingdon, Harlington Hospice and Hillingdon Mind). • Creation of the Integrated Discharge Team. • Development of the Integrated Care Record and plans to share information about residents/patients across care organisations. • Falls prevention work • Joint working to support people at end of life has improved. • Primary Care Navigators (PCNs) employed by Age UK • Public Health initiatives to keep older people active mentally and physically
Areas for further development.
• Development of care home market for people with dementia and challenging behaviours. • Extending integrated care to a wider population group. • Connect between strategic and operational levels to work effectively. • Greater integration between intermediate care services. • Evidencing the delivery of outcomes for residents. • Improving the patient pathway from admission to discharge. • Using pooled budgets to improve the care experience of residents/patients with health and social care needs. • Expanding the use of trusted assessors. • Increasing awareness of Public Health wellbeing initiatives. • Reviewing inter-organisational duplication. • Pursing joint commissioning opportunities. • Improving the standard of care amongst care agencies. • Improving electronic sharing of resident/patient information across health and care organisation.

6. The evaluation matrix and suggestions from partners at the evaluation meeting for improving the effectiveness of individual schemes are set out in **Appendix 3**. These have been reflected in the proposals for the 2016/17 BCF plan contained within a separate report for the Board's consideration.

NHS Digital Roadmap

7. The December Board report was informed that NHSE required all CCGs to develop local digital roadmaps by April 2016 to detail how they will achieve the ambition of being paper-free at the point of care by 2020. The submission date for this has now been postponed to June. The intention is that the roadmap will reflect links with the Council's digital strategy to show how

technology will assist in supporting the health and wellbeing of residents and the Board is asked to approve the draft being brought to its June meeting for consideration.

Financial Implications

8. The BCF monitoring report attached as **Appendix 1** includes the financial position on each scheme within the BCF for 2015/16. This shows a forecast pressure of £553k against the pooled budget of £17,991k.

9. There is currently a pressure against both the Council and CCG's shares of the pooled funds which relates to the supply of equipment and adaptations to residents. This is a reflection that more people with complex needs are being supported in the community in line with agreed priorities. Both partners are working together to implement improvements that will enable the existing equipment budget to go further and potentially reduce the pressure.

10. There is also a pressure on the Care Act new burdens budget from the cost of providing support and care to Carers as a new responsibility following the implementation of the Act. The Council holds a contingency provision to fund pressures relating to the implementation of the Care Act responsibilities.

11. The Council has switched the funding source of Telecare equipment expenditure (£280k forecast in 2015/16) from revenue to capital to utilise the annual Social Care Capital Grant to fund this expenditure in future. This has reduced the forecast pressure by £280k from month 6.

12. Any overspends identified against existing schemes will be addressed by the Council and CCG respectively through their budget monitoring processes.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

13. The monitoring of the BCF will ensure effective governance of delivery via the Health and Wellbeing Board.

Consultation Carried Out or Required

14. The 2015/16 BCF Plan was developed with key stakeholders in the health and social care sector and through engagement with residents. HCCG, Hillingdon Hospital and CNWL have been consulted in the drafting of this report.

15. Stakeholders were involved in an evaluation of the 2015/16 plan and this is addressed within the body of this report. Please see paragraphs 4 to 6 above.

Policy Overview Committee comments

16. None at this stage.

CORPORATE IMPLICATIONS

Corporate Finance Comments

17. Corporate Finance has reviewed this report and the financial implications outlined above, noting that the budget pressure outlined within this report is reflected within the financial position reported to Cabinet on a monthly basis.

Hillingdon Council Legal Comments

18. As is indicated in the body of the report, the statutory framework for Hillingdon's Better Care Fund is Section 75 of the National Health Service Act, 2006. This allows for the Fund to be put into a pooled budget and for joint governance arrangements between the Governing Body of Hillingdon's HCCG and the Council. A condition of accessing the money in the Fund is that the HCCG and the Council must jointly agree a plan for how the money will be spent. This report provides the Board with progress in relation to the plan.

BACKGROUND PAPERS

NIL.

BCF Monitoring Report

Programme: Hillingdon Better Care Fund	
Date: April 2016	**Period covered:** Oct - Dec 2015 - Month 9
Core Group Sponsors: Ceri Jacob /Tony Zaman /Paul Whaymand/Jonathan Tymms/ Kevin Byrne	
Finance Leads: Paul Whaymand/Jonathan Tymms	

Key: RAG Rating Definitions and Required Actions		
	Definitions	**Required Actions**
GREEN	The project is on target to succeed. The timeline/cost/objectives are within plan.	No action required.
AMBER	This project has a problem but remedial action is being taken to resolve it OR a potential problem has been identified and no action may be taken at this time but it is being carefully monitored. The timeline and/or cost and/or objectives are at risk. Cost may be an issue but can be addressed within existing resources.	Escalate to Core Officer Group, which will determine whether exception report required. Scheme lead to attend Core Officer Group.
RED	Remedial action has not been successful OR is not available. The timeline and/or cost and/or objectives are an issue.	Escalate to Health and Wellbeing Board and HCCG Governing Body. Explanation with proposed mitigation to be provided or recommendation for changes to timeline or scope. Any decision about resources to be referred to Cabinet/HCCG Governing Body.

1. Summary and Overview		
	Plan RAG Rating	**Amber**
	a) Finance	**Amber**
	b) Scheme Delivery	**Amber**
	c) Impact	**Green**

A. Financials

Key components of BCF Pooled Fund 2015/16 (Revenue Funding unless classified as Capital)	**Approved Pooled Budget**	**Spend at Month 9**	**Variance as at Month 9**	**Variance as at Month 6**	**Move-ment from Month 6**	**Forecast Outturn**	**Forecast Variance**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding (including non elective performance fund)	10,032	7,686	139	81	58	10,262	230

Care Act New Burdens Funding	838	1,060	432	288	144	1,511	673
LBH - Protecting Social Care Funding	4,712	3,218	(315)	(66)	(250)	4,362	(350)
LBH - Protecting Social Care Capital Funding	2,349	1,745	(17)	(188)	171	2,349	0
BCF Programme management	60	45	0	0	0	60	0
Overall BCF Total funding	**17,991**	**13,755**	**239**	**115**	**124**	**18,544**	**553**

B. Plan Delivery Headlines

1. 1 This report includes the financial position on each scheme within the BCF for 2015/16. This shows a forecast pressure of £553k against the pooled budget of £17,991k a reduction of £403k in the forecast pressure since month 6. This partly arises from the Council having switched the funding source of Telecare equipment expenditure (£280k forecast in 2015/16) from revenue to capital to utilise the annual Social Care Capital Grant to fund this expenditure in future.

1.2 There is also a pressure of £673k on the Care Act new burdens budget from the cost of providing support and care to Carers as a new responsibility following the implementation of the Act. This pressure has reduced by £110k since Month 6 due to a revised forecast of the cost of the support to carers. The council hold a contingency provision to fund pressures relating to the implementation of the Care Act responsibilities.

1.3 There is currently a pressure of £233k against both the Council and CCG's shares of the pooled funds which relates to the supply of equipment and adaptations to residents. This is a reflection that more people with complex needs are being supported in the community in line with agreed priorities. Both partners are working together to implement improvements that will maximise value from existing spend whilst mitigating the effects of demographic change, including increased complexity of need.

1.4 There were 2,560 emergency (also known as non-elective) admissions in Q3 against a ceiling of 2,717 for the quarter, which supports the trend from Q2 and suggests that admissions prevention initiatives are having a positive effect.

1.5 During Q3 2015/16 there were 193 falls-related emergency admissions, compared to 222 during the same period in 2014/15. The trajectory for 2015/16 suggests that the ceiling of 761 may be slightly exceeded.

1.6 There are two delayed transfers of care (DTOC) indicators formally reported to NHS England:

a. The number of delayed days between when a patient is identified as medically fit for discharge and them actually leaving hospital; and
b. Delayed transfers of care from hospital (delayed days) per 100k people aged 18 +. It is this measure that enables NHSE to benchmark each area. This is calculated by dividing the number of actual delayed days by the total population aged 18 and over.

1.7 There were 1,369 delayed days during Q3 against a ceiling of 1,058. However, the total performance for Q1 to Q3 was 2,909 delayed days against a ceiling of 3,376. As the overall ceiling for 2015/16 is 4,790 delayed days this suggests that performance is following the desired trajectory. The projected outturn for the delayed transfers of care from hospital (delayed days) per 100k people aged 18 + indicator is 475.74 against a ceiling of 616.7.

C. Outcomes for Residents: Performance Metrics

1.8 This section comments on the information summarised in the Better Care Fund Dashboard (**Appendix 2**).

1.9 **Emergency admissions target (known as non-elective admissions)** - There were 2,560 emergency admissions in Q3 against a ceiling of 2,717 for the quarter, which suggests that admission prevention initiatives are having a positive impact. The final outturn for 2015/16 will be dependent on the severity of the winter in Q4.

1.10 **Delayed transfers of care (DTOCS) -** A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when:

a) A clinical decision has been made that the patient is ready for transfer; AND
b) A multi-disciplinary team decision has been made that the patient is ready for transfer; AND
c) The patient is safe to discharge/transfer.

1.11 There were 1,369 delayed days during Q3 against a ceiling of 1,058. However, the total performance for Q1 to Q3 was 2,909 delayed days against a ceiling of 3,376. The following table provides a breakdown of the delayed days during Q3.

Delay Source	Acute	Non-acute (CNWL)	Total
NHS	268	405	673
Social Care	261	318	579
Both NHS & Social Care	0	117	117
Total	**529**	**840**	**1,369**

1.12 61% (840) of the delayed days concerned people with mental health needs and of these 71% (599) arose due to difficulties in securing suitable placements, which includes beds in secure rehabilitation units and care home settings for people with challenging behaviours. Three of the CNWL patients who were delayed in Q3 were aged 65 and over. Nearly 70% (369) of the 529 delayed days in an acute setting were as a result of difficulties in securing appropriate placements. This is again related to difficulties in securing providers prepared to accept people with challenging behaviours and there is work underway across partners to support existing local providers to accept people with more challenging needs and to build resilience and capacity within the market to enable it to respond to Hillingdon's ageing population.

1.13 '*Acute'* in the table above includes Hillingdon Hospital, London North West Hospitals (Northwick Park and Ealing Hospitals), Imperial College Hospital, Chelsea and Westminster and the Royal Brompton and Harefield. These are trusts that provide acute care, which is defined in Schedule 3 of the 2014 Care Act as being *'intensive medical treatment provided by or under the supervision of a consultant that lasts for a limited period, after which the person receiving the treatment no longer benefits from it'*. Mental health is specifically excluded from the definition of 'acute care' for the purposes of the discharge from hospital provisions of the Care Act and its supporting regulations. The formal assessment and discharge notice process under the 2014 Act only applies to discharges from acute care. This process was formerly known as 'section 2s' and '5s' under the Community Care (Delayed Discharge) Act, 2003. The following table shows a breakdown of the delayed days by NHS trust.

Trust	Number of Delayed Days (Q3)
Hillingdon Hospitals	294
North West London (Northwick Park and Ealing)	169
Imperial College, London	29
Royal Brompton and Harefield	24
Chelsea and Westminster	13
TOTAL	**529**

1.14 **Care home admission target** - Period 1st April to 31st December 2015 there were 109 permanent placements against a target for 2015/16 of 150. There were 25 new permanent placements during Q3. A straight-line projection based on year-to-date (April to December 2015) information suggests that there will be 145 permanent placements, which indicates that the target is on track.

1.15 It should be noted that the new permanent admissions figure in paragraph 1.8 above is a gross figure that does not reflect the fact that there were 137 people who were in permanent care home placements also left during the period 1st April to 31st December 2015. As a result, at the end of Q3 there were 428 older people permanently living in care homes (206 in residential care and 222 in nursing care). This figure also includes people who reached their sixty-fifth birthday in Q3 and were, therefore, counted as older people.

1.16 **Percentage of people aged 65 and over still at home 91 days after discharge from hospital to reablement** - The target for 2015/16 is 95.4% and the outturn for 2014/15 was 85%. The actual sample period that is used nationally for benchmarking purposes is Q3, which means that the actual performance data will not be able until early Q1 2016/17. However, officers monitor progress during the year and the year to date position at the end of Q3 was 93.3%. If replicated during Q4 then the performance would not achieve the target but would be an improvement on the previous year. The level of frailty of some of the people being supported by the Reablement Team and the volumes of people being supported has a significant influence on the extent to which this result can be improved.

2. Scheme Delivery

Scheme 1: Early identification of people susceptible to falls, dementia and/or social isolation.	Scheme RAG Rating	Green
	a) Finance	Green
	b) Scheme Delivery	Green

Scheme 1 Funding	Approved Budget	Spend at Month 9	Variance as at Month 9	Variance as at Month 6	Movement from Month 6	Forecast Outturn	Forecast Variance
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
HCCG Commissioned Services funding (including non elective performance fund)	180	135	0	0	0	180	0
Total Scheme 1	**180**	**135**	**0**	**0**	**0**	**180**	**0**

Scheme Financials

2.1 Current spend is in line with CCG profiled budget which relates to value contracts (Age UK's Falls Prevention Service and GP networks) that are evenly phased (divided equally over 12 months).

Scheme Delivery

2.2 The mobilisation for the H4All Health and Wellbeing Gateway pilot started following funding approval by the CCG. The service is due to become operational borough-wide from April 2016.

2.3 A new fracture liaison nurse based at Hillingdon Hospital started in December. This post will support people who have attended hospital for the first time with low level fractures, e.g. people who may have fallen from standing height or less, and may be living with osteoporosis (bone thinning).

Scheme 2: Better care at the end of life	Scheme RAG Rating	Amber
	a) Finance	Green
	b) Scheme Delivery	Amber

Scheme 2: Better care at the end of life							
Scheme 2 Funding	**Approved Budget**	**Spend at Month 9**	**Variance as at Month 9**	**Variance as at Month 6**	**Move-ment from Month 6**	**Forecast Outturn**	**Forecast Variance**
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
HCCG Commissioned Services funding (including non-elective performance fund)	100	75	0	0	0	100	0

Total Scheme 2	**100**	**76**	**0**	**0**	**0**	**100**	**0**

Scheme Financials

2.4 Current spend is in line with HCCG profiled budget, which relates to a value contract that is evenly phased (divided equally over 12 months).

Scheme Delivery

2.5 A market testing exercise for the end of life services funded by the CCG, e.g. palliative beds, night sitting, etc, took place and showed that there was limited provider interest in delivering these services. The available options are currently under consideration with the objective of reducing fragmentation and improving the experience of care for people at end of life to support the concept of a 'good death'. Proposals for improving end of life care are included within the draft 2016/17 BCF plan which is subject to Board approval.

Scheme Risks/Issues

2.6 This scheme has been identified as amber because there have been some delays in delivering some tasks within the action plan, e.g. agreeing the end of life pathway and identification of the key issues for carers of people at end of life. These matters will be addressed during Q4.

Scheme 3: Rapid response and joined up intermediate care.	**Scheme RAG Rating**	**Amber**
	a) Finance	**Amber**
	b) Scheme Delivery	**Green**

Scheme 3 Funding	**Approved Budget**	**Spend at Month 9**	**Variance as at Month 9**	**Variance as at Month 6**	**Move-ment from Month 6**	**Forecast Outturn**	**Forecast Variance**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding (including non elective performance fund)	4,099	3,136	39	25	14	4151	52
LBH - Protecting Social Care funding	686.0	496	(18)	(11)	(7)	607	11
Total Scheme 3	**4,785**	**3,632**	**21**	**14**	**7**	**4,848**	**63**

Scheme Financials

2.6 The Council's share of the funding of this scheme relates mainly to the cost of placements in particular bed based intermediate care and Hospital Social Workers. The current forecast is an overspend of £11k against intermediate care of £3k and Hospital Social Workers forecast overspend of £8k.

2.7 The HHCCG spend is showing an increase cost of pressure relieving mattresses partly due to transition costs to a new supplier and increased demand for mattresses.

Scheme Delivery

2.8 During Q3 the Reablement Team received 332 referrals and of these 95 were from the community; the remainder were from hospitals, primarily Hillingdon Hospital. The community referrals represented potential hospital attendances and admissions that were consequently avoided. During this period, 151 people were discharged from Reablement with no on-going social care needs.

2.9 In Q3 the Rapid Response Team received 918 referrals, 56% (513) of which came from Hillingdon Hospital, 18% (169) from GPs, 11% (105) from community services such as District Nursing and the remaining 15% (131) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 513 referrals received from Hillingdon Hospital, 432 (84%) were discharged with Rapid Response input, 14.5% following assessment were not medically cleared for discharge and 8 (1.5%) were either out of area or inappropriate referrals. All 405 people referred from the community source received input from the Rapid Response Team.

2.10 The HomeSafe service providing early supported discharge for residents aged 65 years and over from Hillingdon Hospital has been further developed during 2015/16 with the full service being provided from the specialty wards as well as the Acute Medical Unit (AMU) and the capacity of the community based services correspondingly increased. The service is on track to deliver the targeted increase in the average number of patients being discharged per day from 5.5 to 7.5 by the end of March 2016.

Scheme Risks/Issues

2.11 This scheme is RAG rated amber because of the social care and CCG overspends.

Scheme 4: Seven day working.	**Scheme RAG Rating**	**Green**
	a) Finance	**Green**
	b) Scheme Delivery	**Green**

Scheme 4 Funding	Approved Budget	Spend at Month 9	Variance as at Month 9	Variance as at Month 6	Movement from Month 6	Forecast Outturn	Forecast Variance
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
LBH - Protecting Social Care funding	753	547	(18)	(11)	(7)	746	(8)
Total Scheme 4	**753**	**547**	**(18)**	**(11)**	**(7)**	**746**	**(8)**

Scheme Financials

2.12 This budget is split between Reablement (£653.6k) and Mental Health Teams (£100k). Currently Reablement is forecasting an underspend of £9k and the Mental Health Team is forecasting a pressure of £2k, unchanged since month 6.

Scheme Delivery

2.13 **Appendix 4** shows the comparison in discharge activity at Hillingdon Hospital in Q1 - 3 2014/15 and 2015/16. This shows similar discharge patterns for people who have been admitted for planned (also known as elective) procedures and unplanned (or non-elective) procedures in both years, e.g. an uneven distribution across the week. Actions that have taken place in Q3 that will help to address this include:

- Consultant cover being available over the weekend, 8 hours on a Saturday and 8 hours on a Sunday.
- The Hawthorn Intermediate Care Unit being able to admit people seven days a week, including people with mild dementia.
- The CCG increased funding to CNWL's Tissue Viability Service to support the provision of Vacuum-assisted closure (VAC), which is a specialist therapy for the management of large, complex wounds, as well as chronic wounds that have failed to heal by conventional methods. This therapy was previously available to prevent admission and not to aid discharge and this anomaly has now been addressed. The numbers involved are small but the absence of appropriate treatment in the community can lead to long lengths of stay in hospital.
- The CCG also increased the capacity of CNWL's Ambulatory Wound Clinic to ensure that people with non-post operative wounds who are able to walk have to wait no longer than a week to receive appropriate wound care. At the end of Q3 there were no people on the waiting list for this service.

Scheme Risks/Issues

2.14 Options to support social care staff being permanently based on the Hillingdon Hospital site are still being investigated. The feasibility of any of these options should be clear by the end of Q4.

Scheme 5: Review and realignment of community services to emerging GP networks	**Scheme RAG Rating**	**Amber**
	a) Finance	**Amber**
	b) Scheme Delivery	**Green**

Scheme 5 Funding	**Approved Budget**	**Spend at Month 9**	**Variance as at Month 9**	**Variance as at Month 6**	**Move-ment from Month 6**	**Forecast Outturn**	**Forecast Variation**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding (including non elective performance fund)	5,605	4,304	100	56	44	5,783	178
LBH - Protecting Social Care funding	3,272	2,175	(279)	(43)	(236)	2,918	(353)
Total Scheme 5	**8,877**	**6,479**	**(179)**	**13**	**(191)**	**8,701**	**(175)**

Scheme Financials

2.15 This scheme also includes the expenditure on HCCG's full community equipment budget and £125k of the Council's share of the spend. The balance of the Council's community equipment budget (£486k) is currently held outside of the BCF section 75. As at M9 the current forecast expenditure for community equipment is showing a combined pressure of £233k between the organisations.

2.16 The key LBH variance for the scheme relates to a forecast underspend on the TeleCareLine service of £378k an increase of £280k arising from the council switching the funding source of Telecare equipment expenditure (£280k forecast in 2015/16) from revenue to capital to utilise the annual Social Care Capital Grant to fund this expenditure going forward.

Scheme Delivery

2.17 Support continued to be provided to the three GP networks in the south of the borough to ensure that the maximum benefit can be achieved from the use of the MDT process.

2.18 In Q3 26 people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs), which represented 56% of the grants provided. 80% (20) of the people receiving DFGs were owner occupiers, 18% (5) were housing association tenants, 2% (1) was private tenants. The total DFG spend on older people during Q3 was £290k, which represented 58% of the total spend (£495k) in Q3.

Scheme Risks/Issues

2.19 This scheme is identified as amber because of the identified overspend against community equipment and the TeleCareline underspend.

Scheme 6: Care home initiative	**Scheme RAG Rating**	**Green**
	a) Finance	**Green**
	b) Scheme Delivery	**Green**

Scheme 6 Funding	**Approved Budget**	**Spend at Month 9**	**Variance as at Month 9**	**Variance as at Month 6**	**Move-ment from Month 6**	**Forecast Outturn**	**Forecast variance**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding (including non elective performance fund)	48	36	0	0	0	48	0
Total Scheme 6	**48**	**36**	**0**	**0**	**0**	**48**	**0**

Scheme Financials

2.20 HCCG expenditure is in line with planned activity.

Scheme Delivery

2.21 The work within the scope of this scheme has been completed and the task and finish group dissolved. Proposals for future support and development of the care home market in Hillingdon are contained within a separate report on the draft 2016/17 BCF plan for the Board's consideration.

Scheme 7: Care Act implementation	**Scheme RAG Rating**	**Amber**
	a) Finance	**Amber**
	b) Scheme Delivery	**Green**

Scheme 7 Funding	**Approved Budget**	**Spend at Month 9**	**Variance as at Month 9**	**Variance as at Month 6**	**Move-ment from Month 6**	**Forecast Outturn**	**Forecast Variation**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000**
Care Act New Burdens Funding	838	1,060	432	288	144	1,511	673
Total Scheme 7	**838**	**1,060**	**432**	**288**	**144**	**1,511**	**673**

Scheme Financials

2.22 The current estimated increase in expenditure on delivering the responsibilities under the Care Act is £1,511k, a pressure of £673k. This is a reduction from period 6 as a result of review of the volume of the forecast number of carers' assessments leading to a reduction of £110k for the cost of undertaking the assessments. The financial pressure on this budget arising from the additional demands is fully covered by other Council contingency funds and does not pose any risk to the financial position of the BCF. The table below gives a breakdown of forecast spend for 2016/17.

Care Act Forecast Cost Pressures	
	£000's
Social Care & Carers Assessments	152
Respite Care	384
Carers Services	209
Safeguarding Board	260
Increased clients requiring financial assessments & Contact Centre	82
ICT, Care Market Management & Staff Training	112
Project Management for the implementation of Care Act responsibilities	312
Total	**1,511**

Scheme Delivery

2.23 As at 31st December 2015, Connect to Support Hillingdon had 186 private and voluntary sector organisations registered on the site offering a wide range of products, services and support. A range of activity to engage more local providers and voluntary organisations in the site will commence in February 2016.

2.24 From 1st April (launch) to 31st December 2015, over 5,000 individuals have accessed Connect to Support and completed 7,900 sessions reviewing the information & advice pages and/or details of available services and support. The online social care self- assessment went live on 1st July 2015 and in period to 31st December 2015 51 online assessments have been completed and 35 were by people completing it for themselves and 16 by carers or professionals completing on behalf of another person. 13 self-assessments have been submitted to the Council to progress and the remainder have been sent to residents at their request in order for them to decide in their own time how they wish to proceed. The carers' online assessment will be launched in conjunction with the Council's Carer Awareness Campaign in early February 2016.

2.25 Between 1st April and 31st December 2015 343 carers' assessments were completed. On a straight line projection, this would suggest a total of 457 assessments for 2015/16, which would be 130 (40%) more than in 2014/15. 133 carers received respite or other carer services in 2014/15 at a net cost of £1.5m. 247 carers have been provided with respite or other carer services in the period between 1st April and 31st December 2015 at a total cost of £894k. The forecast for 2015/16 is £1.174k.

Scheme Risks/Issues

2.26 This scheme is RAG rated as amber because of the overspend.

Financial Costs not in schemes							
	Approved Budget	**Spend at Month 9**	**Variance as at Month 9**	**Variance as at Month 6**	**Move-ment from Month 6**	**Forecast Outturn**	**Forecast Variation**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Disabled Facilities Grant (Capital)	1,769.0	1,481	154	100	54	1,769	0
Social Care Grant (Capital)	580.0	56	(379)	(288)	(91)	580	580
BCF Programme Management	60.0	45	0	0	0	60	0
Total	**2,409.0**	**1,582**	**(224)**	**(187)**	**(37)**	**2,409**	**0**

2.27 There is currently an overspend in M9 for the DFG, although for the year this is forecast to be on target. The spend at M9 for the Social Care Capital Grant reflects the switch in funding source for the Telecare equipment referred to in scheme 5 above.

3. Key Risks or Issues

Joined-up IT Systems

3.1 *Digital roadmap* - The December Board report was informed that NHSE required all CCGs to develop local digital roadmaps by April 2016 to detail how they will achieve the ambition of being paper-free at the point of care by 2020. The deadline for delivering this has now been postponed to June 2016 and it is proposed to bring the draft roadmap to the June Board for consideration.

Better Care Fund

Appendix 2

Period: 01/04/2015 to 31/12/2015
Month Number: 9

For further information please contact:
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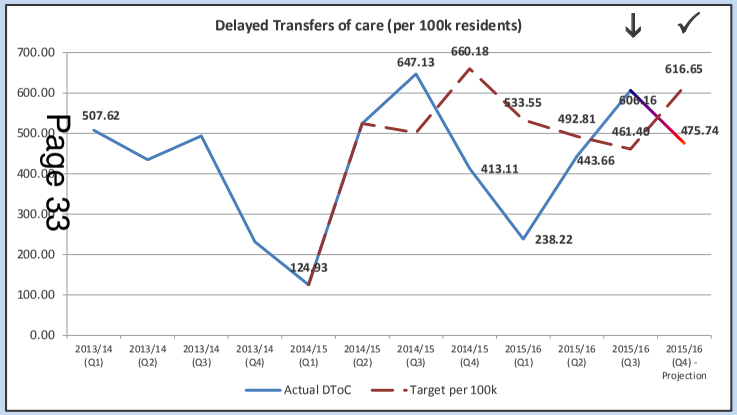
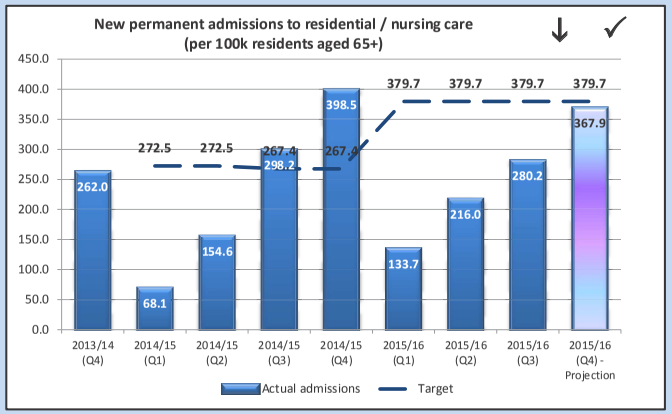
CCG Ceri Jacob

High Level Summary

Non-Elective Admissions		Pay for performance period Q1 (Apr - Jun)	Q2 (Jul - Sept)	Q3 (Oct - Dec)
Non-elective admissions in to hospital (general & acute), 65+.	2014 Actual	2,818	2,756	2,815
	Req. Reduction for 2015	99	96	98
	Target for 2015	2,719	2,660	2,717
	Actual 2015	2,663	2,571	2,560
	Difference from Target	-56	-89	-157
	Target	P4P annual change in admissions		-388
		P4P annual change in admissions (%)		-3.5%
		P4P annual saving		£578,598
	Projected (Based on available and target)	P4P annual change in admissions		-690
		P4P annual change in admissions (%)		-8.2%
		P4P annual saving		£1,028,578

Key components of BCF funding 2015/16	Budget	Actual Spend to Date (M6)	Forecast
	£000's	£000's	£000's
HCCG Commissioned services funding (including non elective performance fund)	10,032	7,686	10,262
Care Act New Burdens Funding	838	1,060	1,511
LBH - Protecting Social Care Funding	4,712	3,426	4,642
LBH - Protecting Social Care Capital Funding	2,349	1,537	2,349
BCF Programme Management	60	45	60
Overall BCF Total funding	17,991	13,754	18,824

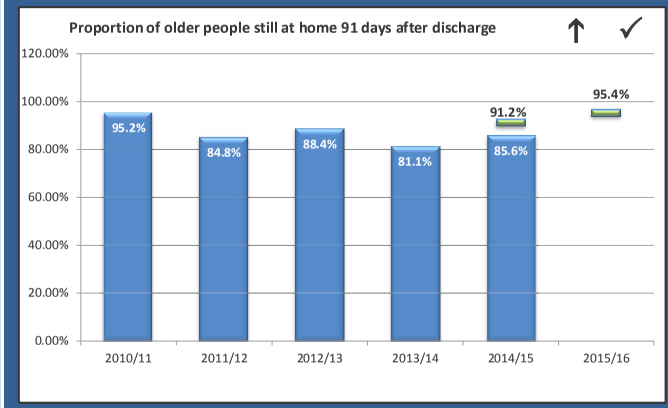


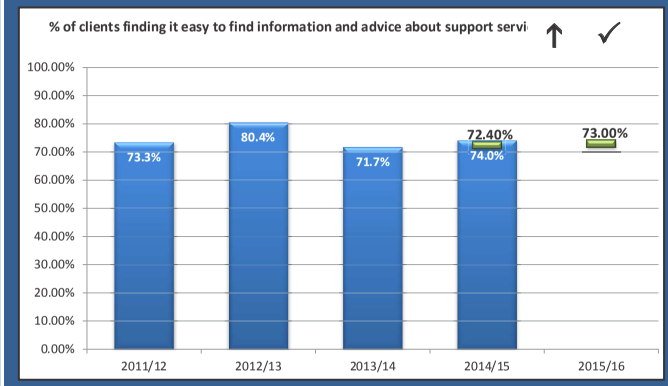


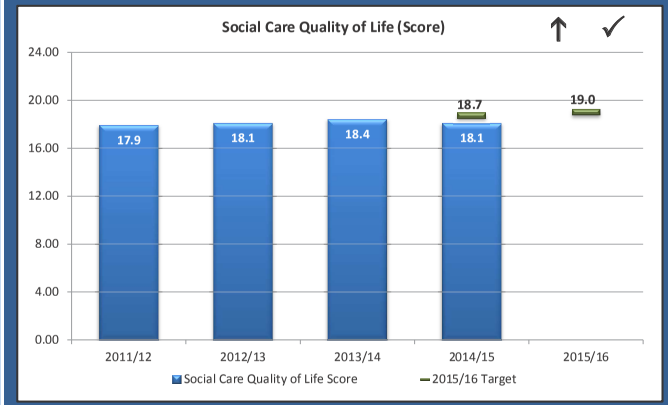
Delayed Transfers of Care (There is a 1 month time lag on the availability of the data)	To the end of period	Number (1/4ly)	Residents	Per 100k
	Baseline (2013/14)	3,666	219,259	1,672.0
	2014/15 (Q1)	278	222,521	124.9
	2014/15 (Q2)	1,168	222,521	524.9
	2014/15 (Q3)	1,440	222,521	647.1
	2014/15 (Q4)	933	225,846	413.1
	2014/15 (Full Year)	3,819	225,847	1,691.0
	2014/15 (Target)	4,053	225,847	1,794.6
	Variance from Target	-234	225,847	-103.6
	2015/16 (Q1)	538	225,846	238.2
	2015/16 (Q2)	1,002	225,846	443.7
	2015/16 (Q3)	1,369	225,846	606.2
	2015/16 (Q4) - Projection	*1,091*	229,303	475.7
	2015/16 (Full Year)	4,000	229,303	1,744.4
	2015/16 (Target)	4,790	229,303	2,088.9
	Variance from Target	-790	229,303	-344.6

Permanent admisisons to Residential / Nursing care (residents aged 65+)	To the end of period	Number (Cum)	Residents	Per 100k
	Baseline (2013/14)	100	36,655	272.8
	2014/15 (Q1)	26	38,169	68.1
	2014/15 (Q2)	56	38,169	146.7
	2014/15 (Q3)	116	38,169	303.9
	2014/15 (Q4)	155	38,895	398.5
	2014/15 (Target)	104	38,895	267.4
	Variance from Target	+51	38,895	131.1
	2015/16 (Q1)	52	38,895	133.7
	2015/16 (Q2)	84	38,895	216.0
	2015/16 (Q3)	109	38,895	280.2
	2015/16 (Q4) - Projection	*145*	*39,500*	*367.9*
	2015/16 (Target)	150	39,500	379.7
	Variance from Target	-5	39,500	-11.8

Annual Measures







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2015/16 Better Care Fund Plan Evaluation

A. BCF Evaluation Matrix

Scheme	1. Is working as planned and delivering on outcomes	2. Represents value for money in the long term	3. Enables new models of health and social care.	4. Evidently supports people effectively, improving patient/service user satisfaction	5. Has buy-in from all stakeholders and workforce: Frontline staff and political, clinical, managerial leaders	6. Reflects a truly whole system approach	7. Promotes shift towards prevention/ early help and community support/self-help	Total Individual Scheme Scores
1. Early identification of people susceptible to falls, dementia and/or social isolation	5	10	8	5	5	5	5	43
2. Better care at end of life	5	10	10	3	4	4	3	39
3. Rapid Response and integrated intermediate care	6	10	10	7	5	6	6	50
4. Seven day working	6	5	6	5	3	4	5	34
5. Alignment of community services with emerging GP networks	5	4	4	4	5	4	4	30
6. Care home initiative	5	8	3	5	8	5	4	38
7. Care Act implementation	8	10	5	5	7	5	6	46

On a scale of 1 – 10 where 1 is “not at all” and 10 is “to a great extent”. Maximum score for each scheme would be 70. Scores identified reflected limited scope of the 2015/16 plan.	

B. Scheme Specific Identified Gaps/Suggestions

Scheme 1: Early identification

- Recognition that ongoing situations increase risk, e.g.poor housing, cognitive impairment, loneliness.
- More and early identification of falls/dementia isolation risks
- Recognition that some events increase the risk of i.e. loss of partner or stroke. Importance of response of referral process - how?/who?/ clear pathways

Scheme 2: End of life

- Renewal of end of life strategy and development of the end of life pathway
- Ensure commonality of training & support for staff across health & social care
- Avoiding of crisis - human impact / impact on service
- Pooled budgets so no push / pull between health & social care provision
- Risk stratification for end of life
- Establish a single Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) form and process
- Ensuring early discussion of EoL Care Pathways

Scheme 3: Rapid response and Joined up intermediate care

- Remove duplication through service integration
- Establish a health and social care single point of access
- Remove silos and barriers e.g. establish joint commissioning arrangements and common/mutual KPI's

Scheme 4: Seven day working

- Increase engagement of mental health, voluntary sector and primary health
- Be more explicit pathways for patients returning home from hospital or being discharged to new care settings.

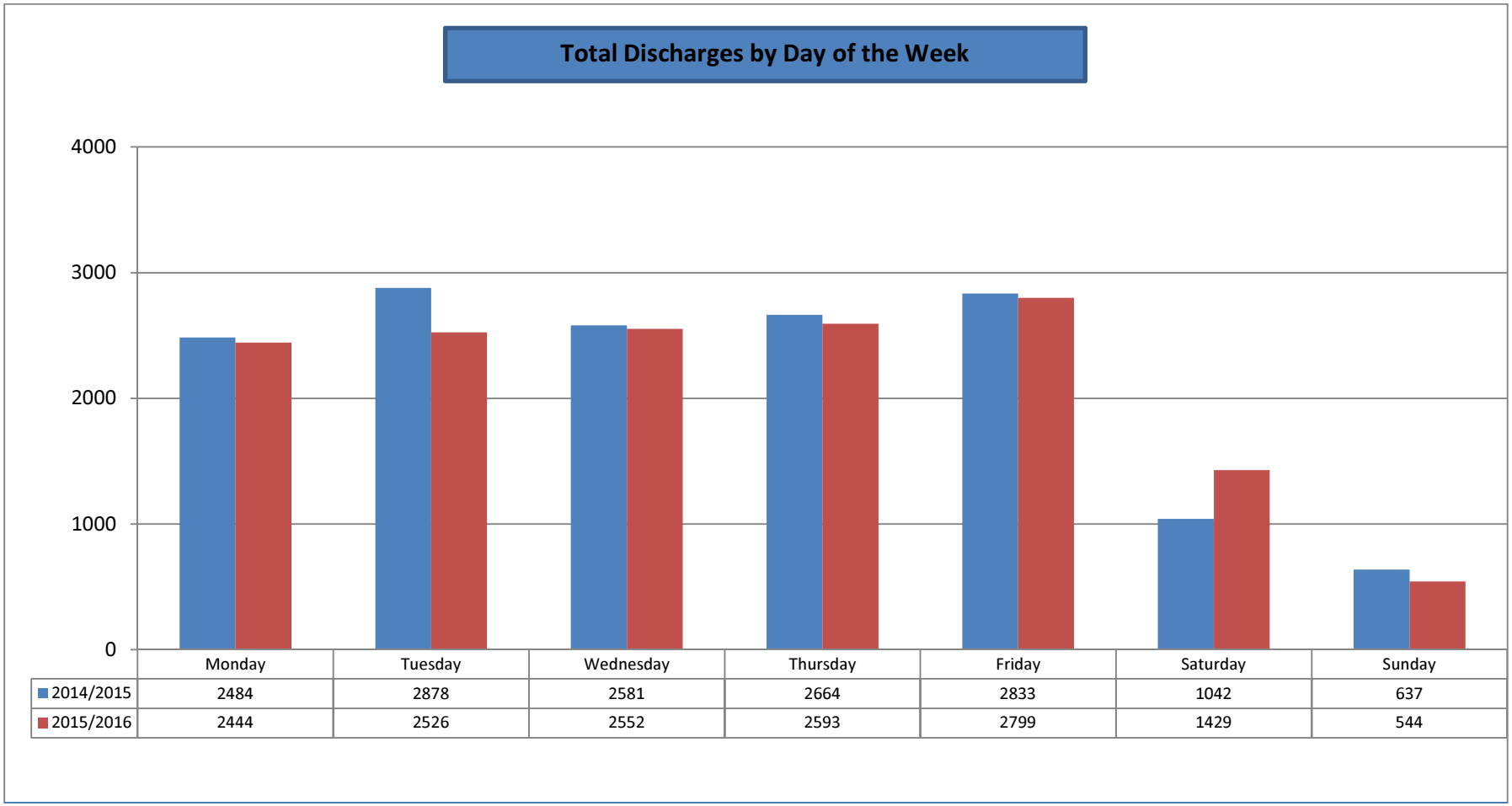
Scheme 6: Care home initiative

- Develop the local care home market to ensure it is suitable to meet current and future demand, e.g. people with dementia and challenging behaviours and younger adults with dementias.
- Support care homes to encourage them to admit people with higher levels of need, e.g. challenging behaviours
- Provide support to extra care and other supported living schemes to keep people out of secondary care and reduce pressure on primary care
- Develop geriatrician support for care homes and extra care schemes.

Scheme 7: Care Act implementation

- Proactively seek out people who are caring for their partners for carers' assessments, e.g. frail older wives/husbands/important others
- Involve carers more with care needs in hospital
- Include young carers within the scheme.

Hillingdon Hospital Discharges Day by Day (April - December 2014/15 and 2015/16)



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015	2484	2878	2581	2664	2833	1042	637
2015/2016	2444	2526	2552	2593	2799	1429	544

2016/17 BETTER CARE FUND PLAN

Relevant Board Member(s)	Councillor Ray Puddifoot MBE Councillor Philip Corthorne
Organisation	London Borough of Hillingdon
Report author	Kevin Byrne, Administration Directorate Tony Zaman, Adults and Children and Young People's Services Directorate
Papers with report	**Appendix 1** - 2015/16 and 2016/17 BCF Plan Comparison Summary. **Appendix 2** - Supporting Narrative Document. **Appendix 3** - Detailed Scheme Descriptions. **Appendix 4** - Sample provider commentary templates. **Appendix 5** - Planning Template **Appendix 6** - Health Impact Assessment. **Appendix 7** - Equality Impact Assessment (inc. Carers).

HEADLINE INFORMATION

Summary	This report sets out the proposals for the 2016/17 Better Care Fund plan and seeks the Board's approval. The Better Care Fund is a Government initiative intended to improve efficiency and effectiveness in the provision of health and care through increasing integration between health and social care. The focus of Hillingdon's Better Care Fund plan is improving care outcomes for older people.
Contribution to plans and strategies	The Better Care Fund is a key part of Hillingdon's Joint Health and Wellbeing Strategy and meets certain requirements of the Health and Social Care Act 2012.
Financial Cost	The proposed total amount for the BCF for 2016/17 is £22,531k, made up of Council contribution of £4,629k and CCG contribution of £17,902k.
Ward(s) affected	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

1. **approves the 2016/17 Better Care Fund plan in principle for submission to the London Regional Assurance Team on 25 April 2016 as described in this report or with any amendments that it requires;**

2. **delegates authority to make any further minor amendments prior to submission, e.g., to reflect feedback from the London Regional Assurance Team and/or Policy Overview and Scrutiny Committees, to the Corporate Director of Adults and Children and Young People's Services, LBH and the Chief Operating Officer, HCCG, with final sign-off by the Chairman of the Board and the Chairman of HCCG's Governing Body; and**

3. **notes the content of the Health and Equality Impact Assessments (Appendices 6 and 7).**

INFORMATION

Strategic Context

1. The Autumn Statement on 25 November 2015 made it clear that the BCF would continue to be the vehicle for delivering integration between health and social care during the 2015 - 2020 Parliament. It was stated that each HWB area would be required to develop a plan for 2016/17 and then a longer-term plan to achieve 'full' integration by 2020. It is understood that guidance as to the definition of 'full' integration is expected to be published by the end of Q1 2016/17 and that the plan to get to 2020 will need to be agreed by the end of 2016/17.

2. The Autumn Statement also included an announcement about a requirement that every health and care system work together to produce a Sustainability and Transformation Plan (STP) covering the period October 2016 to March 2021. The purpose of this plan is to demonstrate how improved health and wellbeing, transformed quality of care delivery and sustainable finances across the health and care system will be delivered. The Better Care Fund (BCF) is seen as a mechanism for delivering on themes within the STP. The schemes in the proposed 2016/17 BCF plan are aligned to the emerging themes within the STP. The STP has to be submitted in June 2016.

3. For the 2015/16 BCF plan, both the Council and the CCG agreed to the minimum permitted value of £17,991k for the 2015/16 plan, which to minimise risk to both organisations for what was then a new initiative. The minimum required contribution for 2016/17 is **£20,015k**, an increase of 9.1%. If the Board approves the recommendations in this report the total value of the 2016/17 plan will be **£22,531k**, which would reflect an incremental progression towards integration between health and social care described in this report.

2016/17 BCF Plan Proposals

4. The 2016/17 BCF plan builds on the work undertaken as part of the 2015/16 plan. An assessment of the performance of the 2015/16 plan is considered in the 2015/16 BCF plan Q3 performance report, which is a separate item on the Board's agenda.

5. The proposals for 2016/17 include some logical extensions of activity undertaken in 2015/16 whilst simultaneously maintaining the cautious and incremental approach to integrated working and the pooling of budgets that minimises the risk to both the Council and HCCG. The proposals include:

- Extending existing schemes where benefits could be achieved for other adult client groups, e.g., development and management of the supported living market that will include all adults and extending the scheme on supporting Carers to all unpaid Carers;
- Adding funds to the pooled budget where this will have demonstrable benefits for residents/patients, e.g., specialist palliative personal care service for people at end of life;
- Extending scope of the plan to include new types of activities, e.g., dementia;

- Accelerating benefits through a greater ambition to integrate services across health and social care, building on progress made in 15/16, e.g., intermediate care; and
- Correcting anomalies from the 2015/16 plan, e.g., bringing the Council's budget for the community equipment contract into the pooled budget with that of the CCG so that the whole budget is under the same governance structure.

6. The intended outcomes of the 2016/17 plan include:

- A stable, cost effective care market that meets local needs.
- A better resident/patient experience of care.
- Reducing the number of emergency hospital attendances and admissions.
- Reducing the hospital readmission rate.
- Reducing the number of permanent admissions to care homes.
- Reducing the demand for on-going care.

7. **Appendix 1** provides a summary comparison between the 2015/16 plan and the proposed 2016/17 plan. Table 1 below shows the proposed schemes for 2016/17. The detailed scheme descriptions can be found in **Appendix 3.**

Table 1: Proposed BCF Schemes 2016/17	
Scheme	**Scheme Title**
1	Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.
2	Better care for people at end of life
3	Rapid Response and Integrated Intermediate Care
4	Seven day working
5	Integrated community-based care and support
6	Care home and supported living market development
7	Supporting Carers
8	Living well with dementia

National Conditions

8. The national conditions from 2015/16 have been rolled forward and two new conditions have been added. Table 2 below summarises the national conditions and the local response.

Table 2: Summary of National Conditions and Local Response		
Rolled Forward Conditions		
1.	There must be a jointly agreed plan approved by the HWB.	Dependent on the Board's decision.
2.	One or more pooled budgets must be established under section 75 of the NHS Act 2006.	Cabinet and HCCG Governing Body will be asked to approve a revised s.75 agreement in May.
3.	The provision of social care services must be maintained.	HCCG contribution includes 2015/16 protecting social care and Care Act new burdens allocation with uplift.
4.	An agreement for the delivery of 7-day services across health and social care must be in place.	There is a dedicated 7-day working scheme that includes actions to deliver this requirement. See **Appendix 3**.
5.	There should be better data sharing arrangements between health and social care.	Data sharing arrangements are in place and work in progress for

Table 2: Summary of National Conditions and Local Response		
Rolled Forward Conditions		
		further development.
6.	There should be a joint approach to assessments.	Most aspects of this condition are in place and dialogue is in progress about joint funding of care packages for older people.
7.	Agreement on consequential impact of changes within the plan on providers.	Providers, e.g. Metrohealth GP network, Hillingdon Hospital, CNWL and H4All will be asked to complete summary statements for final submission.
New Conditions		
8.	Agreement to invest in NHS commissioned out-of-hospital services	Already being met by the CCG and investment increasing in 2016/17 by £1.9m.
9.	Agreement on local action plan to reduce delayed transfers of care (DTOC).	Actions addressed in schemes shown in **Appendix 3**. A separate DTOC action plan will support the final submission.

Risk Share Arrangements

9. The Council and CCG agreed that for the 2015/16 BCF plan both organisations would manage their own risks. It is proposed that a similar approach is taken during 2016/17 except for two specific service areas and these are:

- *Community equipment* - It is proposed that the risks associated with under or over-performance would be shared proportionate to the financial contribution of each organisation; and
- *Specialist palliative personal care service* - It is proposed that the risks associated with under or over-performance should be shared on a 70:30 (CCG:LBH) split and with any under-performance would be shared proportionate to the financial contribution of each organisation.

10. The detail of these arrangements will be reflected in the section 75 agreement that Cabinet and HCCG's Governing Body will be asked to consider in June 2016.

11. During Q1 2016/17, it is proposed that the Council and CCG develop a risk share agreement that can then operated in shadow form for the remainder of 2016/17. The experience of the shadow period will help to inform the shape of any risk share arrangements to be included within the 2017/18 to 2019/20 plan.

12. The national BCF guidance encourages areas to develop risk share arrangements in respect of delayed transfers of care (DTOCs). This is not a requirement for Hillingdon as our performance for this metric is comparatively good. However, any future risk share arrangements could include other partners, such as Hillingdon Hospital and CNWL, in order to ensure a collective approach to managing the costs associated with the hospital discharge process and delayed transfers of care.

Measuring Success

13. The Board is asked to consider the following measures as key determinants of the success of the 2016/17 BCF plan.

14. **Progress towards a joint approach to a sustainable health and care system** - It is suggested to the Board that if agreement on the following areas is in place by the end of 2016/17 this would be a good indicator of success:

- The preferred integration option and procurement route for intermediate care services;
- The preferred integration option and procurement route for end of life services;
- The integrated brokerage and contracting model for care home placements;
- The model of wrap-around services for care homes and supported living schemes;
- An integrated approach to home care market development and management;
- An integrated outcomes framework for older people;
- An agreed understanding of the impact on health of the reduction by the Council in the use of residential care; and
- The risk and benefits share arrangements following a shadow arrangement in 2016/17.

15. **Performance against national metrics** - There were four metrics that were mandated by NHSE in 2015/16 and two locally determined, resident-focused measures. These six measures have been rolled forward in 2016/17 and are summarised in Table 3 below. The results of these metrics will be reportable to NHSE on a quarterly basis and will be reflected in the BCF dashboard that will also be reported to the Board and the CCG's Governing Body on a quarterly basis.

Table 3: National Reportable BCF Metrics 2015/16 and 2016/17

Metric	Target/Ceiling 2015/16	Projected Outturn 2015/16	Proposed Target/Ceiling 2016/17
1. 3.5% reduction in emergency admissions attributed to 65 + population.	- 388	- 556	- 663
2. Reduction in permanent admissions to residential & nursing homes (65 +).	150	145	150
3. Proportion of people (65 +) still at home 91 days of discharge from hospital to reablement.	95.4%	92%	93.8%
4. Delayed transfers of care (delayed days) 18 +.	4,790	4,335	4,117
5. Resident experience: how easy or difficult to access information and advice about support services and benefits.	73%	75%	75.5%

6. Social care-related quality of life.	19	18.4	18.6

16. The Board is asked to note the following about the proposed targets for:

- *Reduction in emergency admissions* - The proposed target reflects the contribution of the 2016/17 BCF plan to achieving the total emergency admissions reduction target in the CCG's 2016/17 Operating Plan. The BCF contribution relates, as in 2015/16, to the emergency admissions attributable to the 65 and over population;
- *Reduction in permanent admissions to care homes* - The proposed target takes into consideration demographic pressures arising from increased levels of frailty amongst the older people population and the limited availability of suitable alternative care settings until the delivery of two new extra care schemes in 2018;
- *Delayed transfers of care (DTOC)* - The Board can see from Table 4 that Hillingdon's DTOC performance for the period Q1 to Q3 2015/16 was significantly better than our North West London partners and other boroughs in our benchmarking family, e.g. Barnet and Croydon. However, improving our performance further is still necessary to minimise the unnecessary length of stay in hospital for residents/patients with all the implications that this has for loss of independence and pressures on the local health and care system. The proposed 5% reduction on the projected outturn for 2015/16 (a reduction of 217 delayed days) is based on the recognition that delivering on some of the causes of DTOCs will not be delivered until we are into 2016/17 and that therefore the impact of this will not be felt until later in the year. A key example of a cause of DTOCs is availability of local care home provision for people with challenging behaviours;
- *Resident experience* - The actual 2014/15 outturn was 74.8% and the provisional 2015/16 outturn figure is suggesting 75%. A similar rate of growth is therefore proposed for 2016/17 to give a target of 75.5%;
- *Social care-related quality of life* - The proposal for 2016/17 is to maintain this level of increase and set a target at 18.6, which recognises that the key area of performance that impacts on this metric is addressing social isolation. This is an area where the H4All's Health Wellbeing Service explained in more detail in scheme 1 (**Appendix 3**) has the potential to have an impact, as is also the case with the resident experience metric. This service is due to be operational in April 2016.

Table 4: Delayed Transfers of Care Performance Compared Q1 - Q3 2015/16

Area	Number of Delayed Days
Barnet	5,660
Brent	7,475
Croydon	4,305
Ealing	7,974
Hammersmith & Fulham	3,624
Harrow	4,274
Hillingdon	***2,909***
Hounslow	5,433
Kensington & Chelsea	3,829
Westminster	3,228

17. **Performance against scheme specific metrics** - The schemes detailed in **Appendix 3** contain a further range of metrics that will not be reported to NHSE but will be reported to the HWB and HCCG's Governing Body as part of the quarterly performance reports. These additional metrics will give a broader understanding of the successful implementation of the plan than the national metrics and will also be supported by specific testing of the service user experience by services. The following are examples of the additional metrics that will be reported:

- Utilisation rates for Connect to Support
- Number of falls-related emergency admissions
- Number of emergency admissions with a length of stay of between 0 and 2 days.
- Number of admissions a day avoided following a referral to Rapid Response by Hillingdon Hospital's Emergency Department.
- Average number of discharges supported home from Hillingdon Hospital wards by Community HomeSafe per day
- Number of referrals to Reablement per month.
- % of Reablement Team service users where there is no request for long-term support.
- Number of readmissions during a period of reablement.
- % of hospital discharges taking place before midday.
- Number of readmissions within 30 days.
- Number of Disabled Facilities Grants provided and value.
- Number of emergency admissions from care home.
- Number of emergency admissions from supported living schemes.
- Number of Carers' assessments completed.
- Number of Carers receiving respite or another Carer's service following an assessment.

Governance

18. The delivery of the 2015/16 plan has been overseen by the Core Officer Group comprising of the Council's Chief Finance Officer, the CCG's Deputy Chief Finance Officer, the Corporate Director of Adults and Children and Young People's Services (a statutory member of the HWB), the CCG's Chief Operating Officer and the Council's Head of Policy and Partnerships. This has worked well in 2015/16 and it is not proposed to make any changes to the governance arrangements in 2016/17.

BCF Plan Submission Timescales

19. The statutory BCF guidance was published on 23rd February with the following timescales for submission:

- *2nd March* - Submission of planning template setting out 2016/17 plan development progress and intended levels of contribution.
- *16th March* - Feedback from regional assurance team on first planning template submission
- *21st March* - Submission of revised planning template and supporting narrative document
- *11th April* - Feedback from regional assurance team on second planning template submission and supporting narrative document.
- *25th April* - Final submission of planning template and narrative document signed off by the Health and Wellbeing Boards and reflecting feedback.
- *13th May* - Confirmation of final assurance rating for 2016/17 plan.
- *30th June* - Deadline for section 75 agreements to be signed.

20. The first submission template was published on 24 February for submission on 2 March. This was submitted on behalf of the CCG reflecting the minimum contributions from both the Council and the CCG. Delays in confirming the proposed financial contribution arrangements for 2016/17 resulted in Hillingdon's second submission being delayed until April.

21. The final Hillingdon submission will comprise of the following documents:

- Supporting Narrative Document - *Appendix 2*
- Detailed Scheme Descriptions - *Appendix 3*
- Provider Commentaries - *Appendix 4*
- Revised Planning Template - *Appendix 5* (Updated template yet to be published)

Approval and Assurance Process

22. A more streamlined approval and assurance process has been introduced for the 2016/17 plan as described below:

- Narrative plans and template details to be submitted for regional moderation and recommendation to be made to NHSE. The London regional assurance team will comprise of the NHSE Director of Commissioning Operations, a representative from the London branch of the Association of Directors of Adult Social Services and a London local authority chief executive.
- Plans will be evaluated on the basis of quality and risk to delivery.
- There are three possible judgements arising from the assurance process and these are: '*Approved*', '*Approved with support*', '*Not approved*'.

Financial Implications

24. The minimum amount for the BCF for 2016/17 required by the Government for Hillingdon has been published as £20,015k. The proposed total amount for the BCF for 2016/17 is £22,531k, made up of Council contribution of £4,629k and CCG contribution of £17,902k. The increased funding above the minimum for 2016/17 is £2,516k and includes additional contributions from the Council of £1,172k and from CCG of £1,344k.

25. For 2016/17, the sum of resources identified within the BCF for Protecting Social Care (including Care Act new burdens) is £10,566k, an increase from 2015/16 of £2,608k. The total value of the NHS commissioned out of Hospital spend is set at £11,965k.

26. Table 5 below sets out each scheme showing funding by each partner.

Table 5: Financial Contribution to Schemes by Partner

Scheme	Funder-HCCG £000's	Funder - LBH £000's	Budget £000's
Scheme 1: Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.	390	657	1,047
Scheme 2: Better care for people at the end of their life.	106	50	156
Scheme 3: Rapid response and joined up intermediate care.	5,347	2,920	8,267
Scheme 4: Seven Day Working.	0	100	100
Scheme 5: Integrated Community-based Care and Support.	6,021	5,405	11,426

Table 5: Financial Contribution to Schemes by Partner			
Scheme	**Funder- HCCG £000's**	**Funder - LBH £000's**	**Budget £000's**
Scheme 6: Care Home and Supported Living Market Development.	83	150	233
Scheme 7: Supporting Carers.	18	899	899
Scheme 8: Living well with Dementia.		305	305
Programme Management.		80	80
Total	**11,965**	**10,566**	**22,531**

27. Monthly budget monitoring of the BCF will continue to be jointly undertaken by the CCG and Council with regular reports to HWBB on progress during the year.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

28. The recommendation will enable a Hillingdon BCF plan to be submitted in accordance with national guidance. The BCF plan will contribute to the development of a sustainable health and care system in Hillingdon that will support residents to regain or maintain their independence.

Consultation Carried Out or Required

29. Extensive consultation was undertaken as part o`f the development of the 2015/16 BCF plan, for which most of the proposals in the 2016/17 are a logical extension. There has been additional consultation with the Metrohealth GP network, Hillingdon Hospital, CNWL (community health and community mental health), the voluntary sector (H4All) and private residential and nursing care home providers through the Older People's Care Home Provider Forum. Residents have been consulted on the proposals through the Disabled Tenants' and Residents' Association and the Older People's Assembly.

30. A range of stakeholders across sectors and including Healthwatch have been involved in updating the Health Impact Assessment and Equality Impact Assessment, which can be found in **Appendices 6 and 7**.

31. A consultation programme as part of the development and delivery of the STP and the supporting three-year BCF plan (2017/18 - 2019/20) is currently being devised.

Policy Overview Committee comments

32. None at this stage. External Services Scrutiny Committee will be asked to comment on the proposed 2016/17 plan at a special meeting on 14 April 2016. Social Services, Housing and Public Health Policy Overview Committee will also be asked to comment at its meeting on the 20 April 2016.

CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

33. Corporate Finance has reviewed this report, noting that the financial impact of the proposed Better Care Fund plan is generally consistent with the Council's 2016/17 budget as approved by Cabinet and Council in February 2016. The proposed plan will maintain the risk share approach taken during 2015/16 for the majority of BCF activity, with each party being responsible for their own elements of the fund, for Community Equipment and Specialist Palliative Care new arrangements are proposed and detailed within this report.

Hillingdon Council Legal comments

34. Section 223GA of the NHS Act, 2006, provides the legal basis for the BCF and gives NHSE power to make any conditions it considers reasonable in respect of the release of NHS funding to the BCF. Where it considers that an area has not met these conditions, it also has the power, in consultation with the DH and DCLG, to make directions in respect of the use of the funds and/or impose a spending plan and impose the content of any imposed plan.

BACKGROUND PAPERS

- *Technical Guidance Annex 4: Better Care Fund Planning Requirements for 2016/17* (NHSE Publications Gateway Reference 04437 - February 2016)
- *BCF Planning 2016/17: Approach to regional assurance of Better Care Fund plans* (NHSE March 2016)

2015/16 Better Care Fund Plan and Proposed 2016/17 Plan Comparison Summary

Scheme Title	2015/16 Plan Scheme Summary	2016/17 Plan Proposed Changes
1. Proactive early identification of people with susceptibility to falls, dementia and/or social isolation.	• Training staff visiting people in their own homes on how to recognise risk factors. • Supporting people who fall and preventing recurrence of falls. • Keeping people active mentally and physically through Public Health, Library and Sports and Leisure Services initiatives. • Developing support from the third sector for people at risk. • Promoting telecare.	**<u>Rename to include stroke</u>** • Promotion and development of Connect to Support, e.g. access to information and advice. • Rolling out approach to Making Every Contact Count (MECC). • Promoting the H4All Health and Wellbeing Gateway as referral point for people identified as being at risk. • Reviewing the falls strategy to take a comprehensive view of the respective Council and CCG functions and funded services and how collectively with partners falls prevention can be supported. • Reviewing patterns of utilisation of third sector provision in response to Gateway interventions to inform how best to target current third sector capacity funded by the Council and/or CCG. in order to maximise the outcomes of supporting people to be independent in the community. • Developing stroke prevention approaches that will also address dementia, e.g. increasing physical activity, addressing excessive weight issues, smoking cessation and looking at early detection.
2. Better care for people at end of life.	• Developing shared care plans through care planning IT system, Coordinate My Care (CMC). • Developing processes to enable seamless care provision between health and social care. • Developing sources of information for professionals and residents.	Extend to cover delivery of first year of new joint (LBH & CCG) end of life strategy, including: • Improving identification of people at end of life. • Improving care and support planning. • Delivering a communications plan for professionals. • Establishing a joint specialist palliative personal care service. • Bringing social care spend for EoL into pooled budget. • Benchmarking 'best practice' for end of life care services with

		a view to commissioning a new integrated model of care with emphasis on shared outcomes and a seamless transition between providers. • Implementing outcome of review of support for carers of people at end of life.
3. Rapid Response and joined up intermediate care.	Achieve closer alignment between intermediate care services to speed up discharge process and prevent admission.	**<u>Rename to: Rapid Response and integrated intermediate care</u>** • Exploration of closer (structural as well as functional) integration options, including procurement choices.
4. Seven day working	• Identifying the services required for an 'ideal' 7-day discharge pathway • Mapping services currently available. • Prioritise commissioning and delivery of services required to close identified gaps.	• Accelerate advanced discharge planning on wards. • Developing the Integrated Discharge Team. • Addressing needs of people with severe mental ill health. • Developing the role of the third sector to support discharge and prevent readmission. • Use contractual levels to deliver seven day assessments in nursing homes. • Embedding earlier referrals to Hospital transport, e.g. before midday. • Changing practice to ensure early referral of patients showing signs of mental distress to the Psychiatric Liaison Service. • Embedding advanced discharge planning on wards through setting ward-specific KPIs and exploring standardisation of MDT process.
5. Review and realignment of community services to emerging GP networks.	• Realigning community health resources around GP networks. • Multi-disciplinary care team (MDT) approach to problem solving. • Establishing care planning and care coordination for people with long-term conditions.	**<u>Rename to: Integrated Community-based Care and Support</u>** • Expanding use of risk stratification tools to identify people those who may benefit from early support. • Rolling out the integrated model of care for older people across the borough. • Mainstreaming personalised care planning for older people

	• Promoting DFGs.	across the borough supported with IT through the Care Information Exchange. • Raise awareness within primary care of community service provision and access routes - Training to be provided to staff within primary care about the range of services provided by the Council to support the health and wellbeing of residents/patients in their own homes, including the provision of Disabled Facilities Grants (DFGs). • Bringing all funding for Medequip contract together and tendering for the service. • Re-launching the retail model for some items of community equipment to increase choice for residents/patients. • Develop an integrated approach to home care market development and management for all adults to reduce need for people to change provider where needs change and help manage risk relating to medication administration. • Development and delivery of a training programme on care standards for homecare providers. • Expansion of Personal Health Budgets.
6. Care home initiative.	• Provide support to care home staff from specialist clinical staff to prevent avoidable hospital admission. • Ensure that care homes implement robust environmental risk assessments and the dignity challenge. • Establish an escalation process between health and social care where there are safeguarding incidents or concerns.	**<u>Rename to: Care Home and Supported Living Market Development</u>** Remit extended to cover all adults in supported living, including extra care. Care homes continue as 65 + only. • Developing the model of care and support for extra care to maximise independence, prevent hospital admission and reduce demand on GP services. • Implementing preferred joint contracting options for care homes for older people. • Launching market position statements to set out medium and long-term needs for developers and providers of care homes and supported living schemes. • Addressing the gap in nursing home provision for people with behaviours that challenge.

		• Development of a menu of in-reach support for care homes and supported living schemes, including medical and clinical support.
7. Care Act Implementation.	• Implementing the Council's new responsibilities to carers through the following activities: - Improved access to information and advocacy; - Providing access to an assessment of need; - Meeting needs identified as a result of an assessment. • Implementing new statutory adult safeguarding requirements. • Implementing new market management and provider failure responsibilities.	**<u>Rename to: Supporting Carers</u>** Remit extended to cover all carers, e.g. young carers and adult carers. Deliver year 2 of the Joint Carers' Strategy: • Deliver a communications campaign to increase awareness and take-up of carers' support/services. • Reviewing assessment capacity across the borough • Implement carers' hub contract. • Deliver GP health checks and flu jab programmes for carers. • Implementing a carers' recognition scheme. • Deliver options to extend services for carers, e.g. extended carer cafes and winter activities. • Deliver an integrated engagement framework for carers. • Implement a range of social activities for young carers.
8. Living well with dementia	Not applicable.	**New scheme** • Implementing a single point of access (SPA) for crisis care that includes dementia. • Exploring feasibility of an integrated multi-disciplinary team that will have case management responsibility for people with dementia. • Developing a local dementia resource centre model. • Developing standardised training for providers. • Securing care home provision for people living with dementia with challenging behaviours. • Securing care provision for people living with dementia at end of life.

NHS
Hillingdon
Clinical Commissioning Group

Better Care Fund Plan 2016/17

HILLINGDON
LONDON

March 2016

Better Care Fund Plan 2016/17
Contents

2016/17 Better Care Fund Plan

1. PLAN DETAILS

1.1 Summary of Plan

Local Authority	**London Borough of Hillingdon**
Clinical Commissioning Groups	**Hillingdon Clinical Commissioning Group (NHS Hillingdon)**
Boundary Differences	**Boundaries are co-terminus**
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Total agreed value of pooled budget:	
2015/16	**£17,991,000**
2016/17	**£22,531,000**

1.2 Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Hillingdon CCG
By	Dr Ian Goodman
Position	Chair or Hillingdon CCG
Date	<date>

Signed on behalf of the Council	London Borough of Hillingdon
By	Cllr Ray Puddifoot MBE
Position	Leader of Hillingdon Council
Date	<date>

Signed on behalf of the Health and Wellbeing Board	Hillingdon Health and Wellbeing Board
By Chairman of Health and Wellbeing Board	Cllr Ray Puddifoot MBE
Date	<date>

2. CONFIRMATION OF FUNDING CONTRIBUTIONS

2.1 All minimum funding contributions are met

The contribution of the CCG and the Council to the BCF plan is as follows:

- HCCG - £11,965k
- LBH - £10,566k

This compares to the following in 2015/16:

- HCCG - £10,032k
- LBH - £7,959k

The detailed scheme descriptions in **Annex 1** provide a breakdown of allocated funding by scheme.

2.2 Agreed plan for use of Disabled Facility Grant monies

As an upper tier local authority, the DFG funds will be utilised to support older and disabled residents in line with previous practice. Scheme 5: *Integrated Community-based Care and Support* in **Annex 1** explains how DFGs will be promoted within primary care.

3. VISION FOR HEALTH AND CARE SERVICES

3.1 How services will be transformed to implement the vision in the Five Year Forward View and moving towards integrated health and social care by 2020 and the role of the 2016/17 BCF.

Introduction

This plan builds on Hillingdon's 2015/16 Better Care Fund Plan. Our continuing vision is that by 2019/20, the residents of Hillingdon will be able to plan their own care; with professionals working together to understand their needs and those of their carer(s), so that they have control over services and that these deliver what is important to them.

There will be a shift to planning for anticipated care needs rather than crisis management and reactive provision of services. The range of services and capacity and competencies of the workforce will meet the physical health, mental health and social care needs of the residents of Hillingdon and be delivered in a way that is integrated and seamless from a service user point of view, in their usual place of residence.

In 2015/16 the BCF was targeted at Hillingdon's 65 and over population and primarily frail elderly people against an agreed definition of frailty. The focus during 2015/16 was:

- All of Hillingdon's residents aged 85 and over
- Frail older people aged 75 and over with one or more long-term conditions
- Older people who are at risk of dementia
- Older people who are at risk of falling for a first time.
- Older people who are socially isolated

The 2015/16 plan has enabled progress to be made in achieving greater functional integration and alignment between health and care services to deliver an improved model of care for older people by 2020. The intention for 2016/17 is to take Hillingdon further along the path to greater integration between health and social care. Although the focus for the 2016/17 plan will once again be Hillingdon's older people population, the success of 2015/16 enables the ambition to extend schemes to cover the needs of other population groups where there are clear benefits and better outcomes for residents, e.g. where the development of particular markets are concerned such as supported living and homecare or where a strategic approach will be more effective if considered across age groups, as is the case with carers.

During 2016/17 the Council and the CCG will be working with partners to develop a longer-term integration plan that will set out a roadmap to achieve full integration between health and social care by 2020. The assumption is made that if the model of care, and wider enablers for integration for older people are further developed in 2016/17, this can deliver both better outcomes for older people, and work equally well for other residents and population groups. The BCF plan for 2016/17 will therefore scale up and build on progress to date, creating another incremental step to achieving further integration in 2017 - 2020.

2015/16 has also seen the development of an Accountable Care Partnership (ACP), which is Hillingdon CCG's preferred model of delivery for integrated care. This presents an opportunity to deliver a new model for addressing the health and wellbeing needs of Hillingdon's residents in line with the Five Year Forward View (5YFV).

Commissioning integrated care from the ACP will initially be for older people with long term conditions, but will progress in scope to all older people and other population groups with long term conditions. Hillingdon CCG and shadow ACP are discussing the scale and pace of this ambition linked to benefits for people in Hillingdon.

The ACP will deliver services in shadow form for a year from April 2016, which will provide an opportunity for all partners to explore the scope for this being a vehicle for the delivery of more integrated services as part of or aligned to the post April 2017 BCF integration plan.

By 2019/20 we expect to have in place a model of care and supporting enablers:

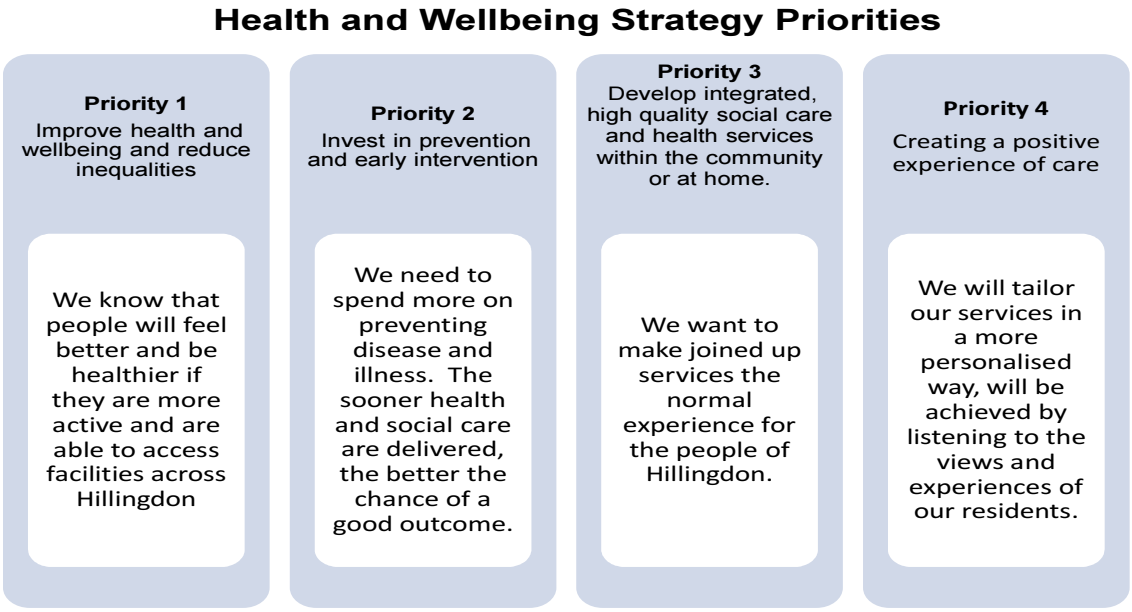
- Where residents have easy access to information and advice about services, including care and support services;
- That has a focus on improving health outcomes for residents with one or more health conditions or care needs;
- Where there is systematic early identification of susceptibility to disease or

exacerbation in the population, alongside integrated management of conditions;

- Where better coordination of services are configured around Hillingdon's residents, including a much stronger focus on case management and prevention;
- Where residents and carers are actively involved in the planning of their care;
- Where people are only admitted to Hillingdon Hospital when they are acutely ill;
- Where a hospital admission is necessary and unavoidable their lengths of stay are reduced;
- That enables people to be treated at or close to their home wherever possible;
- A reduction in the number of people living in residential care; and
- The most effective use of health and care resources is made to achieve best value for the Hillingdon £.
- Enablers such as IT interoperability, development of a sustainable workforce and a vibrant market offering residents/patients quality choices.

Links to the Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy

The data in Hillingdon's JSNA has informed the priorities within Hillingdon's Health and Wellbeing Strategy and these are summarised below.



Whilst the initial focus for the 2016/17 BCF plan is on older people, it is anticipated that other groups with complex needs which can be better met by increased integration of social care and health care provision will be addressed as part of an incremental growth of Hillingdon's integration ambition in the 2017/18 to 2019/20 plan.

3.2 What difference will this make to patient and service user outcomes?

We will know that our plans have delivered our vision if our residents are able to say:

- 'I'm helped to take control of my own health and social care provision.'
- 'It doesn't matter what day of the week it is – as I get the support appropriate to my health and social care needs.'
- 'Social care and health services help me to be proactive. They anticipate my needs before I do and help me to prevent things getting so bad that I need a stay in hospital.'
- 'If I do need to go to hospital, they start to plan for my social and health care in the community from day one of my stay.'
- 'I only have to tell my story once and they pass my details on to others with an appropriate role in my care.'
- 'Systems are sustainable and what might once have been spent on hospital care for me is now spent to support me at home in my community.'

The 2015/16 BCF plan was a stepping stone for Hillingdon on an integration journey and it is not expected that it will be possible to achieve the above responses as standard from residents and patients as a result of the work that has taken place during this first year of the BCF; it will also not be fully achieved from the 2016/17 plan. However, the Council, the CCG and other partners do expect that this will be an increasingly common experience as the benefits of closer integration and the roll out of an integrated model of care are experienced by more people as we get closer to 2020, with the ability to measure residents' experience and the outcome of care across the whole health and care system.

3.3 Relationship between the BCF, the CCG's 2016/17 Operating Plan and the longer-term Sustainability and Transformation Plans

Hillingdon CCG 5-year Sustainability and Transformation Plan (STP)

There are no schemes in the 2016/17 BCF that do not align with Hillingdon CCG's 5 year plan. Going forward, the partners recognise that the BCF plan will be a key mechanism for local delivery of many of the themes contained within the STP.

Hillingdon CCG 2016/17 Operating Plan

BCF alignment with Hillingdon CCG 1 year operating plan includes:

- Contribution to reduction in non elective admissions
- Local quality priority: to reduce admissions as a result of falls

3.4 Alignment with other locally relevant strategic plans and initiatives related to care and support underway in Hillingdon.

Hillingdon Sustainable Communities Strategy, 2011 - 2018

The BCF plan is aligned to the Local Strategic Partnership's statutory Sustainable Community Strategy and will contribute to delivering the following priority under the strategy:

- Help people to lead healthier, more independent lives.

Hillingdon Joint Health and Wellbeing Strategy, 2014 - 2017

The Better Care Fund workstreams support the priorities of Hillingdon's Health and Wellbeing Strategy, especially in regard to developing integrated, high quality social care and health services within the community or at home.

Hillingdon's Joint Health and Wellbeing Strategy action plan has been revised to incorporate the new BCF objectives in support of its priorities.

Integrated Care System Enablers

2015/16 has seen considerable progress in developing an integrated model of care for older people as part of the early adopter pioneer programme approved by the Department of Health in March 2014. This has enabled accelerated progress of delivery of the 2016/17 BCF plan, including:

- Development of a common model of care for frail elderly people;
- Care and support planning by GP networks, shifting to planning for anticipated needs with GPs as lead professional;
- Improved care planning, including risk stratification, care navigation and Multi-disciplinary Team (MDT) working;
- Roll out of an agreed screening tool for older people not known to services;
- Development of effective IT solutions that will support data sharing and facilitate residents and patients only having to tell their story once. See Data Sharing and IT Interoperability under National Conditions.
- Ability to track patients across the whole care system and identify outcomes and experience of care.
- Development of a model to improve people's engagement with their own care through evidence-based use of Patient Activation Measure tools and access via GP networks to a voluntary sector provided Health and Wellbeing Service.

As previously mentioned, 2016/17 will see the ACP operating in shadow form for one year. Alignment of integration initiatives is being overseen by a multi-agency Integrated Care Steering Group and Older People's Model of Care Delivery Group. A joint communication and engagement plan with identified leads is in development that will ensure alignment across initiatives to avoid confusion and particularly maximise ownership and effectiveness of the post April 2017 BCF integration plan.

Hillingdon Resilience and Urgent Care Plans

Initiatives to support reduction in non-elective admissions are aligned with both the Hillingdon Resilience Plan and the Hillingdon Urgent Care Board plans. Several of the

BCF schemes will be contributing to the reduction in non-elective admissions target contained within the CCG's Operating Plan and there is also alignment with the mental health urgent care pathway programme and the mental health frequent flyers programme. For example, the Adult Social Care contribution to the BCF includes funding for mental health social workers in A & E to help prevent avoidable admissions. It also funds a registered mental health nurse in the Rapid Response Team.

The BCF plan will align with funds, e.g. operational resilience, to develop a whole system approach to support admission avoidance, improved initial access points and prevention and community management. The out of hours Approved Mental Health Practitioner (AMHP) in A & E, which is short-term funding from the operational resilience funding stream, is an example of this.

Prime Minister's Challenge Fund

BCF is aligned to improvement in access in primary care. Through use of the Prime Ministers challenge fund, GP practices have been supported to focus on improvements where specific enhancements have been identified to improve the modl of care for older people.

Public Health

There are already a range of initiatives being undertaken by Public Health in partnership with the Library Service, the Sports and Leisure Service and the third sector to help keep older people physically and mentally active. The plan is aligned with this existing activity, which will help to support delivery of Scheme 1: *Early identification of people susceptible to falls, dementia, stroke and/or social isolation*. Included within this scheme is the development within the Council of a new Wellbeing Service, which will see some of the services mentioned above brought together in a more coordinated way to deliver better outcomes for residents and support the prevention agenda.

Strategic Estates Plan

To support the shift in care settings from acute to community Hillingdon is in the process of developing a strategic estates plan that will look at current holdings across statutory partners and consider the opportunities for addressing current and future need going forward. The development of the plan supports delivery of NHS England's Five Year Forward View by taking a collaborative approach to:

- Fully rationalising the NHS estate,
- Maximise use of facilities owned locally by the statutory agencies,
- Deliver value for money, and
- Enhance the resident/patient experience of care.

The draft strategy now needs to be transformed into a strategic planning tool for Hillingdon which will support future premises investment decisions across all stakeholder organisations. This is particularly important as it will inform the investment of Section 106 and CIL contributions and the investment in primary care premises outside of the scope of the proposed hubs.

2020 Digital Roadmap

Partners across health and social care in Hillingdon are engaged in the development of a digital roadmap which will detail how the ambition of being paper-free at the point of care

by 2020 will be achieved. This links with the data sharing and IT interoperability national condition. The target is for the roadmap to be agreed in June 2016 for submission to NHSE.

3.5 Contribution to the ongoing delivery of the aims and changes set out in the Care Act, 2014.

A key underlying theme for Hillingdon's BCF plan for 2016/17 is about ensuring residents have access to relevant support is to help them to achieve the outcomes that matter to them in their life, therefore reflecting the *wellbeing principle* in the 2014 Act. The specific schemes within the plan set out in Annex 1 show that the following responsibilities are addressed:

- Prevention - see in particular scheme 1: *Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation,* but this a theme that runs through all schemes)
- Access to information and advice - see scheme 1 as referred to above.
- Market shaping and management - see in particular schemes 5: *Integrated Community-based Care and Support* and scheme 6: *Care Home and Supported Living Market Development.*
- Managing provider failure - see schemes 5 and 6 as described referred above.
- Supporting Carers - see scheme 7: Supporting Carers, which has been developed specifically to address new responsibilities towards Carers. This scheme in the 2016/17 has been enhanced to address responsibilities under the 2014 Children and Families Act towards young as well. See also Section 7: National Conditions for details of the resource commitment to support Carers in Hillingdon.

4. EVALUATING THE 2015/16 BETTER CARE FUND PLAN

4.1 How successful was the plan?

Although the 2015/16 BCF plan was agreed to be 'first step' in nature and featured pooling only of mandated budgets to minimise the risk to the Council and the CCG, it has provided an opportunity to develop a stronger working relationship between the Council and the CCG and with other health and third sector partners.

In December 2015 an evaluation workshop took place involving representatives from the Council (including Public Health), the CCG, Hillingdon Hospital, CNWL, the local third sector consortium called H4All and Age UK Hillingdon. Using an adapted version of an evaluation tool developed by NHSE, the key conclusions of the workshop are summarised below and these were subsequently tested:

What went well in 2015/16.

- Commitment to work together and the acknowledgement of the importance to do so.
- Closer working between health (including GPs), social care and the voluntary sector.
- Voluntary sector involvement across all schemes.
- Creation of the third sector consortium, H4All (Age UK, Disablement Association Hillingdon, Harlington Hospice, Hillingdon Carers and Hillingdon Mind).
- Creation of the Integrated Discharge Team at Hillingdon Hospital to support timely

discharge to the usual place of care.
- Development of the Integrated Care Record and plans to share information about residents/patients across care organisations.
- Joint working to support people at end of life has improved.
- Primary Care Navigators (PCNs): 6 people employed by Age UK but based in Primary Care who support older people with long-term conditions but low level need to access appropriate support and care services.
- Public Health initiatives to keep older people active mentally and physically.
- Development of the online resident services information portal Connect to Support.
- Increasing numbers of carers receiving carers' assessments and support services, including respite.
- Improved joint management of community equipment services to deliver a more effective and efficient system.
- Development of a joint framework to measure older people's outcomes and experience of care.

Areas for further development

- Development of care home market for people with dementia and challenging behaviours.
- Extending integrated models of care to a other population groups.
- Improved communication between strategic and operational staff within partner organisations.
- Greater integration between intermediate care services.
- Evidencing the delivery of outcomes for residents.
- Improving the patient pathway from admission to discharge.
- Using pooled budgets to improve the care experience of residents/patients with health and social care needs.
- Expanding the use of trusted assessors.
- Increasing awareness of Public Health wellbeing and prevention initiatives.
- Reviewing inter-organisational duplication.
- Pursuing joint opportunities to commission services differently, including commissioning for outcomes.
- Improving the standard of care amongst care agencies.
- Improving electronic sharing of resident/patient information across health and care organisation.

Many of the above points have been addressed in the evolution of the schemes for the 2016/17 BCF plan.

Metrics

Hillingdon's reportable metrics are shown in the table below with the projected outturn for 2015/16 based on the position at the end of Quarter 3.

	Reportable Metrics 2015/16	
Metric	**2015/16 Target or Ceiling**	**Projected Outturn**
1. 3.5% reduction in NEL admissions attributed to 65 + population.	-388 admissions	-556
2. Reduction in permanent admissions to residential & nursing homes (65 +).	150	145
3. Proportion of people (65 +) still at home 91 days of discharge from hospital to reablement.	95.4%	92%
4. Delayed transfers of care (delayed days) 18 +.	4,790	4,335
5. Resident experience: how easy or difficult to access information and advice about support services and benefits.	73% (Source: Adult Social Care Survey)	75%
6. Social care-related quality of life.	19 (Source: Adult Social Care Survey)	18.4

Conclusion

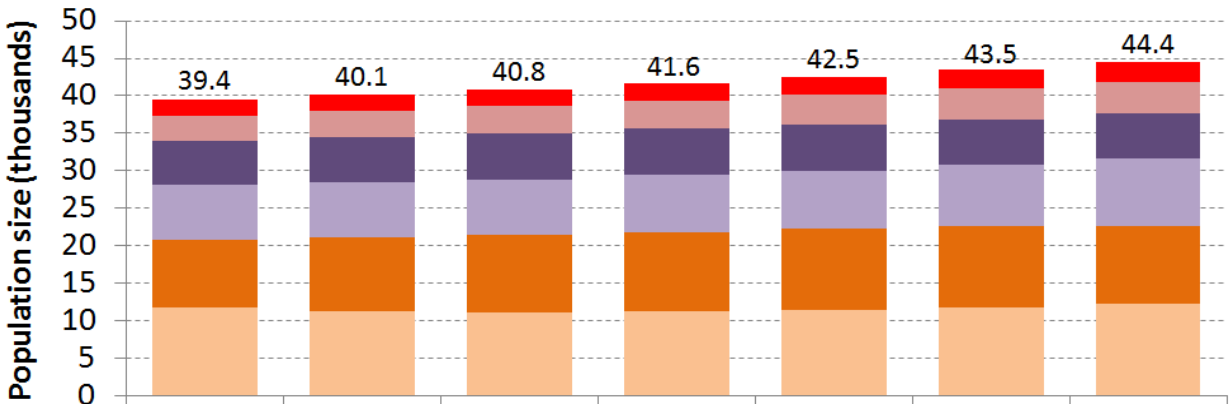
The 2015/16 plan has provided the platform to develop an incrementally more ambitious plan for 2016/17 that will see increased investment from both the Council and the CCG.

5. CASE FOR CHANGE

5.1 Issues the BCF will be used to address within London Borough of Hillingdon

The focus of the 2016/17 BCF Plan will be primarily on older people and the case for change as to why Hillingdon is focusing on this population group set out in the 2015/16 BCF continues to apply. The table below illustrates the steady increase in the 65 and over population and particularly those people aged 80 and over during the period 2016 to 2022.

The 65+ years population size, Hillingdon (2016 to 2022)



	2016	2017	2018	2019	2020	2021	2022
90+	2.1	2.1	2.2	2.3	2.4	2.5	2.7
85-89	3.4	3.5	3.6	3.8	3.9	4.0	4.2
80-84	5.8	6.0	6.1	6.2	6.2	6.0	6.0
75-79	7.4	7.3	7.4	7.6	7.8	8.2	9.0
70-74	9.1	9.9	10.3	10.6	10.8	10.8	10.4
65-69	11.7	11.2	11.1	11.2	11.4	11.8	12.2

Source: 2012 SNPP (National Statistics)

In Hillingdon, there is an increasing focus for our health and care services for older people to become more proactive in supporting people at risk of escalating need instead of being directed at acute interventions. Our planning and our services are also in the process of becoming more joined-up to support older residents in their homes and in their communities.

The case for change issues the BCF will be used to address in Hillingdon will include:-

- More than 39,000 older people live in Hillingdon in 2016, a figure that is likely to increase by approximately 7% by 2020 and 11% by 2022.
- 40% of our non-elective activity in 2014/15 and 39% during Quarters 1 to 3 2015/16 was attributed to the 65 and over population, this group accounted for 56% of the total health emergency admission spend (54% Q1 to 3 2015/16). In 2014/15 the 42% (39% Q1 to 3 2015/16) of emergency admission spend was on the 75 and over population, which accounted for 29% of admissions in 2014/15 (27% Q1 to 3 2015/16). We estimate that some 35% of emergency admission for the 75 and over population grou are avoidable or deferrable, which is based on the proportion of admissions resulting in a length of stay of between 0 and 2 days.
- 56% of the Council's gross spend on care for older people in 2014/15 was on care homes (residential and nursing). This made Hillingdon the 11th lowest in London (22 boroughs have a higher proportion spend than Hillingdon). However, the desired trajectory would be towards the 40% level. The lowest spend in 2014/15 was London's poorest borough, Tower Hamlets, which achieved 38%; in North West London Hammersmith and Fulham achieved the lowest spend on this type of care at 51%. The Council would like to eliminate the use of residential care for new

permanent placements completely for older people by the end of 2018.

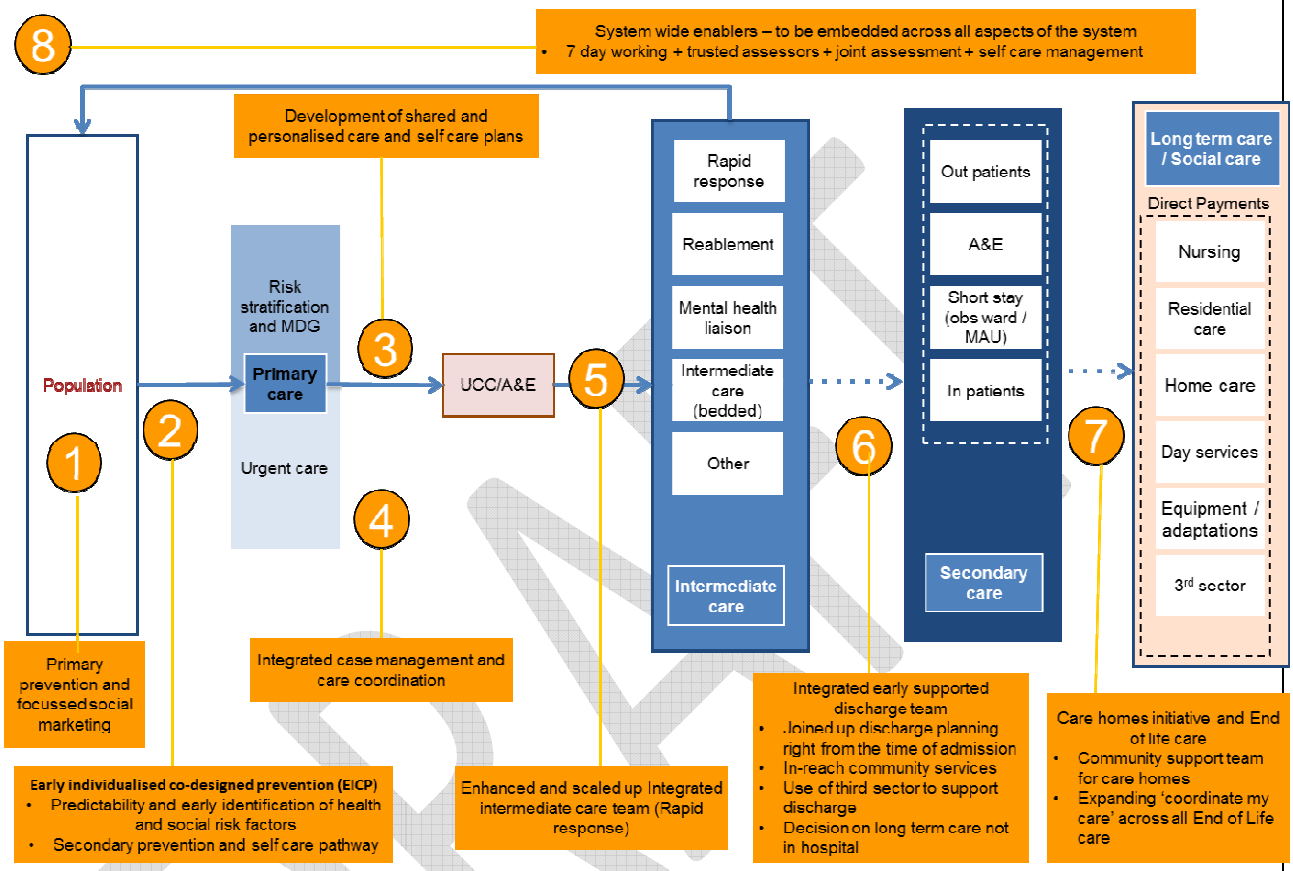
- 31% of all older people live on their own and could be at risk of being socially isolated.
- Overall, Hillingdon is expected to have the greatest increase in the proportion of older people with long term conditions compared to other London boroughs making the management of these conditions a significant priority.
- In 2013/14 there were 3,246 people who had been diagnosed with a stroke in NHS Hillingdon CCG. In the same period there were 310 admissions recorded on the Sentinel Stroke National Audit Programme. Atrial fibrillation is a known risk factor for stroke. The diagnosed prevalence in Hillingdon is 1.1% and the estimated prevalence is 2.0%. There could be an additional 2,500 people with undiagnosed atrial fibrillation in the CCG.
- Projections from Projecting Older People Population Information System (POPPI) suggest that the number of older people living with diabetes in Hillingdon will increase by 9.5% from 4,805 in 2015 to 5,307 by 2020. Similarly, predictions from Projecting Older People Population Information System (POPPI) suggest that the number of people living with dementia will increase by 13.5% from 2,711 in 2015 to 3,133 by 2020.
- Whilst there are discharges from Hillingdon Hospital taking place seven days a week the distribution across the week is uneven and there is considerable scope for making improvements following on from the work that has taken place during 2015/16.
- The structure of the current care home market for older people is not compatible with future needs of Hillingdon's ageing population and does not reflect the impact of the development of extra care sheltered schemes as realistic alternatives to residential care. Clearer messages need to be given to providers about future needs and requirements and suitable levels of support made available to ensure the availability of a sustainable, quality care home market in the borough.
- Expansion of supported living schemes to maximise the opportunities for residents to live fulfilling lives in the least restrictive care setting requires more integrated approaches to support providers, reduce demand on primary care and prevent avoidable hospital attendances and admissions.
- The 2011 census showed that 18% of unpaid carers were aged 65 and over. POPPI projections suggest that this number is likely to increase by 19% to 5,703 by 2020. The census also showed that approximately 10% of carers were aged under 25. Whilst the focus of the BCF in 2015/16 was on older carers, supporting young and younger carers is equally important.

5.2 How integration will be used to improve issues identified

The need and potential for greater integration to result in more timely and effective interventions is recognised and accepted by both the Council and CCG and was reflected in the 2015/16. The diagram below maps the health and care system in Hillingdon as it was at the start of 2015/16 and which is largely still current.. It illustrates a series of

points for intervention across the system that were identified, through stakeholder engagement, where the best opportunities for improving the quality of life for Hillingdon's older residents are. Improvements have been made during 2015/16 and the proposed schemes for 2016/17 build on this work in order to deliver better outcomes for residentspatients and Hillingdon's health and care economy.

Current system map in Hillingdon and key points of intervention



The planned points of integration are:

1. **Population-wide prevention services -** These promote self-care and general well-being. This includes promotion of access to information and advice through an online citizen portal and the development of a third sector provided Wellbeing Service. It also includes the development of wellbeing initiatives to keep older people mentally and physically active. Through the Wellbeing Service assessments against Patient Activation Measures will determine the level of support required by a person to enable them to manage their own long-term condition.

2. **Specific self-care initiatives for older people** – This is designed around their conditions or infirmities. For example, self-management education for older people living with dementia and/or at risk of stroke or who have fallen or through provision of telecare assisted technology to provide monitoring and response services.

3. **Personalised care planning** – This is for people who have regular contact with primary or community health and/or social care. Their personalised care planning will

involve planned contact with a GP, a guided care nurse or care coordinator in general practice.

4. **Integrated case management** – This is a development of personalised care planning for people who need more intensive support to prevent a crisis in their health or care. It would revolve around GP planning and case management across primary, community and social care. This would include the further roll out of the Integrated Care Record that could be accessed by residents/patients online through the Care Information Exchange.

5. **Crisis Response and Intermediate care** – for people who despite all the above support have a care crisis or health exacerbation that causes them to access acute services. Intermediate services intervene here to provide appropriate support to return people to their homes without acute care. Having improved functional alignment during 2015/16 the next stage is to improve effectiveness and efficiency further by looking at structural integration options.

6. **Discharge support initiatives** – These help residents who have had to be admitted to an acute setting return home as soon as possible irrespective of what day of the week it is.

7. **Longer term residential interventions** – This supports people whose needs can only be met safely in a care home environment to prevent hospital admissions that are inappropriate and also to enable people to die in their care home where this is their preferred option.

8. **System-wide enablers** – The last intervention point is actually system-wide and represents a series of measures (including the BCF national conditions) that are catalysts to system improvement. It also includes IT interoperability.

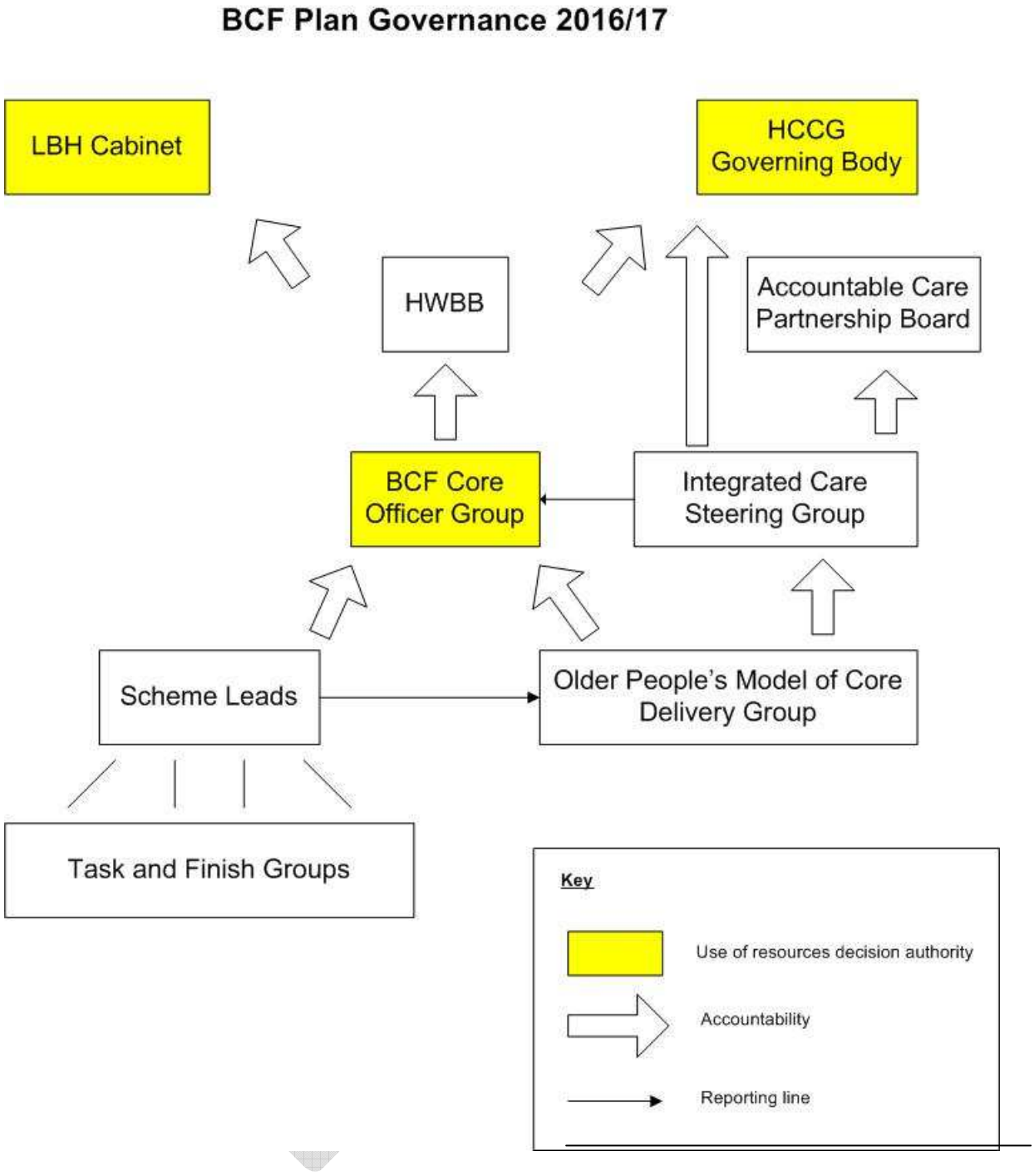
6. COORDINATED AND INTEGRATED PLAN OF ACTION FOR DELIVERING CHANGE

6.1 What will the governance arrangements look like?

The governance arrangements for the 2015/16 BCF plan have enabled delivery of improvements for residents and it is proposed that these will be replicated in 2016/17 with some modifications.

The legal agreement between the Council and the CCG established under Section 75 (s.75) of the National Health Service Act, 2006, for the 2015/16 plan will be updated new financial arrangements and modified governance arrangements. The terms of the updated agreement will be agreed during Q4 for formal sign-off in May 2016 by both the Council's Cabinet and the CCG's Governing Body.

The governance arrangements are summarised in the diagram below.



The **Hillingdon Health and Wellbeing Board** (HHWBB) provides leadership in developing a strategic approach for health and wellbeing in Hillingdon and is responsible for holding partner agencies to account for performance on agreed priorities. It is also responsible for collaborative working to develop social care and health related commissioning plans to improve the health and wellbeing of residents of the Borough and monitor implementation and performance. The board therefore takes strategic oversight for health and care systems in the Borough and has been involved from the outset in the planning for BCF. It is responsible for final sign off of plans and reports on behalf of partners and is the overarching leadership and governing body but does not, however, have authority to take investment decisions on behalf of its members. Individual

partners, therefore, need to be satisfied with the proposals going to the Board and, as necessary, to agree them in advance. This applies to the **HCCG Governing Body** and to **Hillingdon Council's Cabinet**.

Healthwatch Hillingdon, as the local "consumer champion" and full member of the Board needs to be satisfied that plans reflect its understanding of what residents and patients say they need.

A **Core Officer Group** comprising of senior officers from the CCG, Adult Social Care, LBH and CCG Finance and the LBH Corporate Policy team has been established to progress work on the BCF and to have operational responsibility for the management of the s.75 pooled budget. This group meets fortnightly and is jointly chaired by the Director of Adult Social Care and the CCG's Chief Operating Officer. It provides oversight of the programme and also considers opportunities for integrated working and/or joint commissioning for recommendation to the Health and Wellbeing Board as well as the Council's Cabinet and CCG Governing Body for decision about use of resources.

An **Older People's Model of Care Delivery Group is** accountable for the delivery of the model of care for older people in Hillingdon and is a mechanism to enable partner input into the successful delivery of integration priorities including the Better Care Fund plan. It has oversight and creates alignment of the existing plans, strategies and work steams for older people and identifies opportunities for increasing efficiency and effectiveness of service models. Its final function is to make recommendations regarding the strategic development of older people's services in Hillingdon, which will go the Health and Wellbeing Board and the **Integrated Care Steering Group**.

The **Integrated Care Steering Group** will ensure a programme of work is developed which will deliver the integrated model of care for both older people and adults with long-term conditions as well as ssociated system enablers, e.g. IT interoperability, outcome based commissioning, workforce development and the development of an Accountable Care Partnership (ACP). As shown in more detail in section 6: *Alignment*, this work is closely aligned to the BCF plan for 2016/17 with the intention of delivering our shared vision for older peple and the long-term sustainability of Hillingdon's health and care system. The Steering Group reports to HCCG's Governing Body and Accountable Care Partnership Board (see section 5). The Steering Group links with the Health and Wellbeing Board through its formal reporting to HCCG's Governing Body and its informal links with the BCF Core Officer Group.

Each of the eight BCF schemes is led by an identified **scheme lead** who is a senior manager within one of the partner organisations. They are supported by task and finish groups. A single seven day working task and finish group oversees the delivery of the four priority clinical standards as well as the out of hospital standard that is included within the BCF plan. This also reports into Hillingdon's Systems Resilience Group (SRG), which is mandated by NHSE under its 2012 Health and Social Care Act powers to oversee local implementation of the priority seven day working clinical standards.

This structure takes into account the sovereign nature of partners' decision making processes that require each partner to report through their own internal governance, as appropriate, on developments. Where necessary bilateral senior meetings have been arranged, for example, between the CCG Governing Body Chairman and the Leader of the Council, to consider any remedial actions required to resolve issues.

6.2 Details of the management and oversight of the delivery of the Better Care Fund plan, including management of remedial actions.

The practice in 2015/16 has been for the Core Group to receive performance updates on a monthly basis and this will continue in 2016/17. Where there are performance delivery issues escalation to the Core Group enables blockages to be identified and mitigation actions agreed. This group will continue to have operational responsibility for managing the s.75, including the risk share arrangements that are described in section 5: *Risk Share Arrangements*, and will therefore receive financial reports and will also monitor the risk register.

BCF schemes are also integral to achievement of Hillingdon's Health and Wellbeing objectives and this will be reflected in the annual revision of the Health and Wellbeing Strategy. Delivery against key metrics will therefore be reported quarterly to the Health and Wellbeing Board. Separate BCF performance reports to the Health and Wellbeing Board will enable the Board to get a broader understanding of plan delivery and impact on residents and Hillingdon's health and care system.

The whole programme is overseen by a programme manager, who reports to the Core Group and the Older People's Model of Care Delivery Group.

6.3 List of 2016/17 BCF schemes

The individual projects or changes planned as part of the BCF are listed below. **Annex 1** contains detailed descriptions for each of these schemes.

Ref no.	Scheme
1	*Scheme 1* - Early identification of people susceptible to falls, dementia, stroke and/or social isolation
2	*Scheme 2* - Better care for people at the end of life
3	*Scheme 3* - Rapid Response and integrated intermediate care
4	*Scheme 4* - Seven day working
5	*Scheme 5* -. Integrated Community-based Care and Support
6	*Scheme 6* - Care Home and Supported Living Market Development
7	*Scheme 7* - Supporting Carers
8	*Scheme 8* - Living well with dementia

6.4 Key milestones associated with the delivery of the 2016/17 plan

The following reflect some of the key milestones associated with the delivery of the 2016/17 plan:

Quarter 1

- Revision of plan to reflect feedback from Regional Assurance Team.
- Approval of plan by Health and Wellbeing Board and HCCG Governing Body
- Final plan submission.
- Task and finish group meetings and sign-off of detailed scheme action plans for 2016/17.
- Engagement with health and social care staff on content of 2016/17 plan.
- Third sector provided Wellbeing Service becomes operational.
- Stakeholder consultation on Sustainability and Transformation Plan and role of BCF in its delivery.
- Approval of section 75 agreement by Council's Cabinet and HCCG Governing Body.
- Single palliative personal care service operational.
- 2015/16 BCF outturn report considered by HWB/Governing Body.
- Arrangements in place with care homes to support people with challenging behaviours.

Quarter 2

- Joint nursing home brokerage pilot operational.
- Q1 BCF performance report to HWB/Governing Body.
- Decision about scope of 2017 - 2020 BCF plan.
- Training sessions for primary care about community service access provision, including DFGs, and referral routes.
- Joint hospital discharge protocol agreed.

Quarter 3

- Decision on integration and delivery model for intermediate care services.
- Review of Health and Wellbeing Service.
- Q2 BCF performance report to HWB/Governing Body.
- Review results of AF pilot with pharmacists.
- Consultation on proposed 2017 - 2020 BCF plan.
- Appointment of new joint community equipment provider.
- Joint care home market position statement published.

Quarter 4

- Q3 BCF performance report to HWB/Governing Body.
- 2017 - 2020 BCF plan approved by HWB and HCCG Governing Body.
- 2017 2020 BCF plan section 75 agreement approved by Council's Cabinet and HCCG Governing Body.

6.5 A full populated and comprehensive risk log

The risk log is set out in **Annex 2**.

7. RISK SHARE ARRANGEMENTS

7.1 Contingency planning and risk share arrangements that are in place.

Management of the BCF risk register and is addressed in section 6: *Coordinated and Integrated Plan of Action for Delivering Change.*

During 2015/16 the Council and CCG agreed to manage their own risks. It is intended to take a similar approach in 2016/17 but to apply specific risk share arrangements in respect of the following:

- **Specialist palliative personal care service** - With the palliative personal care service the risks associated with under or over-performance will be shared proporotionate to each organisation's financial contribution.

- **Community Equipment** - The risks share on the community equipment contract in respect of under and over- performance will be shared proporotionate to each organisation's financial contribution.

The intention is to develop a risk share agreement early in 2016/17 that can then be run in shadow form in order to inform arrangements to be included in the 2017/18 to 2019/20 BCF plan. It is intended that this would also include hospital discharge and delayed transfers of care and potentially involve providers such as Hillngdon Hospital and CNWL.

8. NATIONAL CONDITIONS

A brief description of how the plan meets each of the national conditions for the BCF.

8.1 Protecting social care services

a) Outline of local definition of protecting adult social care services (not funding)

As in 2015/16, protecting social care services within the London Borough of Hillingdon means that those identified as being in need of social care support, reablement or community equipment continue to receive the services and care they require to promote effective outcomes.

The national eligibility criteria came into effect on 1st April 2015 and this is equivalent to substantial under the previous critieria. In addition, it is intended that disabled facilities capital grants will continue at the pre-BCF level as part of the protection of social care.

The proposals within this plan protect Adult Social Care Services through managing demographic pressures, which may otherwise impact on the level of support that the Council is able to provide to residents with social care needs. The funding provided will also enable the eligibility criteria to be retained at moderate for community equipment,

which recognises the preventative nature of this service.

b) How local schemes and spending plans will support the commitment to protect social care

The 2016/17 plan builds on the work undertaken during 2015/16 to manage the financial pressures arising from demographic growth through earlier identification of older people at risk of escalating need. Through more joined-up and increasingly integrated approaches to early intervention this will help to maximise the independence of older people in their own homes and thereby reduce pressure on Social Care services and budgets, which will in turn reduce pressure on secondary care in Hillingdon.

c) The total amount from the BCF that has been allocated for the protection of adult social care services and confirmation that at least the local proportion of the £138m has been identified for the implementation of the new Care Act duties.

The CCG will be passporting £6,190k for protecting adult social care and the £899k allocation for the implementation of new Care Act. This compares to £4,771k and £838k respectively for 2015/16 and reflects the level required. This funding will contribute to the stability of the local social and health care system as a whole. Achieving stability and sustainability within the local market place is a key objective of the Hillingdon's BCF plan and is reflected in the construction of the schemes for 2016/17.

d) The level of resource that will be dedicated to carer-specific support

Hillingdon's plan for 2016/17 includes a dedicated 'Supporting Carers' scheme with a remit that includes carers of all ages. This scheme will deliver Hillingdon's Joint Carers' Strategy, 2015 - 2018, which was developed by the multi-agency Carers' Strategy Group and approved by both the Council and the CCG in 2015. The agreed vision for the strategy is that we want our carers to be able to say:

- *"I am physically and mentally well and treated with dignity"*
- *"I am not forced into financial hardship by my caring role"*
- *"I enjoy a life outside of caring"*
- *"I am recognised, supported and listened to as an experienced carer"*

There are four areas identified within the strategy that attention is focused on and this is on the basis that addressing these areas will 23aximize the amount of time a carer is prepared to undertake their caring role, which in turn influence key outcomes such as non-elective admissions, delayed transfers of care and permanent admissions to care homes. The four priority areas are:

- Health and wellbeing
- Financial circumstances, including access to information and advice
- A life outside of caring
- Recognition of the caring role

The investment in this scheme for 2016/17 to support delivery of the strategy and contribute to the delivery of key outcomes is approximately £1.4m. This comprises of £771k from the Care Act implementation fund carers' assessments and reviews as well as the provision of respite and other carer support services to address assessed social

care needs. In addition to this is included a further £630k from the Council for the Carers' Hub service provided by the third sector. This service delivers a range of preventative support services to carers, including access to information and advice. A further £18k is invested by the CCG for support provided by the third sector.

8.2 Seven day services to support discharge

a) Local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

A task and finish group has been established that will oversee implementation of the four priority seven day working standards and also standard 9, the out of hospital standard that is a dedicated scheme within Hillingdon's BCF plan for 2016/17. This group will report to the Systems Resilience Group as mandated by NHSE and other accountabilities will be as described in section 4 of this document: *Governance Arrangements*.

Improved discharge planning processes introduced in 2015/16 together with improvements in consultant cover, medication dispensing availability and a change in practice for referrals to hospital transport should result in changes to the discharge distribution across the week during 2016/17. Addressing the needs of people admitted to the Emergency Department at Hillingdon Hospital with acute mental health needs to ensure that they are supported in the most appropriate care setting will be a key piece of work in 2016/17, as will be working with the third sector to ensure that older residents with lower needs receive appropriate levels of support at the point of discharge. Basing the social work team at the main Hillingdon Hospital site, subject to the availability of suitable accommodation, will support clinical hospital staff and contribute to the proactive discharge planning referred to earlier.

Actions contained within other schemes will also contribute to the delivery of this national standard, e.g. ensuring the availability of care home provision for older people with challenging behaviours and ensuring the availability of appropriate local palliative and hospice bed provision .

Many of the actions that will facilitate seven day working will also contribute to a reduction in delayed transfers of care.

b) Evidence of progress towards implementation of four key seven day standards.

Hillingdon Hospital is one of the acute trusts within the North West London sector that has accepted the opportunity to be a national First Wave Delivery Site for the seven day services programme. As part of this programme, the Hospital has agreed to achieve delivery of the four prioritised standards by April 2017(Standard 2: *Time to consultant review*; Standard 5: *Access to diagnostics*; Standard 6: *Access to consultant-directed interventions*; and Standard 8: *On-going review*). The following provides examples of progress:

- The radiology department is close to hitting 70% of the agreed target of reporting scans within 24 hours;
- CCR, MRI and X-ray are all close to meeting targets;

- Modified Early Warning Scores (MEWS) are now in place;
- Consultation is currently in progress with lead clinicians regarding the need for a new model of inpatient care to deliver Standards 2 and 8;
- Procurement for the Radiology Deep Dive is in progress.

c) How local partners will work together to ensure that NHS providers meet the milestones for inclusion of Clinical Standards in 2016/17.

The key deliverables for 2016/17 are:

- Implementaing an inpatient model of care that achieves the first and on-going consultant reviews (Standards 2 & 8);
- Radiology: imaging inpatients within 24 hours of request, developing pathways for readiological diagnostics and interventions and establishing a formalised network across the North West London sector for specialised reporting (Standard 5);
- Establishing robust pathways for inpatient access to consultant interventions 24 hours a day, 7 days a week (Standard 6).

Project groups have been established across the sector to deliver the four priority standards and their is a local, Hillingdon Hospital based group. The Hillingdon 7-day task and finish group referred to above is intended to pull together the Hillingdon-based activity across partner organisations.

d) Risks relating to the move to seven day services.

The following risks and challenges have been identified in respect of the four priority standards as well as the out of hospital standard (9):

- Lack of understanding about funding available for service delivery, e.g. additional clinical posts, could impact on delivery of 4 priority standards;
- Uncertainty about NHSE funding has slowed down progress on Stanards 6 and 8;
- Time it takes to deliver cultural change;
- Robustness of the local care market and corresponding ability to adjust to different ways of working.

8.3 Data sharing

a) The local plans in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Health Providers

The NHS number is already used as the primary identifier in correspondence amongst health providers.

Local Authority

The NHS number is recorded on the Council's social care system, Protocol, and is utilised as the common identifier in accordance with requirements under section 251A of the Health and Social Care Act, 2012.

As at 31st December 2015 up to 95% of all active adult social care records had a confirmed NHS number.

The Council has been progressing realtime verification through identification of the appropriate link to the NHS spine through the N3 connector. The Council is exploring use of the Personal Demographic Servce (PDS) to facilitate a more automated service.

The NHS number is not currently used on correspondence but the intention is to develop standard letters on the Council's adult social care database system called Protocol that will be able to draw through the NHS number. This will be undertaken during 2016/17.

Third Sector

It is a contractual requirement for the third sector provided Health and Wellbeing Service to use the NHS number of patients/residents being supported by the service in any correspondence with other partners. This practise will be put in place by the five constituent organisations that form H4All (the Wellbeing Service provider) over the next six months as part of the process of standardisation.

b) The approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Health Providers

There are a range of systems in place amongst health providers that facilitate the sharing of information and the following are examples:

- All of Hillingdon's 46 GP practices now use a single system called EMIS Web and this enables them to share information between practices and GP networks where there are common services and care pathways.

- Hillingdon GPs are able to submit orders electronically for diagnostic tests (pathology and radiology) at The Hillingdon Hospital (THH), and see the results in their EMIS Web system, using a system called Sunquest ICE. ICE also allows GPs to view tests requested internally at THH. This capability is being extended to tests performed at other hospitals. In addition, ICE is being implemented for selected clinicians in community and mental health care at CNWL.

- At the end of an episode of hospital care at THH, summary letters are sent electronically to GPs.

- GP patient records from EMIS Web are visible across the clinical specialties at THH via the Medical Interoperability Gateway (MIG) and the THH clinical portal. This is especially useful to the Acute Medical Unit (AMU). It is also used in A & E and the Hospital Pharmacy, along with the national NHS Summary Care Record.

- GP patient records have also been made available to the Urgent Care Centre and to

the GP Out of Hours and 111 services operated by Care UK via the MIG.

- Referrals can be sent electronically from Hillingdon GPs to THH via the NHS E-referrals system, which will be extended to CNWL.

- The national Electronic Prescribing System sends prescriptions from GPs to community pharmacies.

16 GP practices in the north of the borough, as well as the Rapid Access Clinics, hospital-based Homesafe Service and Ambulatory Care Clinics within Hillingdon Hospital, CNWL and third sector organisations via H4All are participating in the Care Information Exchange (CIE) pilot as a means of enabling each other to share integrated care plans electronically. This information will also be available online to patients.

Local Authority

The Council is committed to adopting systems that have APIs and Open Standards. standards. The Council is currently participating in the CIE pilot referred to above which, if successful, would see direct links being established between the Council's case management database and that of the CIE provider. In the event that the CIE pilot is unsuccessful will pursue direct linkages to the GP EMIS system through the Medical Interoperability Gateway and it will be apparent during 2016/17 whether this is the route that needs to be pursued with the expectation that delivery would take place during 2017/18.

The Council is also currently working with Hillingdon Hospital to enable the electronic transfer of assessment and discharge notices to take place and funding options are being explored to address the supplier charges being levied.

Third Sector

Plans are in place for identified staff employed by the H4All Health and Wellbeing Service to be authorised to have read and write access to EMIS web via the H4All's IT system to enable them to update patient records to reflect the details of their intervention.

c) The approach for ensuring that the appropriate IG Controls will be in place. These will cover NHS Standard Contract requirements, IG Toolkit requirements and professional clinical practice and in particular the requirements set out in Caldicott 2.

Strategic Oversight

The Pan-Hillingdon Joint IT Project Group oversees the delivery of IT integration in Hillingdon and provides an opportunity to share good practice and advise on new developments, including new legislative requirements. This group includes representatives from Hillingdon Hospital, CNWL, the Royal Brompton and Harefield Hospital, Care UK and also from adult social care and the corporate IT team within the local authority. The group is chaired by a local GP, who is the clinical lead for IT development and integration and is also a member of the CCG's Governing Body.

Health Providers

All GPs and local healthcare providers meet IGT requirements and have signed up to the North West London Information Sharing Protocal (ISP), which commits them to meet NHS standards for information governance and embodies the Caldicott 2 principles and the broader requirements of relevant legislation, common law and professional standards. The ISP governs a number of specific Information Sharing Agreements that cover the data sharing set out above.

Local Authority

The Council has completed the self-assessment for the Information Governance Statement of Compliance (IGSOC) standards and has achieved an 85% scoring by the Health and Social Care Information Centre (HSCIC), which puts Hillingdon in the top quartile for local authorities. The Council's organisational code is 727 should more detail be required.

A bi-monthly Information Assurance Group (HIAG) meeting chaired by our Senior Information Risk Owner (SIRO) has been in place for a number of years and is attended by senior members of the Council's leadership team, including the Corporate Director of Adults' and Children and Young People's Services in his capacity as the Council's Caldicott Guardian. This group has a yearly workplan to ensure the policies, process and guidance are in place to support the local IG Protocols and agreements. The Caldicott workplan feeds in to the overall HIAG workplan

For all Social work staff Data Protection and Information Governance e-learning training is mandatory prior to receiving logon details to the social care systems.

Council-wide data protection and e-learning takes place annually. For employees new to the council they are required to take the full training course. For existing staff they are invited to take a shorter course with the understanding if they do not achieve 85% or above they are required to take the full course.

All potential software suppliers must satisfy the requirements to ensure the correct controls are in place through a series of questions.

The Council has signed-up to the information sharing protocol based on the template developed by NWL CCGs and local authorities.

Third Sector

H4All is currently at level 1 of the IGSOC standards and the plan is get to level 2 by the end of Q1 2016/17.

8.4 Joint assessment and accountable lead professional for high risk populations

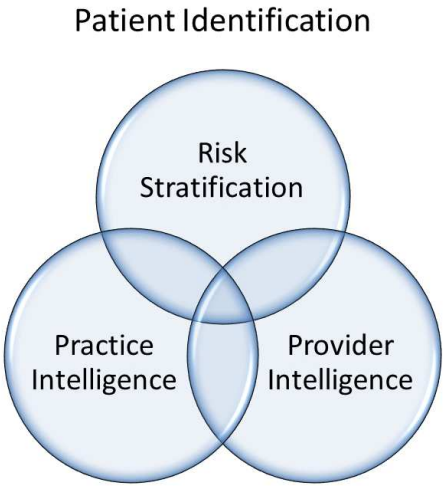
i) The proportion of the adult population that will be receiving case management and a named care coordinator.

Patient/Resident Identification

a) Health Providers

In order to ensure that patients can be identified by all care providers in a variety of settings in the local care economy, Hillingdon has devised a pathway which allows for a network-based collation and weighting of lists.

Patients will be selected by using a combination of multi-provider risk stratification tools, informed practice intelligence and informed provider intelligence. This is illustrated below:



In primary care patients wil be identified from a combination of practice intelligence, the use of the NHSE approved stratification tool QAdmissions and/or clinical judgement. From this information a list of patients for care planning will be developed at practice level.

Hillingdon Hospitals will use the risk stratification tool Parr 30 in order to identify those patients most at risk of readmission and this will be inputted into the information already available at a primary care level.

b) Local Authority

The Council has developed a risk stratification tool for determining the priority of existing service users for a review of their support plans and the extent to which their support plan is meeting their needs. Support plans are generally reviewed within eight weeks of implementation and then within one year thereafter if there is no change of circumstances in the intervening period; this is in accordance with the requirements of the 2014 Care Act. The risk stratification tool will identify people whose circumstances suggest that their review should be undertaken at an earlier stage. It will also help to identify the level of intensity of the review, e.g. whether this could be undertaken by telephone with the consent of the service user or if the complexity of their needs and circumstances requires that this be undertaken face to face.

c) General

A Hillingdon frailty screening tool is in development that will be available to all partner

organisations that come into contact with older residents in their own homes and will to identify whether a referral should be made either to the third sector provided Health and Wellbeing Service or to primary care.

Case Management and Named Care Coordinator

Hillingdon's model of care for older people is being implemented in the north of the borough and led by the Metrohealth GP network; it is intended that this will start to be rolled out to the rest of the borough during 2016/17. The model of care is based on the principle that the GP will remain the lead professional, although other professionals will often lead the coordination of care.

The process of risk stratification will identify people with high needs and those with potentially complex needs who are currently stable and will refer them for case management and care coordination. Care coordination is for both stable and escalated care needs. It is anticipated that escalated level care coordination will be carried out by a member of the Care Connection Team (CCT) as a key worker. Based on initial modelling by the Metro Health care connection team pilot , it is assuming 50 people per 1,000 will require escalated care then the total number requiring this level of support is approximately 770 (370 in the north of the borough and 400 in the south). The escalated care model is also being piloted in the north of the borough as a proof of concept.

The CCT comprises of a Guided Care Nurse, who works closely with patients, physicians and others to ensure coordinated, patient-centred care is provided for people at the greatest risk of hospital admission, and a care co-ordinator working with the GPs over 2 practices. The GPs, Guided Care Nurse and care co-ordinator are further supported by dedicated care of the elderly consultants available on the phone for advice and support and also by H4All. Where a patient is identified as being very high risk they are referred to the Rapid Access Clinics (RACE) provided by the Care of the Elderly Team at Hillingdon Hospital for a comprehensive geriatric assessment (CGA).

The CCT is linked into Adult Social Care to ensure appropriate local authority involvement to address eligible social care needs. Where an individual is already known to Adult Social Care and there is an allocated social worker, then they will continue to undertake a care coordination role in liaison with the CCT.
People with stable needs, e.g. those requiring less than a monthly intervention from a health care professional, will be supported by the care coordinator within the CCT, who will undertake a monitoring role, liaise with other members of the CCT and partners and ensure that care plans are updated.

Multi-disciplinary team (MDTs) meetings are being held in all GP networks across Hillingdon that involve all partner organisations to look at the most complex cases to identify the most effective ways of maximising patient independence and wellbeing and reducing demand on statutory services that is avoidable. MDTs are needs and outcome focused but their effectiveness is currently at different levels across the borough. Support will continue to be provided to ensure that these are an effective tool for managing complex needs.

MDTs are being supplemented in GP practices in the north of the borough by daily 'planning huddles' that involve some of the same professionals as at the MDTs to consider the very high risk patients. The activities that can occur within a huddle include:

- Discussion of the patient's wishes so that solutions can be modified to reflect their preferences, priorites and intentions;
- Communicating case management assessment findings to those that need to know;
- Establish treatment goals that meet the patient's health care and social needs as well as the referral source's requirepments;
- Medication review;
- Discussion of referrals to other community based services; and
- Discussion about laboratory, consultant and diagnostic reports.

ii) The proportions of the adult population that will be receiving self-management help.

Escalated Care Model

A principle supporting the escalated care model is that patients should be empowered and enabled through appropriate information, advice and support to manage their own conditions to the extent that they are able. It is in this context that assessments include, where possible, utilisation of the Patient Activation Measures (PAM), which help to determine the extent to which an individual is motivated to self-manage their own long-term condition (s).

People with Stable or Lower Level Needs

A single gateway to services provided by a range of voluntary and community groups is being managed by the third sector consortium, H4All. This is called the Health and Wellbeing Service. The service will:

- Take direct referrals from health and social care professionals to support people with low to moderate social care needs;
- Attend MDTs to ensure appropriate access and support to those whose needs can best be met from the third sector;
- Identify residents who are isolated, anxious and de-motivated.

The model for the Wellbeing Service has been developed to use the PAM tool to set a baseline on which to evaluate intervention and as a measure to target support and resources to people who require it. The service will work with residents to raise their participation and motivation in self-management.

A key to people being able to manage their own long-term conditions is access to information and advice and a range of services funded by the Council through Public Health money and provided by third sector organisations are in place. An online directory of services called Connect to Support is being developed and promoted as the key electronic source of information for borough residents, including links to the 111

service and NHS Choices and the Directory of NHS services. See scheme 1 in **Annex 1**: *Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation* for more detail.

8.5 Investment in NHS commissioned out-of-hospital services

2016/17 BCF plan includes an investment by the CCG of £10.6m in out of hospital services that are included within the BCF. This includes:

- Early supported discharge (Community Homesafe)
- Rapid Response
- Community Rehabilitation
- District Nursing Service
- Community matrons
- Hawthorn Intermediate Care Service
- Franklin House step-down beds
- Community equipment (including pressure mattresses)
- Falls Services (Hillingdon Hospital, CNWL and Age UK)
- Prevention of Admission to Hospital (PATH) Service

This reflects an increase of £1.9m of investment in out of hospital services that were contained within the BCF in 2015/16.

8.6 Agreement on local action plan to reduce delayed transfers of care, including a risk share agreement.

The number of delayed days in Hillingdon is low in comparison with other London boroughs and our BCF plan is designed to reduce this further and the detail is set out in **Annex 1** (see schemes 3: *Rapid Response and Integrated Intermediate Care*, scheme 4: *Seven Day Working,* scheme 5*: Integrated Community-based Care and Support* and scheme 6: *Care Home and Supported Living Market Development* . The key components of our approach are:

- Proactive discharge planning in Hillingdon Hospital supported by the Integrated Discharge Team and social work staff being permanently based on the main hospital site.
- Development of a consistent approach to MDTs within the acute hospital and mental health to ensure a common process and outcomes.
- Range of out of hospital services funded by the CCG to expedite discharge and prevent admission, including Hawthorne Intermediate Care Unit and step-down beds.
- Early support discharge services in the form of Community Homesafe Service provided by CNWL and Age UK for people with lower levels of need.
- Council provided Reablement Service to expedite discharge and prevent admission for residents who do not require health professional intervention.
- Developing a more integrated approach to support a stable local homecare market.
- Development of in-reach support services to encourage existing care homes to accept people with challenging behaviours as well as working with providers to ensure suitable local supply to meet future demand.
- Creation of a Social Care and Housing Board to identify solutions where access to suitable accommodation is likely to result in a delayed discharge.

The level of DTOCS in Hillingdon is such that the partners do not consider a risk share agreement in this area to be necessary.

8.7 Agreement on consequential impact of changes on providers

a) Impact of local plans have been agreed with relevant health and social care providers

i) Implications for acute providers

Our BCF plans have been developed with both acute and community providers and represents a local progression from the 2015/16 plan.

Work to date on the development of Out of Hospital Hubs in Hillingdon has incorporated projected changes from integrated working for older people including new ways of working and seven day working.

A provider commentary is provided by THH is available in **Annex 3**.

ii) Primary care providers

Metrohealth primary care network has been engaged in the development of the plan as a result of the alignment of the BCF with the pioneer integration pilot. Engagement with other networks will be undertaken during Q1 2016/17 with a view to informing the development of the 2017/18 to 2019/20 plan. A provider commentary provided by Metrohealth is available in **Annex 3**.

iii) Social care providers and providers from the voluntary and community sector

Social Care Providers

The content of the plan reflects engagement with private providers, such as care homes and there will be engagement with other providers commissioned by the Council to inform the development of the 2017/18 to 2019/20 plan, e.g. home care providers.

Third Sector Providers

The third sector consortium H4All (Age UK, DASH, Harlington Hospice, Hillingdon Carers and Hillingdon Mind) has been engaged in the development of the plan through its alignment with the pioneer integration pilot. The pooled budget for 2016/17 includes the Council's core funding to four out of the five organisations within H4All. A provider commentary provided by H4All is available in **Annex 3**.

Iv) Implications for acute providers

Our BCF plans have been developed with both acute and community providers and represents a local progression from the 2015/16 plan.

Work to date on the development of Out of Hospital Hubs in Hillingdon has incorporated projected changes from integrated working for older people including new ways of working and seven day working.

A provider commentary is provided by THH is available in **Annex 3**.

8.8 Better integration between mental and physical health

The links between mental health and physical health are reflected in the construction of the 2016/17 plan. This can be seen in the strongly prevention focused scheme 1: *Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.* Specific actions have been taken to increase integration between the two areas of need, as can be seen with the creation of the Registered Mental Nurse post in Rapid Response (see scheme 3: *Rapid Response and integrated intermediate care*). The creation of a specifc scheme on supporting people living dementia (scheme 8) is also intended to achieve greater integration to deliver better outcomes both for people living with dementia and their Carers.

9. NATIONAL METRICS

9.1 Non-elective admissions (General and Acute)

a) Explanation for how the target has been reached.

The target for non-elective admissions to be avoided in 2016/17, which is contained is reflected in the CCG's Operating Plan is 2,691 (1,280 in 2015/16). The contribution of the BCF plan to the achievement of this target is 714 admissions avoided. The target for 2016/17 has been based on consideration of 2015/16 activity and taking into consideration improvements that will be delivered in 2016/17.

b) Analysis of previous performance and assessment of impact of 2016/17 plan.

Performance in 2015/16 suggests that the falls-reduction ceiling will be slightly exceeded but will still be lower than the outturn for 2014/15. Emergency admissions from care homes was maintained at 2014/15 levels. However, embedding the new model of care for older people and the proposals contained within the detailed scheme descriptions set out in **Annex 1** should deliver improved performance in 2016/17 and the table below identifies the source for the contribution to the Operating Plan NEA target.

Scheme	Service Area	Hillingdon Hospital-related Reductions	London North-west-related Reductions
1	Falls	70	13
1	Health & Wellbeing Service	85	0

3	Intermediate Care	153	29
5	Integrated Care Planning	115	21
5	Rapid Access to Care of the Elderly Team clinics (RACE)	88	13
6	Care home-related admissions	64	12
	TOTAL	**575**	**88**
TOTAL NEA REDUCTION BCF TARGET		**663**	

9.2 Permanent admissions to residential and nursing care homes.

a) Explanation for how the target has been reached.

The target of 150 permanent admissions reflects the demographics of the borough and the lack of realistic alternatives to residential care pending the delivery of two extra care schemes comprising of 148 self-contained flats in 2018.

b) Analysis of previous performance and assessment of impact of 2016/17 plan.

The 2015/16 ceiling (104) was adjusted with the approval of the HWB to reflect the fact that the assumption made in 2014/15 in setting the ceiling that a 50 flat extra care scheme would be delivered in-year was not going to come to fruition. Increasing the effectivenss of Reablement to give more focus on people with reablement potential and the promotion of Disabled Facilities Grants (DFGs) are examples of specific actions that will be taken to help curtail the growth in the number of permanent admissions to care homes. However, the scope for the 2016/17 plan to significantly reduce the number of permanent placements is limited by the fact that the two new extra care schemes referred to above will not be delivered until late 2017/18. Work being undertaken as part of scheme 6 (see **Annex 1**): *Care Home and Supported Living Market Development,* will help to support older people within existing extra care schemes more effectively and for longer, but this will not take effect until early in 2017/18. A key objective of this work will also be to reduce the impact on primary care and avoidable emergency admissions.

9.3 Effectiveness of reablement

a) Explanation for how the target has been reached.

During 2015/16 the number of people entering the Reablement Service increased by 38%. The target for 2016/17 (93.8%) has been arrived at on the basis of 960 people being seen by the service during the year but with greater focus on people with reablement potential and therefore a 1.8% increase in the number of people still at home after 91 days following the hospital discharge.

b) Analysis of previous performance and assessment of impact of 2016/17 plan.

The practice during 2015/16 has been for the majority of service users being discharged via Hillingdon Hospital and for all new referrals from the community to be referred to the Reablement Service. This has proved not to be an efficient use of resources and following a review a restructure is proposed that provide more focus on people with reablement potential, which means that a significant increase in the target for people to be seen by the service would not be appropriate or deliverable.

9.4 Delayed transfers of care

a) Explanation for how the target has been reached.

The ceiling agreed for 2016/17 assumes an outturn for 2015/16 of 4,334 delayed days based on a straightline projection using year to date data to the end of January 2016. The 5% reduction target (or 217 delayed days) is based on how quickly it will be possible to address the key causes of the delay, 70% of which are due to issues in securing appropriate placements for people with challenging behaviours.

b) Assessment of impact of 2016/17 plan.

The 16/17 plan will deliver the key actions that will impact on reducing DTOCs and this includes: • Ensuring a common understanding of the definition of a DTOC. • Establishing an agreed discharge protocol and procedure. • Improving advanced discharge planning on acute wards. • Establishing common practices across acute and non-acute. • Improving liaison between acute and mental health professionals • Addressing supply of suitable, local care setting provision for people with behaviours that challenge. • Establishing seven day assessments in nursing homes. • Establishing a secure homecare market. More detail is provided in the individual scheme descriptions in **Annex 1**. See schemes 3, 4, 5 and 6.

Appendix 3

NHS
Hillingdon
Clinical Commissioning Group

Better Care Fund Plan 2016/17

Annex 1

Detailed Scheme Descriptions

HILLINGDON
LONDON

March 2016

Better Care Fund Plan 2016/17
Annex 1: Detailed Scheme Descriptions
Contents

BCF Plan 2016/17
ANNEX 1 – Detailed Scheme Descriptions

Scheme One
a) Scheme Name
Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation
b) Scheme Strategic Objectives
This scheme seeks 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.
c) Scheme Overview
This scheme builds on the work undertaken under Hillingdon's 2015/16 BCF plan to take forward the anticipatory model of care and apply a more preventative approach to addressing health and social care need. The scheme's focus is people whose current level of need is low and as a result their risk factors would not be identified through the risk stratification process being undertaken in primary care. See scheme 5: *Integrated Community-based Care and Support* for details of the utilisation of risk stratification as part of the delivery of better anticipatory care in Hillingdon. Identification of this cohort of people will enable early engagement in self-directed care and support and facilitate access to preventative pathways. People living with dementia, people susceptibility to falls and/or who are socially isolated are disproportionately represented in our non-elective admissions and admissions to long term residential care. In addition, stroke is one of the main causes of disability in the 55 and over population and one of the main causes of death in the 75 and over population. Susceptibility to stroke increases as people age and there are factors that can contribute to a person being particularly at risk. As stroke is a largely preventable condition, early identification of people at risk can help to prevent this life changing condition from occurring. There is a loss of opportunity in not being able to identify people with these conditions early on in their development and to intervene sooner. The potential impact on outcomes in the medium to long term could be significant. Key initiatives include: • <u>*Promotion and further development of an online citizen portal*</u> - Access to good information and advice is fundamental to people being able to self-manage their own health and wellbeing. The Connect to Support portal established in 2015/16 will be promoted further in 2016/17 to make it the go-to place for information and advice, including about activities and services to support the health and wellbeing of Hillingdon's residents.

- *Making every contact count (MECC)* - Training delivered to frontline staff in Q4 about how to identify people who may be at risk of dementia, falls and/or social isolation and how to respond will be evaluated. This will shape the content of any further training to staff who visit people in their own homes. The extent to which this is rolled out further will depend on the readiness of the response to issues raised following staff contact with residents at risk;

- *Delivering a system-wide response* - This entails setting out what to do when we identify people with these susceptibilities. It could include a referral to the pilot Hillingdon Health and Wellbeing Service provided by the third sector consortium H4All, which will provide support to older people with one or more long-term condition who need assistance to manage their condition. People referred to this service can also benefit from an assessment using the Patient Activation Measures (PAM). This assessment is intended to identify people needing support to engage more actively in the management of their own condition. People identified as needing support to engage with self-care plans are at greatest risk of increased health and care need and will receive a programme of direct support from the service. Other people will be advised about the options available to address their needs, including being sign-posted to services provided by third sector organisations.

- *Reviewing the falls strategy* - A centralised falls service (with multi-factorial assessment management), assisted discharge from hospital for people who have fallen and a community based falls prevention service were established prior to 2015/16 and have proved successful in preventing emergency admissions. Hillingdon's strategy for supporting people at risk of falling as well as those who have fallen will be reviewed in 2016/17. This will take a comprehensive view of the respective Council and CCG functions and funded services and how collectively with partners falls prevention can be supported.

- *Supporting and developing the role of the third sector* - The evaluation of the impact of the Health and Wellbeing Service pilot will include patterns of utilisation of services provided by Hillingdon's third sector. This will inform how best to target current third sector capacity funded by the Council and/or CCG in order to maximise the outcomes of supporting people to be independent in the community and preventing or delaying escalation and subsequent demand on statutory services. This will help inform commissioning decisions about the appropriate configuration of services to meet local need in the period up to 2020 as part of an integrated model community based care for older people, which links to scheme 5: *Integrated community-based Care and Support*.

- *Stroke prevention*: There are four components to a stroke prevention strategy and these are: increasing physical activity, addressing excess weight issues, smoking cessation and early detection. During the 2016/17 the following initiatives will be undertaken:

    - *Increasing physical activity* - There is an existing physical activity programme and targeting this at people aged 55 and over carrying excess weight is expected to have a beneficial outcome.

    - *Addressing excess weight issues* - In 2015/16 a weight management project

working with 200 residents has been piloted. The results of this will inform the development of a business cases for a tier 2 weight management service directed at obese or overweight people who need personal, time-limited interventions in the community to support them in managing lifestyle changes;

- *Smoking cessation* - The Council, through its public health function, already provides a successful smoking cessation service and this will continue. It will be reviewed during 2016/17 to explore how its effectiveness can be maximised;

- *Early detection* - A key method for detecting at an early stage susceptibility to stroke is through the NHS health check programme. We currently have an active programme but at 12% of the eligible population being targeted per annum the rates are lower than is ideal and aiming for 20% would be more effective in disease prevention. Hypertension and high cholesterol (both important in causing stroke) are already tested for in NHS health checks. Atrial fibrillation (AF), a disturbance of heart rhythm, is a major cause of stroke and is not tested as part of the health check programme. During 2016/17 options to increase the rate of health checks (as well as extending them to cover AF) will be explored.

- *Delivering older people's wellbeing initiatives* - The Council will implement the reorganisation of its Health Promotion and Sports Development Services into a Wellbeing Service, which will be able to develop more comprehensive initiatives in partnership with the third sector to improve health and wellbeing by helping to keep people active, both mentally and physically.

- *Preventing dementia* – The actions set out above to prevent stroke and promote the wellbeing of older people will also help to prevent or delay the onset of dementia. This links with scheme 8: *People living well with dementia*.

- *Identification of carers* - Many people who provide care for loved ones free of charge are not aware that they are carers. The work undertaken under this scheme provides an opportunity to identify carers and refer them to the Council for a carer's assessment and/or the third sector for information, advice and appropriate support. This links with scheme 7: *Supporting carers.*

- *Making best use of assistive technology* - The work undertaken under this scheme provides an opportunity to identify people who may benefit from assistive technology, e.g. telecare and telehealth, and to make referrals. This technology can help to provide the residents/patients and their families with greater confidence about them remaining in their own home.

d) The Delivery Chain

Scheme Lead Role

The Council will be the lead for this scheme.

Scheme Delivery

- The online resident portal, Connect to Support, is commissioned by the Council;
- A multi-agency, multi-disciplinary clinical working group (CWG) co-ordinates the development of falls and falls prevention services in Hillingdon. The current falls-specific prevention and treatment services are commissioned by the CCG and provided by CNWL, Age UK and THH;
- Support for people with dementia will come from a range of providers including GP Networks, NHS community services, direct Council provision, e.g. TeleCareLine, and the third sector;
- The current screening programme is undertaken in primary care;
- The new Wellbeing Team will work in partnership with the Library Service and the third sector to support older residents to become or remain mentally and physically active. This will help to prevent or delay the onset of dementia, as well as help to prevent stroke;
- The Council provides telecare through its in-house TeleCareLine Service, which includes a response service for those without a family responder or where the family responder is not contactable in the event of an emergency. Telecare equipment is supplied by a private provider.

e) The Evidence Base

Feedback from residents both nationally and locally identifies the importance of access to information and advice to be fundamental to people being able to self-manage their long-term conditions and also to having choice and control over how their needs are met.

During 2014/15 there were 871 emergency admissions as a result of falls at a total cost of £2.9m. During the period Q1 to Q3 2015/16 there were 578 falls-related emergency admissions, compared to 671 during the same period in 2014/15.The cost during the period Q1 to Q3 2015/16 was £1.7k compared with £2.1m during the same period in 2014/15. The target falls-related admissions ceiling for 2015/16 is 761 and activity from Q1 to Q3 suggests that on a straightline projection this may be slightly exceeded, although the performance will be improved upon that of the previous year.

However, the ageing population increases the necessity of addressing this area of risk both in terms of the loss of independence for older residents but also the additional costs to Adult Social Care and the NHS that may result from an admission to nursing care homes.

f) Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Health and Wellbeing Service	H4All	543	195	738

b) Connect to Support	Shop4Support	45	0	45
c) Online Services Coordinator	LBH	44	0	44
d) Atrial Fibrillation screening equipment	P & V	5	0	5
e) Older People Wellbeing initiatives	LBH	20	0	20
f) Falls Prevention Service	Age UK	0	140	140
	Primary Care	0	55	55
TOTALS		**657**	**390**	**1,047**

g) Contribution to BCF Metrics

This scheme will contribute to the following key BCF metric:

- Reduction in non-elective admissions

h) Other Success Measures

The following measures will be used to identify whether the scheme is working:

- Increase in utilisation rates for Connect to Support (new and repeat users) – Baseline to be established in Q4 2015/16.
- % of users of Adult Social Care who have found it easy or difficult to access information and advice about services and/or benefits (Test through the Adult Social Care Survey).
- Reduction in falls-related emergency admissions (83 admissions prevented).
- Proportion of residents/patients who have an improved PAM scoring where there is tangible improvement in engagement in self-directed support.
- Number of people assessed through the Health and Wellbeing Service receiving active support from a support coordinator.
- Number of people supported by the Health and Wellbeing Service who receive appropriate information or signposting to local groups through the service's triage assessment. This will require a separate survey of service users.
- Number of successful referrals to voluntary and community organisations from the H4A Service and the referral outcomes. This will require a system to be put in place to monitor user feedback and identify delivery of intended outcomes.
- Numbers of people aged 55 and over participating in stroke prevention activities. Activities that help to prevent stroke will also contribute to reducing the risk of dementia.

- % of people aged 55 and over participating in screening programmes.
- Evaluation of the training programme for frontline staff who visit residents in their own homes.

Scheme Two

a) Scheme name

Better care for people at the end of their life

b) Scheme Strategic Objectives

This scheme seeks 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.' This is intended to maximise the dignity of the person at end of life, ensure that they receive the right services at the right time and relieve as much as is possible the stress for them and their carers and/or family.

c) Scheme Overview

This scheme builds on the work undertaken in 2015/16. 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 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.

To achieve these goals the key initiatives under this scheme will include:

- *Identification of people at end of life* - The process for identifying people at end of life resulting from work undertaken in 2015/16 will be implemented. This will ensure that key professionals are supported in diagnosing people with advanced disease who are in the last months/year of life and who are in need of supportive and palliative care. This will support appropriate anticipatory planning being undertaken. This action links with scheme 8: *Living well with dementia*.

- *Delivering a communications plan for professionals* - The communications plan developed in 2015/16 setting out Hillingdon's end of life pathway, including the support available to residents/patients and their carers and/or families will be delivered. This will help to raise awareness of the support available to people at end of life whose preferred place of care is at home and help to prevent hospital admissions that are inappropriate in the context of expressed resident/patient wishes.

- *Increasing utilisation of multi-disciplinary care and support planning* – During 2016/17 partners will be increasing the utilisation of Co-ordinate My Care (CMC) as the advance care planning tool for people at end of life, which is in line with practice across London. This will include exploration of access to Adult Social Care staff and the provision of appropriate training to facilitate this. Increasing the utilisation of CMC

will link in to the expansion of the care information exchange (CIE) platform, subject to the success of the pilot which will be undertaken early in 2016/17.

- *Facilitating seamless care provision between health and social care* – The Council will bring its social care spend for people at end of life within the pooled budget to ensure that a disruption in care is not caused by a transition in funding responsibility between health and social care. The Council will also explore the feasibility of removing the potential charge for people diagnosed as likely to have only having six months to live whose needs are primarily social care. This would help to avoid the complexities and potential disputes that can arise when trying to determine at what point a person's care should be health funded.

- *Implementing results of market testing of end of life services* – In order to reduce the fragmentation of end of life services and avoid the disruption that can arise from a change of provider resulting from a person's needs transitioning from being primarily social care to health care at critical time, the Council and CCG will move towards single or lead provider arrangements.

- *Developing appropriate training for providers* - 'Difficult conversations' training will be delivered to health and social care providers to assist with planning for anticipatory care needs, which will help to avoid crisis situations leading to hospital attendances and admissions, especially where the latter is not the preferred place of care.

- *Implementing outcome of review of support for carers of people at end of life* – Any gaps in service provision to support carers of people at end of life will be considered as part of the work undertaken in scheme 7: *Supporting Carers*. Where additional funding is required appropriate business cases will be developed for consideration by the Council and/or CCG.

- *Reviewing available information* – Access to good, up to date information is critical to support residents/patients and their Carers and families. For residents/patients this will be promoted through the resident online portal Connect for Support. For professionals the additional route is the NHS Directory of Services. The range of services advertised and accuracy of the data will be monitored by the End of Life Forum.

d) The Delivery Chain

Scheme Lead Role

HCCG will lead on this scheme, the implementation of which will be overseen by the multi-agency End of Life Forum.

Scheme Delivery

The providers will be a combination of primary care, community NHS services, acute, social care, London Ambulance Service and voluntary and community sector providers.

e) The Evidence Base

The three main causes of death in Hillingdon and recorded on death certificates as

primary underlying causes were cardiovascular disease (29.0%), cancers (28.0%) and respiratory disease (14.5%). Respiratory causes of death rose to 34.3% if mentioned or recorded as 'contributory' to the cause of death. Alzheimer's and other forms of dementia accounted for about 12% and though it is the fourth cause of death, this is rising. In the last 3 years, deaths from cardiovascular disease, cancer and respiratory causes appear to be falling while the number and proportion of deaths from Alzheimer's and forms of dementia are rising. All these causes are considered demanding of end of life care.

The average number of deaths per year in Hillingdon for the period 2008 - 2012 was between 1800 and 1900.

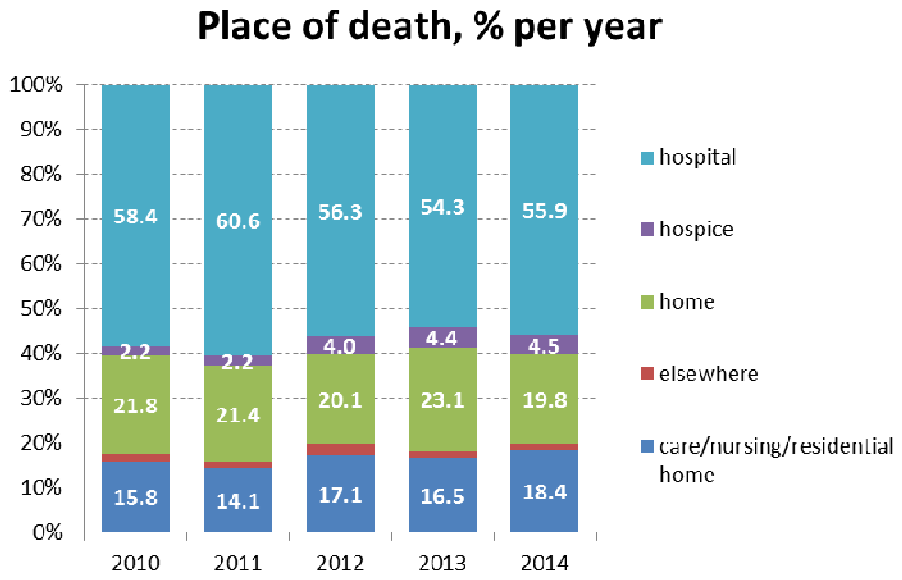
- People aged 65+ accounted for 85% of all deaths (88% in the North and 82% in the south)
- People aged 75+ accounted for 70% of all deaths (76% in the North and 65% in the south)
- Percentage of deaths in both those aged 75+ and 85+ are lower than national average but higher than London average though not significantly different
- More deaths in 75+ in Care homes based in the North than in the South (or more deaths in Hospital with residents in the South).

ONS, 2014MYE shows that over half (56.5%) of Hillingdon's 65 and over population live in the south of the borough, e.g. south of the A40. By 2020 the growth in the 65 and over population is estimated to be over 700 people per year broken down as follows:

- 85-89 by an extra 110 per year
- 75-84 by an extra 220 per year
- 65-74 by an extra 360 per year

There are more care home beds per 1000 population for 75+ based in the North (88/1000) than in the South (56/1000) and this helps to explain why there are proportionately more deaths in care homes in the north of the borough than in the south, where more people die in hospital.

The Primary Care Mortality Data there were 1,823 deaths in 2014. 51% (926) of these were female and 49% (897) male. The diagram below shows place of death between 2010 and 2014.



f) Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Specialist Palliative Personal Care Service	Third Sector	50	106	156
TOTALS		**50**	**106**	**156**

g) Contribution to BCF Metrics

This scheme will contribute to the following key BCF metric:

- Reduction in non-elective admissions

h) Other Success Measures

The following measures will be used to identify whether the scheme is working:

- To achieve 90% of people at end of life with an advanced care plan on CMC.
- >50% of people with an advanced care plan on CMC dying in their preferred place of care.
- Positive family/carer experience of the quality of care and support provided at end of life. Securing this information will require a separate survey to be undertaken the sensitive nature of which is likely to necessitate one to one support.

Scheme Three

a) Scheme name
Rapid Response and Integrated Intermediate Care
b) Scheme Strategic Objectives
Prevention of 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.
c) Scheme Overview
Existing crisis response services for adults (aged 18 years and above) with both health and mental health conditions are provided in the community and in-reach to the emergency department (ED) at The Hillingdon Hospital (THH). They also link with the Psychiatric Liaison Service in the ED. The Rapid Response service provides nursing, therapeutic and care needs for up to 10 days and has a fast track referral process to the LBH to establish packages of care or reablement. For people with more severe mental health conditions, including dementia, the Home Treatment Service is available for up to 14 weeks. There is also access to night carers for up to 3 nights and a service which will escort people home from the ED. This scheme is aligned with the early supported discharge HomeSafe Service, which is clinically led by Hillingdon Hospital through the Care of the Elderly Team (COTE). The service entails older people aged 65 and over who are admitted through the ED being screened for a comprehensive geriatric assessment (CGA). Patients who receive a CGA will be managed on the HomeSafe pathway. Health and care needs identified are met by community based providers for up to 10 days to facilitate clinically appropriate and timely discharge from acute care. Appropriate onward referrals to address on-going needs are then made. The intermediate care provision is made up of the 22 bed Hawthorn Intermediate Care Unit (HICU) on the Hillingdon Hospital site, the Community Rehabilitation Team, Reablement Team, community equipment, telecare services and Prevention and Admission to Hospital Service provided by Age UK for people with low social care needs. 5 step-down beds are provided at Franklin House Nursing Home for people who are medically stable and are a) on a rehabilitation pathway, need a bed-based service but unable to weight bear for 3 weeks or more; or b) are undergoing an assessment for continuing health care (CHC) which has not yet been completed. There is also a flat at the Cottesmore House extracare sheltered housing scheme that is used to meet step-up or step-down needs and supported by private sector care provider with in-reach support from the Reablement Team. During 2015/16 an integrated discharge team has been set up in the Acute Medical Unit (AMU) to identify adults with care needs as soon as they are admitted to hospital and to take a more proactive and joint approach between health and social care to discharge management. This will continue into 2016/17. Although there has been greater functional alignment between services during 2015/16

they still remain fragmented. During 2016/17 work will take place to explore integration options, including possible incentivisation of providers, that will deliver the following outcomes:

- Reduction in the number of hand-offs between different organisations.
- Resident/patient needs being addressed by the most suitably qualified professional first time.
- Reduction in the number of points of access.
- Reduction in length of stay in intermediate care services.
- Improved resident/patient experience of care.
- Value for money.

Service options development will also include consideration of procurement routes.

d) The Delivery Chain

Scheme Lead Role

HCCG will lead on this scheme, the implementation of which will be overseen by the Systems Resilience Group.

Scheme Delivery

Crisis response and home treatment services are provided by CNWL and commissioned by the CCG. They link with the Reablement Team which is provided by LBH. They also link into private sector provided homecare commissioned by LBH.

Telecare services are also provided by LBH and the ED and home from hospital (up to 6 weeks for people with low care needs) service is jointly commissioned by the CCG and LBH, as is the community equipment provision. The night carer service is provided by Harlington Hospice and commissioned by the CCG.

It is expected that delivery options during 2016/17 will be shaped by the emerging Accountable Care Partnership (ACP).

e) Evidence Base

A review of intermediate care and development of a new model of care was commissioned by the CCG from Libera partners, consulted on with partner organisations and reported on locally in January 2012. This recommended a number of changes to the way that intermediate care services were delivered, which led to a business case being agreed by the CCG in 2012/13 that led to changes in the provision and capacity of intermediate care and community-based crisis response services and to early supported discharge arrangements, e.g HomeSafe Service.

2014/15 there were 10,341 non-elective admissions of Hillingdon residents who were aged 65 and over at a cost of £25.8m. During 2014/15 46.5% of non-elective admissions of the 65 and over population had a length of stay of between 0 and 2 days, thereby suggesting these admissions were avoidable and this trend was repeated during the first half of 2015/16.

f) Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Rapid Response	CNWL	0	1,546	1,546
b) Hawthorn Intermediate Care Unit	CNWL	0	1,614	1,614
c) Community Rehab	CNWL	0	1,094	1,094
d) Prevention of Admission/Readmission to Hospital (PATH)	Age UK	29	91	120
e) Take Home & Settle	Age UK	0	63	63
f) Reablement Team	LBH	2,211	0	2,211
g) Reablement Physio	CNWL	51	0	51
e) Community Homesafe	CNWL	0	688	688
f) Spot purchased intermediate care beds	Various P & V	341	0	341
g) Step-down beds (Franklin House)	Care Uk	0	198	198
h) Support to step-down beds	CNWL	0	53	53
i) Cottesmore Reablement Flats	Paradigm Housing Group	38	0	38
j) Hospital Social Workers	LBH	210	0	210
k) Mental Health Nurse in Rapid Response	CNWL	40	0	40
TOTAL		**2,920**	**5,347**	**8,267**

g) Contribution to BCF Metrics

This scheme will impact on the following BCF metrics:

- Reduction in the number of non-elective admissions.
- Reduction in permanent admissions of older people aged 65 years and over to residential and nursing care homes, per 100,000 population from 2015/16 baseline.
- Increase in % of older people aged 65 years and over who are still at home 91 days post hospital discharge into reablement service from 2015/16 baseline.

h) Other Success Measures

The following measures will be used to identify whether the scheme is working:

- 7 admissions a day avoided following referral to Rapid Response by Hillingdon Hospital's Emergency Department and 1 admission per day avoided following referrals from other routes.
- Average number of discharges supported home from Hillingdon Hospital wards by HomeSafe per day.
- Reduction in admissions resulting in a length of stay (LOS) of between 0 and 2 days.
- 78 admissions avoided as a result of the availability of the Rapid Access Care of the Elderly (COTE) clinics.
- Average of 80 referrals to Reablement per month.
- % of new clients who received Reablement where no further request was made for

long-term support.
- Number of reablement cases closed within 6 weeks.
- Number of people readmitted to hospital whilst receiving reablement.

Qualitative feedback will be sought through surveys of residents/patients to capture their feedback about their experience.

Baselines will be established in Q4 2015/16 against which progress in 2016/17 can be measured.

Scheme Four

a) Scheme name

Seven Day Working

b) Scheme Strategic Objectives

To improve quality and patient safety through reducing inconsistent care provision by:-
- Enabling discharge from the acute trust seven days a week for people admitted for either planned or unplanned procedures;

- Enabling access to community services seven days a week thereby preventing unnecessary emergency department attendances and admission and reducing length of stay for people admitted to hospital for either planned or unplanned procedures;

Reducing the uneven rate of hospital discharge across the week.

c) Scheme Overview

This scheme is intended to deliver standard 9 of the 10 Seven Day Working Clinical Standards.

There are a number of interdependencies with other schemes that are critical to the delivery of standard 9 and these include:

- *Placements for people with challenging behaviour needs* - Securing suitable local placements for people with challenging behaviour needs is a key cause of delayed transfers of care and this piece of work falls within the remit of scheme 6: *Care Home and Supported Living Market Development;*

- *Seven day assessments in nursing homes* - The availability of suitably qualified staff in nursing homes to undertake assessments of people who have been admitted to hospital and are medically fit for discharge will contribute to delivering a more even spread of discharges across the week. This requirement will be included as a condition of the Dynamic Purchasing System (DPS) tender for care homes that the Council is undertaking with the West London Alliance (WLA) of local authorities. This piece of work falls within the remit of scheme 6: *Care Home and Supported Living Market Development.*

- *Palliative & hospice bed provision* - The ability of the Hospital to discharge people who are at end of life is impacted by available service provision and this will also be addressed under scheme 6: *Care Home and Supported Living Market Development.* This also links with scheme 2: *Better care at end of life*.

Improvements in managing the discharge process from Hillingdon Hospital introduced in 2015/16 will be carried forward into 2016/17. Essential components of this will be earlier planning and this will be assisted by the following:

- *Advanced discharge planning on wards* - Hospital wards will be set specific targets to facilitate advanced discharge planning to ensure that key enablers such as medication and transport are available. Opportunities for standardising the MDT process on wards on the Hillingdon Hospitals sites will be explored. The objective of this work will be to apply the most effective MDT model consistently to achieve a better experience of care for patients and expedite the discharge of people who no longer need to be in hospital.

- *Embedding earlier referrals to Hospital transport* - The Hospital has transport available 24/7 365 days a year but earlier planning will assist in enabling referrals to be made earlier in the day in order to avoid a glut of activity around 4pm. This will also help to improve the experience of care by preventing patients being taken back home late at night.

- *Developing the Integrated Discharge Team* (IDT) - The continuation of the IDT into 2016/17 is subject to the outcome of an evaluation into its effectiveness that will take place in Q4 2015/16. However, the practice of Adult Social Care proactively engaging with the wards to facilitate advanced discharge planning will continue in one form or another. Subject to the availability of accommodation on the Hospital site, there will be an increased social care presence to ensure a prompt response to addressing social care needs, which will contribute to a more even seven day flow out of the Hospital. This links into scheme 3: *Rapid Response and Integrated Intermediate Care*.

Other required components of the work to improve the discharge process will include:

- *Addressing needs of people with acute mental health needs* - Caring for people admitted to the Emergency Department with acute health needs in addition to severe mental health needs can be very resource intensive and this can impact on the delivery of a smooth discharge pathway for other patients. Through joint working between the CCG, Hillingdon Hospital, CNWL and the UK Border Agency the intention is to release acute mental health beds to ensure that people with acute mental health needs are cared for in the most appropriate setting to support their recovery.

- *Earlier referrals to Psychiatric Liaison Service* (PLS) - Changing practice to ensure early referral of patients showing signs of mental distress are referred to the PLS prior to discharge will also assist in preventing readmission that is avoidable.

- *Developing the role of the third sector* - Linking into scheme 3: *Rapid Response and*

Integrated Intermediate, the support from the third sector to people at the point of discharge and in the first few weeks after they have returned home will be considered. The purpose of this will be to ensure that maximum benefit can be obtained from the unique skills available from the third sector to support the independence of residents and prevent readmissions that are avoidable.

- *Developing a common functional assessment in hospitals in North West London (excluding Hillingdon Hospitals)* - Assessment of patient need and function occurs within the hospital and is carried out by the hospital Multi-disciplinary Team (MDT) however, decision-making about which community service(s) is most appropriate is undertaken by the community team. The development of a common tool for assessing a patient's needs and function in hospitals other than Hillingdon Hospital would assist in supporting the discharge process where Hillingdon residents are admitted to other hospitals in north west London.

d) The Delivery Chain

Scheme Lead Role

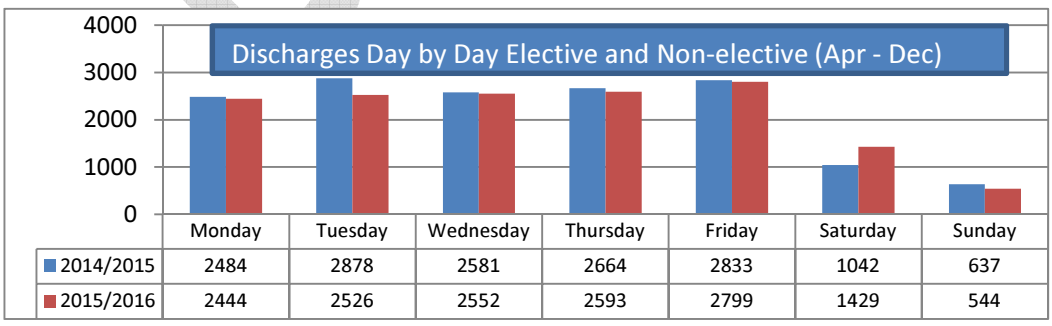
Hillingdon Hospital will continue as the lead for this scheme, which will be overseen by the System Resilience Group (SRG). The SRG has responsibility for monitoring delivery of all the clinical standards mandated by NHSE.

Scheme Delivery

The services required to deliver a more even hospital discharge process across the week will be provided by a combination of the following providers: The Hillingdon Hospital Foundation Trust, Central North West London Community Health and Mental Health Services, Hillingdon's four GP networks, Adult Social Care, Hillingdon's third sector and the private sector.

e) The Evidence Base

This scheme is being rolled forward from 2015/16 in accordance with national policy requirements. The chart below illustrates the scope for improving the distribution of hospital discharges (planned and unplanned) over the week.



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015	2484	2878	2581	2664	2833	1042	637
2015/2016	2444	2526	2552	2593	2799	1429	544

f) Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	

a) Mental Health Social Workers	LBH	100	0	100
TOTALS		**100**	**0**	**100**

g) Contribution to BCF Metrics

The scheme will impact on the following BCF metrics:

- Reduction in non-elective admissions through a reduction in readmissions
- % of people supported at home 91 days post discharge into reablement by reducing the number of readmissions related to the cause of the original admission.

h) Other Success Measures

The following measures will be used to identify whether the scheme is working:

- 35% of discharges should occur before midday 7/7.
- Weekend discharges are 80% of weekday rates.
- Number of people discharged at weekends.
- % of people supported at home 91 days post discharge into reablement.
- Reduction in differential mortality rates between weekdays and weekends.
- Reduction in readmissions within 30 days.
- Resident/patient feedback
- Carer feedback

With the exception of the last two measures, this data is collected automatically. The last two qualitative measures will require new surveys to be undertaken of patients and carers.

Scheme Five

a) Scheme Name

Integrated Community-based Care and Support

b) Scheme Strategic Objectives

To ensure that community based care and support works as effectively and as efficiently as possible and is aligned across primary care and community services to deliver anticipatory care in community settings that achieves the best outcomes for patients/residents and delivers value for money.

c) Scheme Overview

There has been a review and improvement in efficiency of a range of community health services to ensure that value for money from existing services is being achieved. An integrated model of care for older people will be extended where integrated care and support planning approaches facilitate closer integration between health, social care and third sector providers and delivers improved outcomes.

This scheme will contribute to this through the following actions:

- *Expanding the use of risk stratification tools* - The Metrohealth GP network in the north of the borough has been using a combination of multi-provider risk stratification tools, informed GP practice intelligence and informed provider intelligence to detect early signs of frailty to trigger earlier support. During 2016/17 risk stratification tools will be refined and this learning will be rolled out across the borough to all practices.

- *Mainstreaming personalised care planning* - Care planning processes and outcomes have been reviewed in 2015/16. This will enable work the undertaken in 2015/16 and linked to the application of risk stratification tools to be fully embedded in GP networks across the borough to support a reduction in avoidable emergency admissions to hospital. This will be supported by the development of the co-produced Integrated Care and Support Record (ICSR) and, subject to the outcome of the pilot, the further scale up of the care information exchange (CIE) platform.

- *Embed a multi-disciplinary team (MDT) approach to addressing the needs of residents/patients with complex needs* - GP networks will be supported to embed the MDT approach as a cost effective tool for maximising the health and wellbeing of residents/patients living with long-term conditions. This will include training for MDT chairs as well as practical support for the administration of meetings.

- *Scaling up the integrated model of care for older people across the borough* - Building on integrated care planning in primary care, an enhanced model of integrated care provision for older people is currently being piloted with Metrohealth GP network in the north of the borough. This will inform commissioning a system wide integrated model of care for older people in shadow form in 2016/17 and will enable the involvement of other networks as maturity builds. This approach requires new contractual relationships with primary care, community health, acute and the third sector and the development of enablers to drive better outcomes.

- *Raise awareness within primary care of community service provision and access routes* - Training will be provided to staff within primary care about the range of services provided by the Council to support the health and wellbeing of residents/patients in their own homes, including the provision of Disabled Facilities Grants (DFGs). Training will include promotion of the online resident portal Connect to Support and how to access information about the range of services provided by the voluntary and community sector.

- *Deliver an integrated community equipment service* - Community equipment is critical to supporting people with physical disabilities and/or sensory impairments in their own home. People of all ages often have a variety of equipment needs, ranging from daily living equipment such as bath board, hoists, electric beds, etc, to more medical equipment, e.g. pressure relieving mattresses and/or oxygen. To avoid the coordination difficulties posed by having different providers delivering different types of equipment, the community equipment service will be retendered in 2016/17 under a model that brings together as many types of equipment as possible to improve efficiency in meeting the equipment needs of residents/patients. This provision will apply to all adults and children.

- *Relaunch the retail model for community equipment* - The purpose of the retail model is to give residents greater choice by enabling them to access more personalised equipment than is available from the standard catalogue available to the Council and the NHS. Under this model they can pay a top-up if the cost of the equipment item is greater than the equipment prescription value.

- *Develop an integrated approach to home care market development and management* - This will bring together health and social care to ensure better management of medication in the community. A key intended outcome would be to prevent residents/patients needing to change provider to address their respective health or social care needs unless this was necessary for clinical reasons. Another outcome would be to ensure service availability to support people who had care needs but who did not meet the national eligibility criteria for social care. As part of the joint approach to the management of the homecare market is ensuring the availability of provision to support people in the community living with dementia, which links with scheme 8: *People living well with dementia*.

- *Expansion of Personal Health Budgets (PHB)* – A local offer for PHBs will be developed for residents/patients living with one or more long-term conditions and also children with special educational needs. The PHB offer will not be restricted to people who are eligible for NHS funded Continuing Healthcare. During 2016/17 a three year plan to expand the take-up of PHBs will be developed and this will include joint PHBs and Direct Payments where an adult meets the national eligibility criteria for a financial contribution from the local authority to meet their social care needs. The plan will also address market development issues.

d) The Delivery Chain

Scheme Lead Role

HCCG will lead for this scheme, which will be overseen by the multi-agency Integrated Care Steering Group.

Scheme Delivery

An Accountable Care Partnership (ACP) is HCCG's preferred model of delivery for integrated care. An ACP is where a group of providers agree to take responsibility for providing all care for a given population for a defined period of time under a contractual arrangement with a commissioner. Under this model providers are held accountable for achieving a set of pre-agreed quality outcomes within a given budget or expenditure target. In Hillingdon the ACP comprises of The Hillingdon Hospitals Foundation Trust, Central North West London Foundation Trust (CNWL), Metrohealth GP network and the H4All third sector consortium.

Commissioning integrated care from the ACP will initially be for older people with long term conditions, but will progress in scope to all older people and other population groups with long term conditions. This is not expected to occur in 2016/17, which will be a shadow year before the ACP becomes fully operational in 2017/18. The ACP will deliver services under the current contracts held by its constituent organisations and a shadow capitated budget will be developed in 2016/17. A capitated budget is a sum of money

based on the estimated needs of a population group and for 2016/17 this will initially be older people with long-term conditions. Both the CCG and the ACP will monitor the cost of the model of care and outcomes in readiness for moving to a full capitated model after April 2017.

The Council will commission care and support provision in extra care schemes from an independent sector provider and the CCG will commission community health services either from the existing community provider or an independent sector provider following a procurement process. Primary care services will be co-commissioned between the CCG and NHSE from the appropriate GP networks.

Community equipment is commissioned by the Council on its own behalf and that of the CCG and the service is provided by a private company. Hillingdon is part of a consortium comprising of 16 London boroughs and CCGs that is led by Hammersmith and Fulham. The success of the retail model for community equipment is dependent on ther being a range of approved providers. There are currently 16 participating pharmacists and expanding this coverage will be a task for 2016/17.

Both the Council and the CCG commission homecare providers from a range of private and independent sector companies.

Individual residents/patients will commission services directly from a range of third sector or private sector providers.

e) The Evidence Base

This scheme has been developed following a multi-agency evaluation of the schemes under the 2015/16 BCF plan.

f) Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Community equipment contract	Medequip Assistive Technology LTD	763	703	1,466
b) Pressure relieving mattresses	DHS	0	200	200
c) Telecare	Tunstall/LBH	262	0	262
d) Continence service	CNWL	0	529	529
e) Community matrons	CNWL	0	677	677
f) District Nursing	CNWL	0	3,287	3,287
g) Twilight	CNWL	0	167	167

Service				
h) Tissue Viability	CNWL	0	386	386
i) Disabled Facilities Grants	LBH	3,457	0	3,457
j) Packages of care: maintaining eligibility criteria	Various P & V	655	0	655
k) Medication Administration Record (MAR chart) provision	Pharmacists	0	8	8
l) Medication administration training	Opus	0	16	16
m) Homecare provider care standards training	Independent Sector	15	0	15
n) Adult Safeguarding	LBH	260	0	260
TOTALS		**5,412**	**5,973**	**11,385**

g) Contribution to BCF Metrics

This scheme will impact on the following BCF metrics:

- Reduction in non-elective admissions
- Reduction in permanent admissions to care homes of 65 + population.
- Reduction in delayed transfers of care.
- Social care quality of life.

h) Other Success Measures

The following measures will be used to identify whether the scheme is working:

- Proportion of residents identified as in need of preventative care who have been offered a care plan.
- Proportion of patients who have care planning where there is a tangible improvement in quality of life and level of independence.
- Proportion of patients who have achieved jointly agreed goals in 6 months or have shown a very positive progression towards achievement of their goals.
- Improved patient experience tested by part of patient survey.
- Number of people in receipt of a Personal Health Budget

Scheme Six

a) Scheme Name

Care Home and Supported Living Market Development

b) Scheme Strategic Objectives

Through market reshaping secure:

a. A vibrant, quality care home market that meets current and future local need; and

b. An appropriate mix of supported living provision that provides people with a realistic alternative to care home admission.

c) Scheme Overview

This scheme is focused on two areas:

a) The care home (residential and nursing) primarily for older people but also for younger adults with physical disabilities; and
b) The supported living markets for all adults and not just older people.

The scheme will include the following actions:

- *Launch of market position statements (MPSs)* - Through MPSs developers and providers of care homes for older people and other population groups and developers and providers of supported living schemes for older people and other population groups will be advised of LBH/HCCG needs over the next 3 - 5 years to address health and care needs of the population;

- *Securing suitable care home provision for people with challenging behaviour needs* - Securing suitable local placements for people with challenging behaviour needs, including those associated with dementias, is a key cause of delayed transfers of care. This will be accomplished through providing appropriate wrap-around support for care homes that includes access to medical and clinical expertise to existing providers as well as facilitating new supply, where appropriate. This links with scheme 4: *Seven day working;*

- *Palliative & hospice bed provision* - A review of bed based services will consider the need for additional palliative and bed-based hospice provision. Delivery of the outcomes of the review will start in 2016/17 but any new locally based services may take up to two years to come on stream. This links with scheme 2: *Better care at end of life* and scheme 4: *Seven day working*;

- *Monitoring quality of service provision*: A jointly agreed process for encouraging and monitoring quality of provision within the care home and supported living markets will be embedded;

- *Managing business failure* - A jointly agreed process for identifying and responding to provider business failure that will ensure continuity of service provision will be embedded;

- *Agreed price for care tool implementation* - Implementing an agreed tool for establishing a fair price for care will provide a transparent basis for determining care home fees that allow for market stability and are affordable and provide value for money for commissioners;

- *Securing agreement on integrated brokerage options* – Options for integration of nursing care home brokerage placements following work undertaken in 2015/16 will be considered jointly by the Council and CCG alongside options for joint contracting arrangements;

- *Implementing preferred contracting options for care homes* - Development of a joint care home specification that employs appropriate contractual levers to implement national policy priorities, e.g. seven day working. This will also include partnership working with the West London Alliance (WLA) of local authorities to tender for a Dynamic Purchasing System (DPS) for care homes. A DPS is a fully-electronic process used by public sector bodies to award contracts for works or services and it ensures that the end-to-end procurement process is competitive, fair and transparent.

- *Development of a menu of in-reach support for care homes and supported living schemes* - This would include medical and other clinical advice that will prevent hospital admissions that are avoidable;

- *Developing the model of care and support for extra care* - The development of wrap-around services to ensure that the health and care needs of older people in existing extra care sheltered schemes, Cottesmore House and Triscott House, are met as well as those in two new schemes (Grassy Meadow and Parkview) to be opened in 2018. The intention will be to minimise the circumstances where it is necessary for people living in these schemes to be admitted to care homes to address their needs.

d) The Delivery Chain

Scheme Lead Role

The Council will lead on this scheme and will be supported by a multi-agency task and finish group.

Scheme Delivery

The Council and CCG currently commission care home placements separately and often from the same private providers. The need for care home provision will be met by the private or independent sector market and through this scheme different commissioning options will be considered, including lead commissioning arrangements.

In-reach support from community matrons to care homes is commissioned by the CCG from CNWL. Any enhancement to this service to include other clinical and medical support and also to include supported living schemes would be subject to approval of proposed business cases and could be further developed within the emerging ACP.

The Council currently commissions a private provider to deliver care to the tenants of two existing extra care schemes, Cottesmore House and Triscott House. Housing-related support is provided directly to tenants by the Council. The Council will continue to be the lead commissioner for the service provided to tenants at these schemes and the new ones due to open in 2018. It is expected that core care and support hours, e.g. the level of care required for the safe running of the schemes, will be delivered by a private or independent sector

e) The Evidence Base

There are 58 care homes in Hillingdon of which 17 are registered nursing homes and 41 residential homes without nursing. 29 cater for the 65 and over population and 29 for people aged under 65. The total bed capacity is 1,390 but 1,195 of these are for older people. Hillingdon has the seventh largest supply of older people's care homes in

London and the fifteenth largest supply of care homes for people aged under 65.

The Council makes 12% fewer placements of older people per head of population than the London average but ranks 8th highest out of London's 33 boroughs for placements for people with learning disabilities of working age. 45% of the older people's care home supply is utilised by self-funders compared with a London average of 41%. In accordance with national and local policy the Council will be making less residential care home placements in coming years. To create real alternatives to residential care that will promote independent living two new extra care schemes for people aged 65 and over will open in early 2018 and these are Grassy Meadow, which will have 88 self-contained flats and an onsite dementia resource centre and Parkview, which have 66 self-contained flats. A 14 flat supported living scheme for people with learning disabilities is also scheduled to open during 2018 in Ruislip and a 12 flat scheme for adults with functional mental health needs in Uxbridge.

The older adult market is quite diverse with 40% of beds being owned by large national providers, e.g. those owning 40 or more homes elsewhere in England. The Council is largest provider of care home beds for younger adults and only 11% are owned by large providers.

In 2014/15 there were 885 emergency admissions to Hillingdon Hospital from care homes in the borough at a total cost of £2.2m. 71% (632) of these admissions were of the 65 and over care home population at a cost of £1.8m. During the first half of 2015/16 this trend was replicated with a total of 447 emergency admissions of which 70% (314) were of the 65 and over care home population. This shows that initiatives during 2015/16 have prevented an increase in the level of emergency admissions from care homes rather than improving it.

f) Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Quality Assurance Team	LBH	150	0	150
b) Care Home Prescriber	HCCG	0	32	32
TOTAL		**150**	**32**	**182**

g) Contribution to BCF Metrics

This scheme will impact on the following BCF metrics:

- Reduction in non-elective admissions
- Reduction in permanent admissions to care homes of 65 + population.
- Reduction in delayed transfers of care (mental health).
- Social care quality of life.

h) Other Success Measures

The following measures will be used to identify whether the scheme is working:

- Reduction in non-elective admissions from care homes.
- Reduction in non-elective admissions from supported living schemes, including extra

care.

- Reduction in number of people aged 65 + dying in hospital within seven, fourteen and twenty-one days of admission from a care home where the hospital is not their preferred place of care. This links to scheme 2: *Better care at end of life*.

Scheme Seven

a) Scheme Name

Supporting Carers

b) Scheme Strategic Objective

This strategic objective of this scheme is that carers are able to say:

- "I am physically and mentally well and treated with dignity"
- "I am not forced into financial hardship by my caring role"
- "I enjoy a life outside of caring"
- "I am recognised, supported and listened to as an experienced carer"

c) Scheme Overvew

The 2014 Care Act increased the responsibilities of local authorities towards adult carers. The Act changed the definition of who is a carer so that any adult providing unpaid care to another adult is legally regarded as a carer whether or not they regard themselves as such. Any carer within this definition has a right to a carer's assessment and also to have their own care and support needs identified from the assessment met by the local authority. This scheme seeks to support the health and wellbeing of carers, both adults and young carers and this will be achieved through the following actions:

- *Deliver a communications campaign to increase awareness and take up of carers' support/services* - The campaign will include identifying "hidden", e.g. people who do not necessarily identify themselves as carers. It will also include a *'What would you do? Where would you go?*' initiative to raise awareness for all residents who could become carers at any time.

- *Reviewing assessment capacity across the borough to provide additional support to carers* - The expectation is that as the population ages the number of carers will increase and there consequently needs to be sufficient capacity within the system to permit timely carers' assessments to take place. Some demand may be absorbed by the online self-assessment facility through Connect to Support but the Council will ensure sufficient capacity through its contracts with the third sector. From the autumn of 2016 this flexible response to demand for carers' assessments would come within the carers' hub contract.

- *Implement the carers' hub contract* - Following a tender for an integrated support service for carers in 2015/16 the new contract will be implemented in the autumn of 2016.

- *Deliver GP annual health checks and flu jab programmes for carers* - GP practices will be supported by the Communications Team to proactively identify carers and to register them as carers. Where feasible each practice will identify someone as a carers' champion and the definition of this role will be agreed in consultation with teh GP networks. A mechanism for referring carers for a health check following a carer's assessment will also be developed.

- *Deliver options to extend services for carers -* e.g. weekend carers cafes, more activities in winter months and condition specific cafes e.g. dementia, MH, autism and provide access to appropriate and improved 7 day health care services

- *Delivery of an integrated engagement framework for carers* - This is being developed in 2015/16 and is intended to enhance the voice of carers in service planning and delivery, across all providers. It will include use of technology to enable carers to give their views online in a way that is least disruptive to them. Subject to the outcome of a feasibility study, it may also include establishing a Carers' Assembly.

- *Support for carers of people at end of life* – The results of the review of the needs of carers of people at end of life undertaken as part of the work of the End of Life Forum under scheme 2: *Better care at end of life*, will be implemented. Where additional funding is required appropriate business cases will be developed for consideration by the Council and/or CCG.

d) The Delivery Chain

Scheme Lead Role

The Council will lead on this scheme and will be support by the multi-agency Carers Strategy Group.

Scheme Delivery

Carers' assessments are undertaken by the Council with additional capacity commissioned from Hillingdon Carers by the borough. This will continue during 2016/17.

Information and advice for carers is commissioned by the Council from a range of third sector providers and these include Hillingdon Carers, Rethink and the Alzheimers' Society. It is intended that the new carers' hub service being tendered during 2015/16 will be delivered by a third sector organisation and provide a single point of access to services for carers. This will include information and advice to young carers and a range of support services, including some therapeutic services.

The Council has commissioned the Carers' Trust to provide a sitting service for carers of people who do not meet eligibility criteria. This enables carers to take a break of four hours a week. A carers' assessment is not required for them to be able to access this service and any carer requiring more support may be able to receive this following an assessment. This service will be part of the new Carers' Hub Service that will operational from 1st October 2016.

Local GP networks are responsible for delivering health checks for carers. Where appropriate, Personal Health Budgets will be made available during 2016/17 to address the specific healthcare needs of carers identified from the health check process. See scheme 5: *Integrated Community-based Care and Support*.

e) The Evidence Base

The 2011 census shows that there were at least 25,702 Carers in Hillingdon; in fact, this figure was and is probably much higher when taking into consideration the fact that some people who are providing care to their partner or other relatives do not identify themselves as Carers. These 'hidden Carers' may not be accessing the support and advice that is available to them.
The table below provides a breakdown of the age of Carers as identified by the 2011 census.

Age Breakdown of Carers in Hillingdon	
Carer Age Group	**Number**
0 - 24	2,450
25 - 64	18,609
65 +	4,643
TOTAL	**25,702**

The census also showed that 36% of the Carers aged 65 and above were providing 50 hours a week or more unpaid care and of those 17% identified themselves as having bad or very bad health.

According to estimates within the Institute of Public Care's 2009 *Estimating the prevalence of severe learning disability in adults* - working paper 1, there should currently be approximately 400 people living with parents and this should rise to approximately 440 in 2020. Of the 220 people with learning disabilities currently being supported by the Council who live with parents or other relatives who are identified as their main Carers. 77 of these Carers are aged 65 and over and of these 11 are aged 75 and over. This illustrates both the importance of supporting older Carers and the need to plan for a time when they will be unable to continue their caring role because of the effects of old age.

f) Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
a) Carers' hub, assessments and review	Third sector	600	0	600
b) Services to carers (inc respite)	Various P & V	209	0	209

c) Support to Hillingdon Social Care Direct	LBH	70	0	70
d) Training	Third sector	20	0	20
TOTALS		**899**	**0**	**899**

g) Contribution to BCF Metrics

This scheme will impact on the following BCF metrics:

- Reduction in non-elective admissions.
- Reduction in permanent admissions to care homes of 65 + population.

h) Other Success Measures

The following measures will be used to identify whether the scheme is working:

- Number of carers' assessments completed.
- Number of carers receiving respite or a carer specific service following an assessment.
- Through the national carers' survey:
  - Proportion of Carers who have found it easy or difficult to find information and advice about support services or benefits
  - Carer quality of life questions about:
    - Getting enough sleep and eating well
    - Having sufficient social contact
    - Receiving encouragement and support.
- Number of carers on GP Carers' Registers.
- Number of Carers in receipt of a Personal Health Budget. Links with scheme 5: *Integrated Community-based Care and Support*.

Scheme Eight

a) Scheme Name

People living well with Dementia

b) Scheme Strategic Objective

The objective of this scheme is that people with dementia and their family carers are enabled to live well with dementia.

c) Scheme Overview

Hillingdon's ageing population means that dementia, a condition primarily associated with old age, is going to have a significant impact on the local health and care economy for the foreseeable future. Through more integrated working across health and social care it is intended that this scheme will contribute to people affected by dementia being 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.

To achieve this the following actions will be taken:

- *Preventing or delaying the onset of dementia* - This action links in with the work being undertaken under scheme 1: *Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation*, as the actions intended to prevent stroke will also assist in preventing or delaying the onset of dementia, e.g. promoting physical activity, nutrition guidance, smoking cessation and early detection of conditions such as hypertension and high cholesterol.

- *Implementing a single point of access (SPA) for crisis care* - Building on a single point of access to urgent and crisis care in 2015/16, the service will be developed in 2016/17 so that people with urgent mental health needs, including dementia, are able to receive multi-disciplinary assessments of need and onward referral as appropriate. It is envisaged that referrals into the SPA would come from professionals and voluntary and community organisations as well as residents themselves and/or their carers.

- *Completion of Integrated Multi-disciplinary Team business case* - Following modelling work undertaken in 2015/16, a business case will be developed in 2016/17 for a multi-disciplinary service model encompassing Memory Assessment, older people mental health beds and community home treatment services to provide a more integrated service for older people with dementia requiring diagnosis and post-diagnosis support. This will include case management approaches for people living with dementia and other long-term physical health needs. This links into existing integrated care planning for older people and specifically with scheme 5: *Integrated Community-based Care and Support.*

- *Developing a local dementia resource centre model* - A dementia resource centre will be included in the 88 flat Grassy Meadow extra care scheme due to open in early 2018. This resource is primarily intended to meet the social care needs of people living with dementia in the community with family carers, but during 2016/17 health and social care partners will work together to identify how the maximum benefit can be obtained from this facility.

- *Developing standardised training for providers* - The multi-agency Dementia Working Group will develop a training framework for health and social care staff that will address the following three tiers:

  - Tier 1: Dementia Awareness ('Essential information') that highlights the basic, essential competencies relevant to all sections of workforce and society.

  - Tier 2: 'Enhanced' builds on tier 1 and highlights competencies needed for those working in general health or social care settings and for those working with people with dementia.

  - Tier 3: 'Specialist' builds on tiers 1 & 2 and is relevant to those working in a more specialist and intensive way with people with dementia.

  It is envisaged that tier 1 and 2 would be available as an e-learning modules.

- *Securing care home provision for people living with dementia with challenging behaviours* – The current limited availability of this provision is the cause of people with dementia staying in inappropriate care settings for longer than is desirable and can contribute to delayed transfers of care. The work being undertaken under scheme 6: *Care Home and Supported Living Market Development* is intended to address this gap in provision.

- *Securing care provision for people living with dementia at end of life* – The work being undertaken under scheme 5: *Integrated Community-based Care and Support* and scheme 6: *Care Home and Supported Living Market Development* will ensure that appropriate service provision is available to address need at this particularly sensitive time.

d) The Delivery Chain

Scheme Lead Role

HCCG will lead on this scheme, which will be overseen by the multi-agency Dementia Working Group task and finish project group.

Scheme Delivery

Information and advice about dementia is commissioned by the Council from the Alzheimer's Society, who also provide an advice centre at the Templeton Centre in Northwood. The CCG commissions CNWL to provide a memory assessment service which is based at the Woodland Centre on the main Hillingdon Hospital site. In-patient provision is also based at the Woodland Centre, which is commissioned by the CCG. Both the Council and the CCG commission CNWL to provide an Admiral Nurse service, which supports carers of people living with dementia.

There are 29 care homes in Hillingdon that support older people and 26 of these are registered to support people with dementia. The direction for national and local policy is to support people living with dementia in their own homes or in as least restrictive environment as possible for as long as possible, which is one of the reasons for the

development of extra care schemes. The commissioning of care homes and care and support provision is addressed within scheme 6: *Care Home and Supported Living Market Development.* This includes provision to address the needs of people living with dementia with challenging behaviours.

Both the Council and the CCG commission homecare provision from private and independent sector providers to support people in their own homes with their personal care and health needs. The availability of a service to address the care needs of people living with dementia will be addressed under scheme 5: *Integrated Community-based Care and Support.*

The Council's Wellbeing Team, in partnership with the Libraries Service, provides a range of activities to keep people living with dementia mentally and physically active. This links with scheme 1: *Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.*

e) The Evidence Base

Hillingdon's Joint Strategic Needs Assessment (JSNA) estimates that in 2015 2,750 people in the borough are living with dementia that this will rise to 3,120 in 2020. This is a projected increase of around 13%. For those aged over 85 it is estimated that in 2015 there are 1,250 people in Hillingdon living with dementia and that this figure is likely to rise to 1,500 by 2020, an estimated increase of 19%. These estimates are based on information from the Projecting Older People Population Information service (POPPI) using data from Dementia UK: A report into the prevalence and cost of dementia prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society, 2007.

Research suggests that dementia may be more common in older adults with intellectual disability than in the general population. Incidence of dementia in older people with intellectual disabilities have been found to be up to five times higher than older adults in the general population. (source: Strydom *et al*. 2013, Research in Developmental Disabilities)

The number of people with learning disabilities living into old age is increasing and it is predicted that there will be an increase of around 10% of people over 65 with learning disabilities in Hillingdon between 2015 and 2020. This is in line with the average for all London boroughs (source: POPPI data March 2015).

This scheme is compatible with the *National Dementia Strategy* (DH 2009), the required actions identified in *Dementia: A state of the nation* (DH 2013) and *Dementia today and tomorrow: A new deal for people with dementia and their carers*, produced by the Deloitte Centre for the Alzheimer's Society in February 2015.

f) Investment Requirements

Service	Provider	Funder		Total
		LBH	HCCG	
Wren Centre	LBH	300	0	300

Staff & provider training	Third sector	5	0	5
	Totals	**305**	**0**	**305**

g) Contribution to BCF Metrics

This scheme will impact on the following BCF metrics:

- Reduction in permanent admissions to care homes of 65 + population.
- Social care quality of life.
- .

h) Feedback Loop

The following measures will be used to identify whether the scheme is working:

- Diagnosis rate as a percentage of projected prevalence of dementia within the Hillingdon population.
- Proportion of residents identified as in need of preventative care who have been offered a care plan.
- Number of people in receipt of a Personal Health Budget.
- Evaluation of training delivered to providers.

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ANNEX 3 (a)

Provider Commentary (Primary Care)

Name of Health & Wellbeing Board	Hillingdon Health and Wellbeing **B**oard
Name of Provider organisation	Metrohealth GP Network
Name of Lead GP	Dr Martin Hall
Signature (electronic or typed)	

2016/17 BCF Plan Key Performance Indicators

1. Reduction in Non-elective Admissions	
a) Net over-arching NEA reduction target 2015/16.	1,280
b) Projected 2015/16 outturn.	
c) Target contribution of 2015/16 BCF Plan (65 +).	-388
d) Net over-arching NEA reduction target 2016/17	2,691
e) Target contribution of 2016/17 BCF Plan (65 +).	-663

2. Permanent Admissions to Care Homes	
a) 2014/15 Outturn	155
b) 2015/16 Plan	150
c) Projected 2015/16 Outturn	145
d) 2016/17 Plan	150

3. Effectiveness of Reablement: % of people 65 + still at home 91 days after discharge from hospital to reablement.	
a) 2014/15 Outturn	85.6%
b) 2015/16 Plan	95.4%
c) Projected 2015/16 Outturn	92%
d) 2016/17 Plan	93.3%

4. Delayed Transfers of Care (DTOCs) (Delayed Days)	
a) 2014/15 Outturn	3,819
b) 2015/16 Plan	4,790
c) Projected 2015/16 Outturn	4,334
d) 2016/17 Plan	4,117

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 16/17 compared to planned 15/16 outturn?**	
2.	**If you answered 'no' to Q.1 above, please explain why you do not agree with the projected impact?**	
3.	**Do you recognise the other BCF KPIs for 2016/17 and understand the reasoning behind them?**	
4.	**Can you confirm that you have considered the resultant implications on services provided by your organisation of the BCF KPIs?**	

ANNEX 3 (d)

Provider Commentary (Third Sector)

Name of Health & Wellbeing Board	Hillingdon Health and Wellbeing **B**oard
Name of Provider organisation	H4All
Names of Chief Officers	Sally Chandler, Steve Curry, Christopher Geake, Peter Okali & Angela Wegener
Signature (electronic or typed)	

2016/17 BCF Plan Key Performance Indicators

1. Reduction in Non-elective Admissions	
a) Net over-arching NEA reduction target 2015/16.	1,280
b) Projected 2015/16 outturn.	
c) Target contribution of 2015/16 BCF Plan (65 +).	-388
d) Net over-arching NEA reduction target 2016/17	2,691
e) Target contribution of 2016/17 BCF Plan (65 +).	

2. Permanent Admissions to Care Homes (65 +)	
a) 2014/15 Outturn	155
b) 2015/16 Plan	150
c) Projected 2015/16 Outturn	145
d) 2016/17 Plan	150

3. Effectiveness of Reablement: % of people 65 + still at home 91 days after discharge from hospital to reablement.	
a) 2014/15 Outturn	85.6%
b) 2015/16 Plan	95.4%
c) Projected 2015/16 Outturn	92%
d) 2016/17 Plan	93.3%

4. Delayed Transfers of Care (DTOCs) (Delayed Days)	
a) 2014/15 Outturn	3,819
b) 2015/16 Plan	4,790
c) Projected 2015/16 Outturn	4,334
d) 2016/17 Plan	4,117

5. Resident/Patient Experience: Access to information about support services or benefits	
a) 2014/15 Outturn	74.8%
b) 2015/16 Plan	73%
c) Projected 2015/16 Outturn	75%
d) 2016/17 Plan	77%

5. Resident/Patient Experience: Quality of Life	
a) 2014/15 Outturn	18.2%
b) 2015/16 Plan	19%
c) Projected 2015/16 Outturn	18.4%
d) 2016/17 Plan	19%

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 16/17 compared to planned 15/16 outturn?**	
2.	**If you answered 'no' to Q.1 above, please explain why you do not agree with the projected impact?**	
3.	**Do you recognise the other BCF KPIs for 2016/17 and understand the reasoning behind them?**	
4.	**Can you confirm that you have considered the resultant implications on services provided by your organisation of the BCF KPIs?**	

Template for BCF submission 1: due on 02 March 2016

Better Care Fund 2016-17 Planning Template

Sheet: Guidance

Overview

The purpose of this template is to collect information from CCGs, local authorities, and Health and Wellbeing Boards (HWBs) in relation to Better Care Fund (BCF) plans for 2016-17. The focus of the collection is on finance and activity information, as well as the national conditions. The template represents the minimum collection required to provide assurance that plans meet the requirements of the Better Care Fund policy framework set out by the Department of Health and the Department of Communities and Local Government (www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017). This information will be used during the regionally led assurance process in order to ensure that BCF plans being recommended for sign-off meet technical requirements of the fund.

The information collected within this template is therefore not intended to function as a 'plan' but rather as a submission of data relating to a plan. A narrative plan will also need to be provided separately to regional teams, but there will be no centrally submitted template for 2016-17. CCGs, local authorities, and HWBs will want to consider additional finance and activity information that they may wish to include within their own BCF plans that is not captured here.

This tab provides an overview of the information that needs to be completed in each of the other tabs of the template. This should be read in conjunction with Annex 4 of the NHS Shared Planning Guidance for 2016-17; Better Care Fund Planning Requirements for 2016-17', which is published here: www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

Timetable

The submission and assurance process will follow the following timetable:

- NHS Planning Guidance for 2016-17 released – 22 December 2015
- BCF Allocations published following release of CCG allocations – 09 February 2016
- Annex 4 - BCF Planning Requirements 2016-17 released - 22 February 2016
- BCF Planning Return template, released – 24 February 2016
- **First BCF submission by 2pm on 02 March 2016, agreed by CCGs and local authorities, to consist of:**
  - **o BCF planning return template (this template)**

All submissions will need to be sent to DCO teams and copied to the National Team (england.bettercaresupport@nhs.net)

- First stage assurance of planning return template and initial feedback to local areas - 02 to 16 March 2016
- Second version of the BCF Planning Return template, released (with updated NEA plans) – 9th March
- **Second submission following assurance and feedback by 2pm on 21 March 2016, to consist of:**
  - **o High level narrative plan**
  - **o Updated BCF planning return template**
- Second stage assurance of full plans and feedback to local areas - 21 March to 13 April 2016
- BCF plans finalised and signed off by Health and Wellbeing Boards in April, and submitted 2pm on 29 April 2016

This should be read alongside the timetable on page of page 15 of Annex 4 - BCF Planning Requirements.

Introduction

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell
Pre-populated cell

To note - all cells in this template requiring a numerical input are restricted to values between 0 and 1,000,000,000.

The details of each sheet within the template are outlined below.

Checklist

This is a checklist in relation to cells that need data inputting in the each of the sheets within this file. It is sectioned out by sheet name and contains the question, cell reference (hyperlinked) for the question and two separate checks
- the 'tick-box' column (D) is populated by the user for their own reference (not mandatory), and
- the 'checker' column (E) which updates as questions within each sheet are completed.

The checker column has been coloured so that if a value is missing from the sheet it refers to, the cell will be Red and contain the word 'No' - once completed the cell will change to Green and contain the word 'Yes'. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (B6) will change to 'Complete Template'.

Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. The selection of your Health and Wellbeing Board (HWB) on this sheet also then ensures that the correct data is prepopulated through the rest of the template.

On the cover sheet please **enter the following information:**
- The Health and Wellbeing Board;
- The name of the lead contact who has completed the report, with their email address and contact number for use in resolving any queries regarding the return;
- The name of the lead officer who has signed off the report on behalf of the CCGs and Local Authority in the HWB area.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 6 cells are green should the template be sent to england.bettercaresupport@nhs.net

2. Summary and confirmations

This sheet summarises information provided on sheets 2 to 6, and allows for confirmation of the amount of funding identified for supporting social care and any funds ring-fenced as part of risk sharing arrangement. To do this, there are 2 cells where data can be input.

On this tab please **enter the following information:**
- In cell E37 ,please confirm the amount allocated for ongoing support for adult social care. This may differ from the summary of HWB expenditure on social care which has been calculated from information provided in the 'HWB Expenditure Plan' tab. If this is the case then cell F37 will turn yellow. Please use this to indicate the reason for any variance;
- In cell F47 please indicate the total value of funding held as a contingency as part of local risk share, if one if being put in place. For guidance on instances when this may be appropriate please consult the full BCF Planning Requirements document. Cell F44 shows the HWB share of the national £1bn that is to be used as set out in national condition vii. Cell F45 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F49 will show any potential shortfall in meeting the financial requirements of the condition.

The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary of the return.

3. HWB Funding Sources

This sheet should be used to set out all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2016-17. It will be pre-populated with the minimum CCG contributions to the Fund in 2016/17, as confirmed within the BCF Allocations spreadsheet. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan

These cannot be changed. The sheet also requests a number of confirmations in regard to the funding that is made available through the BCF for specific purposes.

On this tab please **enter the following information:**

- Please use rows 16-25 to detail Local Authority funding contributions by selecting the relevant authorities and then entering the values of the contributions in column C. This should include all mandatory transfers made via local authorities, as set out in the BCF Allocations spreadsheet, and any additional local authority contributions. There is a comment box in column E to detail how contributions are made up or to allow contributions from an LA to split by funding source or purpose if helpful. Please note, only contributions assigned to a Local Authority will be included in the 'Total Local Authority Contribution' figure.
- Please use cell C42 to indicate whether any additional CCG contributions are being made. If 'Yes' is selected then rows 45 to 54 will turn yellow and can be used to detail all additional CCG contributions to the fund by selecting the CCG from the drop down boxes in column B and enter the values of the contributions in column C. There is a comment box in column E to detail how contributions are made up or any other useful information relating to the contribution. Please note, only contributions assigned to an additional CCG will be included in the 'Total Additional CCG Contribution' figure.
- Cell C57 then calculates the total funding for the Health and Wellbeing Board, with a comparison to the 2015-16 funding levels set out below.

- Please use the comment box in cell B61 to add any further narrative around your funding contributions for 2016-17, for example to set out the driver behind any change in the amount being pooled.

The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.

- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

4. HWB Expenditure plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.

On this tab please **enter the following information:**

- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B71 - C78); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme)

This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

5. HWB Metrics

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

On this tab please **enter the following information:**

- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)
- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

- Please use rows 93-95 (columns K-L for Q3-Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figure in cells K94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells K93-O93. Please add a commentary in column H to provide any useful information in relation to how you have agreed this figure.

- Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your 2015/16 approved BCF plan and 2015/16 Q1 return - these local metrics can be amended, as required.

- You may also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your 2015/16 approved BCF plan and 2015/16 Q1 return - these local metrics can be amended, as required.

5b. HWB Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:

https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

6. National Conditions

This sheet requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2016-17. The conditions are set out in full in the BCF Policy Framework and further guidance is provided in the BCF Planning Requirements document. Please answer as at the time of completion.

On this tab please **enter the following information:**

- For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met, or will be by 31st March 2016. 'No - in development' should be used when a condition is not currently being met but a plan is in development to meet this through the delivery of your BCF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition by 31st March 2017.
- Please use column C to indicate when it is expected that the condition will be met / agreed if it is not being currently.
- Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.

CCG - HWB Mapping

The final tab provides details of the CCG to HWB mapping used to calculate contributions to Health and Wellbeing Board level non-elective activity plans.

Template for BCF submission 1: due on 02 March 2016

Better Care Fund 2016-17 Planning Template

Sheet: Checklist

This is a checklist in relation to cells that need data inputting in the each of the sheets within this file. It is sectioned out by sheet name and contains the question, cell reference (hyperlinked) for the question and two separate checks
- the 'tick-box' column (D) is populated by the user for their own reference (not mandatory), and
- the 'checker' column (E) which updates as questions within each sheet are completed.The checker column has been coloured so that if a value is missing from the sheet it refers to, the cell will be Red and contain the word 'No' - once completed the cell will change to Green and contain the word 'Yes'. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (B6) will change to 'Complete Template'.Please ensure that all boxes on the checklist tab are green before submission.

Incomplete Template

1. Cover

	Cell Reference	Complete?	Checker
Health and Well Being Board	C10	☐	Yes
completed by:	C13	☐	Yes
e-mail:	C15	☐	Yes
contact number:	C17	☐	Yes
Who has signed off the report on behalf of the Health and Well Being Board:	C19	☐	No

Sheet Completed:	No

2. Summary and confirmations

	Cell Reference	Complete?	Checker
Summary of BCF Expenditure : Please confirm the amount allocated for the protection of adult social care : Expenditure (£000's)	E37	☐	Yes
Summary of BCF Expenditure : If the figure in cell D29 differs to the figure in cell C29, please indicate please indicate the reason for the variance.	F37	☐	Yes
Total value of funding held as contingency as part of lcoal risk share to ensure value to the NHS	F47	☐	Yes

Sheet Completed:	Yes

3. HWB Funding Sources

	Cell Reference	Complete?	Checker
Local authority Social Services: <Please Select Local Authority>	B16 : B25	☐	Yes
Gross Contribution: £000's	C16 : C25	☐	Yes
Comments (if required)	E16 : E25	☐	N/A
Are any additional CCG Contributions being made? If yes please detail below;	C42	☐	Yes
Additional CCG Contribution: <Please Select CCG>	B45 : B54	☐	Yes
Gross Contribution: £000's	C45 : C54	☐	Yes
Comments (if required)	E45 : E54	☐	N/A
Funding Sources Narrative	B61	☐	N/A
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	C70	☐	Yes
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	C71	☐	Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	C72	☐	Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	C73	☐	Yes
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority? Comments	D70	☐	Yes
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified? Comments	D71	☐	Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? Comments	D72		Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? Comments	D73	☐	Yes

Sheet Completed:	Yes

4. HWB Expenditure Plan

	Cell Reference	Complete?	Checker
Scheme Name	B17 : B66	☐	Yes
Scheme Type (see table below for descriptions)	C17 : C66	☐	Yes
Please specify if 'Scheme Type' is 'other'	D17 : D66	☐	Yes
Area of Spend	E17 : E66	☐	Yes
Please specify if 'Area of Spend' is 'other'	F17 : F66	☐	Yes
Commissioner	G17 : G66	☐	Yes
if Joint % NHS	H17 : H66	☐	Yes
if Joint % LA	I17 : I66	☐	Yes
Provider	J17 : J66	☐	Yes
Source of Funding	K17 : K66	☐	Yes
2016/17 (£000's)	L17 : L66	☐	Yes
New or Existing Scheme	M17 : M66	☐	Yes
Total 15-16 Expenditure (£) (if existing scheme)	N17 : N67	☐	Yes

Sheet Completed:	Yes

5. HWB Metrics

	Cell Reference	Complete?	Checker
5.1 - Are you planning on any additional quarterly reductions?	E43	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q1	G45	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q2	I45	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q3	K45	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q4	M45	☐	Yes
5.1 - Are you putting in place a local risk sharing agreement on NEA?	E49	☐	Yes
5.1 - Cost of NEA	E54	☐	Yes
5.1 - Comments (if required)	F54	☐	Yes
5.2 - Residential Admissions : Numerator : Forecast 15/16	G69	☐	Yes
5.2 - Residential Admissions : Numerator : Planned 16/17	H69	☐	Yes
5.2 - Comments (if required)	I68	☐	N/A
5.3 - Reablement : Numerator : Forecast 15/16	G82	☐	Yes
5.3 - Reablement : Denominator : Forecast 15/16	G83	☐	Yes
5.3 - Reablement : Numerator : Planned 16/17	H82	☐	Yes
5.3 - Reablement : Denominator : Planned 16/17	H83	☐	Yes
5.3 - Comments (if required)	I81	☐	N/A
5.4 - Delayed Transfers of Care : 15/16 Forecast : Q3	K94	☐	Yes
5.4 - Delayed Transfers of Care : 15/16 Forecast : Q4	L94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q1	M94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q2	N94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q3	O94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q4	P94	☐	Yes
5.4 - Comments (if required)	Q93	☐	N/A
5.5 - Local Performance Metric	C105	☐	Yes
5.5 - Local Performance Metric : Planned 15/16 : Metric Value	E105	☐	Yes
5.5 - Local Performance Metric : Planned 15/16 : Numerator	E106	☐	Yes
5.5 - Local Performance Metric : Planned 15/16 : Denominator	E107	☐	Yes
5.5 - Local Performance Metric : Planned 16/17 : Metric Value	F105	☐	Yes
5.5 - Local Performance Metric : Planned 16/17 : Numerator	F106	☐	Yes
5.5 - Local Performance Metric : Planned 16/17 : Denominator	F107	☐	Yes
5.5 - Comments (if required)	Q105	☐	N/A
5.6 - Local defined patient experience metric	C117	☐	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Metric Value	E117	☐	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Numerator	E118	☐	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Denominator	E119	☐	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Metric Value	F117	☐	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Numerator	F118	☐	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Denominator	F119	☐	Yes
5.6 - Comments (if required)	G117	☐	N/A

Sheet Completed:	Yes

6. National Conditions

	Cell Reference	Complete?	Checker
1) Plans to be jointly agreed	C14	☐	Yes
2) Maintain provision of social care services (not spending)	C15	☐	Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	C16	☐	Yes
4) Better data sharing between health and social care, based on the NHS number	C17	☐	Yes
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	C18	☐	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	C19	☐	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services	C20	☐	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	C21	☐	Yes
1) Plans to be jointly agreed, Comments	D14	☐	Yes
2) Maintain provision of social care services (not spending), Comments	D15	☐	Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate, Comments	D16	☐	Yes
4) Better data sharing between health and social care, based on the NHS number, Comments	D17	☐	Yes
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional, Comments	D18	☐	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans, Comments	D19	☐	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services, Comments	D20	☐	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan, Comments	D21	☐	Yes

Sheet Completed:	Yes

Template for BCF submission 1: due on 02 March 2016

Better Care Fund 2016-17 Planning Template

Sheet: 1. Cover Sheet

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. The selection of your Health and Wellbeing Board (HWB) on this sheet also then ensures that the correct data is prepopulated through the rest of the template.

On the cover sheet please enter the following information:
- The Health and Wellbeing Board;
- The name of the lead contact who has completed the report, with their email address and contact number for use in resolving any queries regarding the return;
- The name of the lead officer who has signed off the report on behalf of the CCGs and Local Authority in the HWB area. Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 6 cells are green should the template be sent to england.bettercaresupport@nhs.net

Health and Well Being Board	**Hillingdon**
Completed by:	GARY COLLIER
E-Mail:	gcollier@hillingdon.gov.uk
Contact Number:	01895 250730
Who has signed off the report on behalf of the Health and Well Being Board:	

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	4
2. Summary and confirmations	3
3. HWB Funding Sources	13
4. HWB Expenditure Plan	13
5. HWB Metrics	34
6. National Conditions	16

3. HWB Funding Sources

	Gross Contribution
Total Local Authority Contribution	£4,629,000
Total Minimum CCG Contribution	£16,558,000
Total Additional CCG Contribution	£1,344,000
Total BCF pooled budget for 2016-17	**£22,531,000**

Specific funding requirements for 2016-17	Select a response to the questions in column B
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	Yes
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes

4. HWB Expenditure Plan

Summary of BCF Expenditure

	Expenditure
Acute	£0
Mental Health	£0
Community Health	£10,469,000
Continuing Care	£0
Primary Care	£122,000
Social Care	£10,566,000
Other	£1,374,000
Total	**£22,531,000**

Please confirm the amount allocated for the protection of adult social care	If the figure in cell E37 differs to the figure in cell C37, please indicate the reason for the variance.
Expenditure	
£10,566,000	

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

	Expenditure
Mental Health	£0
Community Health	£10,469,000
Continuing Care	£0
Primary Care	£122,000
Social Care	£0
Other	£1,374,000
Total	**£11,965,000**

BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share

	Fund
Local share of ring-fenced funding	£4,705,314
Total value of NHS commissioned out of hospital services spend from minimum pool	£11,965,000
Total value of funding held as contingency as part of local risk share to ensure value to the NHS	£0
Balance (+/-)	**£7,259,686**

Template for BCF submission 1: due on 02 March 2016

Sheet: 3. Health and Well-Being Board Funding Sources

Selected Health and Well Being Board:

Hillingdon

Data Submission Period:

2016/17

3. HWB Funding Sources

This sheet should be used to set out all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2016-17. It will be pre-populated with the minimum CCG contributions to the Fund in 2016/17, as confirmed within the BCF Allocations spreadsheet. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan

These cannot be changed. The sheet also requests a number of confirmations in regard to the funding that is made available through the BCF for specific purposes.
On this tab please enter the following information:
- Please use rows 16-25 to detail Local Authority funding contributions by selecting the relevant authorities and then entering the values of the contributions in column C. This should include all mandatory transfers made via local authorities, as set out in the BCF Allocations spreadsheet, and any additional local authority contributions. There is a comment box in column E to detail how contributions are made up or to allow contributions from an LA to split by funding source or purpose if helpful. Please note, only contributions assigned to a Local Authority will be included in the 'Total Local Authority Contribution' figure.
- Please use cell C42 to indicate whether any additional CCG contributions are being made. If 'Yes' is selected then rows 45 to 54 will turn yellow and can be used to detail all additional CCG contributions to the fund by selecting the CCG from the drop down boxes in column B and enter the values of the contributions in column C. There is a comment box in column E to detail how contributions are made up or any other useful information relating to the contribution. Please note, only contributions assigned to an additional CCG will be included in the 'Total Additional CCG Contribution' figure. - Cell C57 then calculates the total funding for the Health and Wellbeing Board, with a comparison to the 2015-16 funding levels set out below. - Please use the comment box in cell B61 to add any further narrative around your funding contributions for 2016-17, for example to set out the driver behind any change in the amount being pooled.The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

Local Authority Contribution(s)	Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
Hillingdon	£4,629,000	
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
Total Local Authority Contribution	**£4,629,000**	

CCG Minimum Contribution	Gross Contribution
NHS Hillingdon CCG	£16,558,000
Total Minimum CCG Contribution	**£16,558,000**

Are any additional CCG Contributions being made? If yes please detail below;	Yes

Additional CCG Contribution	Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
NHS Hillingdon CCG	£1,344,000	
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
Total Additional CCG Contribution	**£1,344,000**	

Total BCF pooled budget for 2016-17	**£22,531,000**

Funding Contributions Narrative

The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

Specific funding requirements for 2016-17	Select a response to the questions in column B	Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	Yes	
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes	
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes	
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	

Template for BCF submission 1: due on 02 March 2016

Sheet: 4. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:
Hillingdon

Data Submission Period:
2016/17

4. HWB Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.

On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B71 - C78); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

					Expenditure							
Scheme Name	Scheme Type (see table below for descriptions)	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	if Joint % NHS	if Joint % LA	Provider	Source of Funding	2016/17 Expenditure (£)	New or Existing Scheme	Total 15-16 Expenditure (£) (if existing scheme)
Scheme 1 : Early Identification	Personalised support/ care at home		Other	Falls Prevention	CCG			Charity/Voluntary Sector	CCG Minimum Contribution	£140,000	Existing	£130,000
Scheme 1 : Early Identification	Personalised support/ care at home		Primary Care		CCG			NHS Community Provider	CCG Minimum Contribution	£55,000	Existing	£50,000
Scheme 1 : Early Identification	Personalised support/ care at home		Other	Working with Older population	CCG			NHS Community Provider	CCG Minimum Contribution	£195,000	Existing	£0
Scheme 1 : Early Identification	Personalised support/ care at home		Social Care		Local Authority			Local Authority	Local Authority Social Services	£612,000	New	
Scheme 1 : Early Identification	Personalised support/ care at home		Social Care		Local Authority			Private Sector	Local Authority Social Services	£45,000	New	
Scheme 2: Better care for people at the end of their life	Personalised support/ care at home		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£106,000	Existing	£100,000
Scheme 2: Better care for people at the end of their life	Personalised support/ care at home		Social Care		Local Authority			Charity/Voluntary Sector	Local Authority Social Services	£90,000	New	
Scheme 3: Rapid response and joined up intermediate care	Intermediate care services		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£4,253,000	Existing	£3,821,000
Scheme 3: Rapid response and joined up intermediate care	Intermediate care services		Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£939,000	New	
Scheme 3: Rapid response and joined up intermediate care	Intermediate care services		Other	Age UK	CCG			Charity/Voluntary Sector	Additional CCG Contribution	£154,000	New	
Scheme 3: Rapid response and joined up intermediate care	Intermediate care services		Social Care		Local Authority			Local Authority	Local Authority Social Services	£2,472,000	Existing	£2,824,000
Scheme 3: Rapid response and joined up intermediate care	Intermediate care services		Social Care		Local Authority			Private Sector	Local Authority Social Services	£379,000	Existing	£379,000
Scheme 3: Rapid response and joined up intermediate care	Intermediate care services		Social Care		Local Authority			NHS Community Provider	Local Authority Social Services	£40,000	Existing	£40,000
Scheme 3: Rapid response and joined up intermediate care	Intermediate care services		Social Care		Local Authority			Charity/Voluntary Sector	Local Authority Social Services	£29,000	New	
Scheme 4 : Seven Day Working	7 day working		Social Care		Local Authority			Local Authority	Local Authority Social Services	£100,000	Existing	£100,000
Scheme 5 : Integrated Community-based Care and Support	Integrated care teams		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£5,046,000	Existing	£4,849,000
Scheme 5 : Integrated Community-based Care and Support	Intermediate care services		Other	Community Equipment	CCG			Private Sector	CCG Minimum Contribution	£885,000	Existing	£942,000
Scheme 5 : Integrated Community-based Care and Support	Intermediate care services		Primary Care		CCG			NHS Community Provider	CCG Minimum Contribution	£67,000	Existing	£63,000
Scheme 5: Integrated Community-based Care and Support	Intermediate care services		Community Health		CCG			CCG	Additional CCG Contribution	£24,000	New	
Scheme 5: Integrated Community-based Care and Support	Intermediate care services		Social Care		Local Authority			Private Sector	Local Authority Social Services	£1,018,000	Existing	£807,000
Scheme 5: Integrated Community-based Care and Support	Intermediate care services		Social Care		Local Authority			Local Authority	Local Authority Social Services	£930,000	Existing	£411,000
Scheme 5: Integrated Community-based Care and Support	Intermediate care services		Social Care		Local Authority			Local Authority	Local Authority Social Services	£3,457,000	Existing	£2,349,000
Scheme 6: Care Home and Supported Living Market Developme	Improving healthcare services to care		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£51,000	Existing	£48,000
Scheme 6: Care Home and Supported Living Market Developme	Improving healthcare services to care		Community Health		CCG			CCG	CCG Minimum Contribution	£32,000	Existing	£30,000
Scheme 6: Care Home and Supported Living Market Developme	Improving healthcare services to care		Social Care		Local Authority			Local Authority	Local Authority Social Services	£150,000	Existing	£150,000
Scheme 7: Supporting Carers	Support for carers		Social Care		Local Authority			Local Authority	Local Authority Social Services	£899,000	Existing	£838,000
Scheme 7 : Supporting Carers	Support for carers		Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£18,000	New	
Scheme 8 : People Living with Dementia	Personalised support/ care at home		Social Care		Local Authority			Local Authority	Local Authority Social Services	£305,000	New	
Programme Management	Other	Programme Management	Social Care		Local Authority			Local Authority	Local Authority Social Services	£80,000	Existing	£60,000

Scheme Type	Description
Reablement services	The development of support networks to maintain the patient at home independently or through appropriate interventions delivered in the community setting. Improved independence, avoids admissions, reduces need for home care packages.
Personalised support/ care at home	Schemes specifically designed to ensure that the patient can be supported at home instead of admission to hospital or to a care home. May promote self management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term. Admission avoidance, re-admission avoidance.
Intermediate care services	Community based services 24x7. Step-up and step-down. Requirement for more advanced nursing care. Admissions avoidance, early discharge.
Integrated care teams	Improving outcomes for patients by developing multi-disciplinary health and social care teams based in the community. Co-ordinated and proactive management of individual cases. Improved independence, reduction in hospital admissions.
Improving healthcare services to care homes	Improve the quality of primary and community health services delivered to care home residents. To improve the consistency and quality of healthcare outcomes for care home residents. Support Care Home workers to improve the delivery of non essential healthcare skills. Admission avoidance, re-admission avoidance.
Support for carers	Supporting people so they can continue in their rdes as carers and avoiding hospital admissions. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. Admission avoidance
7 day working	Seven day working across health and/or social care settings. Reablement and avoids admissions
Assistive Technologies	Supportive technologies for self management and telehealth. Admission avoidance and improves quality of care

Template for BCF submission 1: due on 02 March 2016

Sheet: 5. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board:
Hillingdon

Data Submission Period:
2016/17

5. HWB Metrics

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

5.1 HWB NEA Activity Plan

- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)

		Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total (Q1 - Q4)	
Contributing CCGs	% CCG registered population that has resident population in Hillingdon	% Hillingdon resident population that is in CCG registered population	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**
NHS Chiltern CCG	0.1%	0.1%	7,268	7	7,348	8	7,348	8	7,188	7	29,152	30
NHS Ealing CCG	5.2%	6.9%	7,904	408	7,899	408	7,899	408	7,899	408	31,601	1,632
NHS Hammersmith and Fulham CCG	0.3%	0.3%	4,013	19	4,008	19	4,008	19	4,008	19	16,037	76
NHS Harrow CCG	2.2%	1.8%	4,443	100	4,304	97	4,373	98	4,304	97	17,424	391
NHS Hillingdon CCG	94.3%	90.0%	6,323	5,962	6,125	5,776	6,224	5,869	6,124	5,775	24,796	23,381
NHS Hounslow CCG	1.0%	0.9%	6,461	62	6,456	62	6,456	62	6,456	62	25,829	247
Totals		100%	36,412	6,558	36,140	6,368	36,308	6,463	35,979	6,367	144,839	25,757

Are you planning on any additional quarterly reductions?	No						
If yes, please complete HWB Quarterly Additional Reduction Figures							
HWB Quarterly Additional Reduction Figure							
HWB NEA Plan (after reduction)							
HWB Quarterly Plan Reduction %							

Are you putting in place a local risk sharing agreement on NEA?	No
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share ***	£4,705,314
Cost of NEA used during 15/16 ***	£1,490
Cost of NEA in 16/17 ***	
Additional reduction delivered through the BCF	
HWB Plan Reduction %	

Please add the reason for any adjustments to the cost of NEA for 16/17 in the cell below

* This is taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level
** This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)
*** Within the risk subject to the condition on NHS out of hospital commissioned services/risk share, for any local area putting in place a risk share for 2016/17 as part of its BCF planning, we would expect the value of the risk share to be equal to the cost of the non-elective activity that the BCF plan seeks to avoid. Source of data:
https://www.england.nhs.uk/wp-content/uploads/2016/02/bcf-allocations-1617.xlsx
**** Please use the following document and amend the cost if necessary in cell E54. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477919/2014-15_Reference_costs_publication.pdf

5.2 Residential Admissions

- In cell G89 please enter your forecasted level of residential admissions for 2015-16. In cell H89 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15****	Planned 15/16****	Forecast 15/16	Planned 16/17	Comments
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	358.9	267.4	365.7	360.3	The target for 2015/16 was revised to 150 to reflect change in circumstances that led to 104 target being agreed, e.g. development of 80 uni
	Numerator	137	104	150	150	
	Denominator	38,169	38,895	38,895	39,445	

****Actual 14/15 & Planned 15/16 collected using the following definition - 'Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population'

5.3 Reablement

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	86.3%	95.4%	92.0%	93.8%	A 38% increase in the number of people receiving support from the Reablement Team took place in 2015/16. The target for 2016/17 has bee
	Numerator	125	124	184	225	
	Denominator	145	130	200	240	

5.4 Delayed Transfers of Care

- Please use rows 93-95 (columns K-L for Q3-Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figure in cells K94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells K93-O93. Please add a commentary in column H to provide any useful information in relation to how you have agreed this figure.

		15-16 plans				15-16 actual (Q1 & Q2) and forecast (Q3 & Q4) figures				16-17 plans				
		Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)	Comments
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	533.5	492.8	468.5	616.7	236.2	445.7	606.2	621.4	293.9	403.0	588.7	503.1	5% reduction based on assumption that the full effect of addressing the key cause of Hillingdo
	Numerator	1,205	1,113	1,058	1,414	538	1,002	1369	1425	674	924	1350	1169	
	Denominator	225,846	225,846	225,846	229,303	225,846	225,846	225,846	229303	229303	229303	229,303	232,374	

5.5 Local performance metric (as described in your approved BCF plan / Q1 return)

- Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your 2015/16 approved BCF plan and 2015/16 Q1 return - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
Social care-related quality of life	Metric Value	18.2	18.4	The outturn for 2014/15 was 18.2. The provisional score for 2015/16 is 18.4 this is a 1% increase. The proposal for 2016/17 is to maintain th
	Numerator	44970.0	0.0	
	Denominator	2441.0	0.0	

5.6 Local defined patient experience metric (as described in your approved BCF plan / Q1 return)

- You may also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your 2015/16 approved BCF plan and 2015/16 Q1 return - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
Adult Social Care Survey Q12 - In the past year, have you generally found it easy or difficult to find information and advice about support services or benefits	Metric Value	73.0	75.5	The outturn for 2014/15 was 74.8%, the provisional score for 2015/16 is 75%. The proposal for 2016/17 is to maintain this level of increase
	Numerator	1830.0	0.0	
	Denominator	2441.0	0.0	

Template for BCF submission 1: due on 02 March 2016

Sheet: 5b. Health and Well-Being Board Better Care Fund NEA and DTOC Tool

Selected Health and Well Being Board:

Hillingdon

Data Submission Period:

2016/17

Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:

https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

5.1 HWB NEA Activity

Hillingdon Data Source Used - 15/16	SUS				
	Q1	Q2	Q3	Q4	Total
Hillingdon 14/15 Baseline (outturn)	2,818	2,756	2,815	2,754	11,143
Hillingdon 15/16 Plan	2,719	2,660	2,717	775	8,871
Hillingdon 15/16 Actual	2,663	2,571			5,234

14/15 baseline and plan data has been taken from the "Better Care Fund Revised Non-Elective targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection" returned by HWB's in July 2015. The Q1 15/16 actual performance has been taken from the "Q1 Better Care Fund data collection" returned by HWB's in August 2015. The Q2 actual performance 15/16 and the Q4 15/16 plan figure have been taken from the "Q2 Better Care Fund data collection" returned by HWB's in November 2015. Actual Q3 and Q4 data is not available at the point of this template being released.

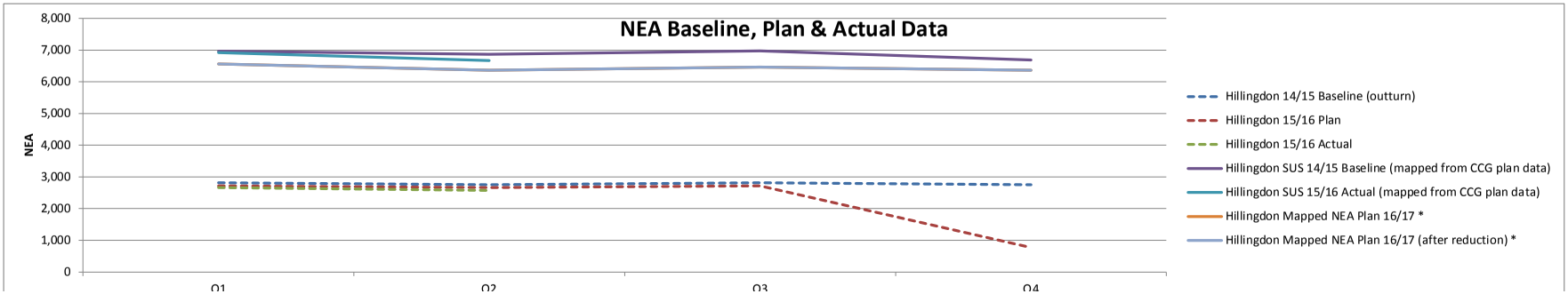
Hillingdon SUS 14/15 Baseline (mapped from CCG plan data)	**6,966**	**6,864**	**6,976**	**6,688**	**27,494**
Hillingdon SUS 15/16 Actual (mapped from CCG plan data)	6,918	6,672			13,589
Hillingdon SUS 15/16 FOT (mapped from CCG plan data)					27,615

SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures were mapped from the baseline data supplied to assist the CCGs with the 16/17 shared planning round.

Over the last year the monitoring of non-elective admission (NEA) activity has shifted away from the use of the Monthly Activity Return (MAR) towards the use of Secondary Users Service data (SUS). This has been reflected in the latest planning round where NHS England, Monitor and TDA have worked with CCGs and providers to create a consistent methodology to enable the creation of consistent NEA plans. The SUS CCG mapped data included here has been derived using this methodology. More details on the methodology used to define NEA can be found in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

Hillingdon Mapped NEA Plan 16/17 *	**6,558**	**6,368**	**6,463**	**6,367**	**25,757**
Hillingdon Mapped NEA Plan 16/17 (after reduction) *	**6,558**	**6,368**	**6,463**	**6,367**	**25,757**

*See tab 5. HWB Metrics (row 41) to show how this figure has been calculated



Template for BCF submission 1: due on 02 March 2016

Sheet: 5b. Health and Well-Being Board Better Care Fund NEA and DTOC Tool

Selected Health and Well Being Board:

Hillingdon

Data Submission Period:

2016/17

Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:

https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

Template for BCF submission 1: due on 02 March 2016

Sheet: 5b. Health and Well-Being Board Better Care Fund NEA and DTOC Tool

Selected Health and Well Being Board:

Hillingdon

Data Submission Period:

2016/17

Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:

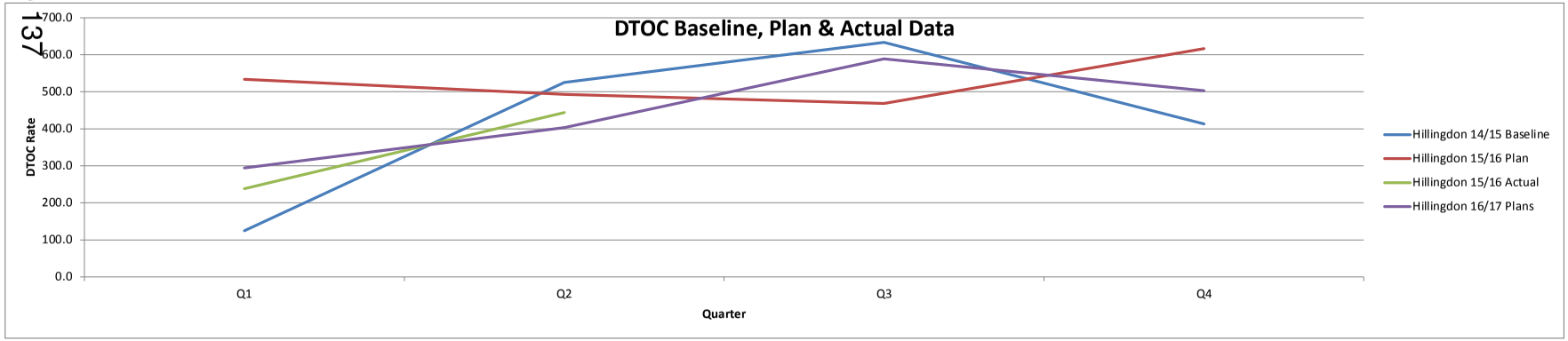
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

5.4 Delayed Transfers of Care

	Q1	Q2	Q3	Q4	Total
Hillingdon 14/15 Baseline	124.9	524.9	633.6	413.1	1,696.6
Hillingdon 15/16 Plan	533.5	492.8	468.5	616.7	2,111.5
Hillingdon 15/16 Actual	238.2	443.7			681.9

Delayed Transfers Of Care numerator data for baseline and actual performance has been sourced from the monthly DTOC return found here http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/. Actual Q3 and Q4 data is not available at the point of this template being released.

Hillingdon 16/17 Plans	**293.9**	**403.0**	**588.7**	**503.1**	**1,788.7**



Template for BCF submission 1: due on 02 March 2016

Sheet: 6. National Conditions

Selected Health and Well Being Board:

Hillingdon

Data Submission Period:

2016/17

6. National Conditions

This sheet requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2016-17. The conditions are set out in full in the BCF Policy Framework and further guidance is provided in the BCF Planning Requirements document. Please answer as at the time of completion. On this tab please enter the following information:

- For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met, or will be by 31st March 2016. 'No - in development' should be used when a condition is not currently being met but a plan is in development to meet this through the delivery of your BCF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition by 31st March 2017.
- Please use column C to indicate when it is expected that the condition will be met / agreed if it is not being currently.
- Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.

National Conditions For The Better Care Fund 2016-17	Does your BCF plan for 2016-17 set out a clear plan to meet this condition?	Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.
1) Plans to be jointly agreed	No - in development	The draft plan will be considered by the CCG's Governing Body on 1/04/16 and the Health and Wellbeing Board on the 12/04/16. If approved the plan will be jointly agreed.
2) Maintain provision of social care services (not spending)	Yes	
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	
4) Better data sharing between health and social care, based on the NHS number	Yes	
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	No - in development	There is a joint approach being taken to assessments and care planning and GPs have been identified as the accountable professional, but joint funding for packages of care is not currently being provided. Dialogue is taking place to ensure resolution and delivery of this by 31/08/16.
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	No - in development	High level narrative plan and scheme descriptions have been shared with providers. Providers will be asked to complete commentary templates which will form part of the final plan submission.
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	No - in development	Proposed targets have been developed and actions set out in the proposed scheme descriptions for 2016/17 but not as yet agreed by both the Council and CCG. Currently consulting with acute, community health and mental health providers.

CCG to Health and Well-Being Board Mapping

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	89.7%	88.4%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	6.8%	8.3%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.2%	0.4%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.1%	2.9%
E09000003	Barnet	07M	NHS Barnet CCG	91.1%	92.9%
E09000003	Barnet	07P	NHS Brent CCG	2.0%	1.8%
E09000003	Barnet	07R	NHS Camden CCG	0.8%	0.5%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000003	Barnet	07X	NHS Enfield CCG	2.9%	2.4%
E09000003	Barnet	08D	NHS Haringey CCG	2.1%	1.6%
E09000003	Barnet	08E	NHS Harrow CCG	1.2%	0.8%
E09000003	Barnet	08H	NHS Islington CCG	0.1%	0.0%
E09000003	Barnet	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.0%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.4%	98.2%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.3%
E08000016	Barnsley	03A	NHS Greater Huddersfield CCG	0.2%	0.2%
E08000016	Barnsley	03L	NHS Rotherham CCG	0.3%	0.3%
E08000016	Barnsley	03N	NHS Sheffield CCG	0.2%	0.4%
E08000016	Barnsley	03R	NHS Wakefield CCG	0.4%	0.6%
E06000022	Bath and North East Somerset	11E	NHS Bath and North East Somerset CCG	94.0%	98.3%
E06000022	Bath and North East Somerset	11H	NHS Bristol CCG	0.3%	0.8%
E06000022	Bath and North East Somerset	11X	NHS Somerset CCG	0.2%	0.5%
E06000022	Bath and North East Somerset	12A	NHS South Gloucestershire CCG	0.0%	0.1%
E06000022	Bath and North East Somerset	99N	NHS Wiltshire CCG	0.1%	0.3%
E06000055	Bedford	06F	NHS Bedfordshire CCG	37.5%	97.4%
E06000055	Bedford	06H	NHS Cambridgeshire and Peterborough CCG	0.4%	1.9%
E06000055	Bedford	04G	NHS Nene CCG	0.2%	0.7%
E09000004	Bexley	07N	NHS Bexley CCG	93.6%	89.4%
E09000004	Bexley	07Q	NHS Bromley CCG	0.0%	0.1%
E09000004	Bexley	09J	NHS Dartford, Gravesham and Swanley CCG	1.5%	1.6%
E09000004	Bexley	08A	NHS Greenwich CCG	7.7%	8.9%
E08000025	Birmingham	13P	NHS Birmingham Crosscity CCG	92.0%	57.3%
E08000025	Birmingham	04X	NHS Birmingham South and Central CCG	96.9%	20.5%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05J	NHS Redditch and Bromsgrove CCG	2.9%	0.4%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	40.1%	18.6%
E08000025	Birmingham	05P	NHS Solihull CCG	15.0%	3.0%
E08000025	Birmingham	05Y	NHS Walsall CCG	0.5%	0.1%
E06000008	Blackburn with Darwen	00Q	NHS Blackburn with Darwen CCG	89.0%	95.8%
E06000008	Blackburn with Darwen	00T	NHS Bolton CCG	1.2%	2.3%
E06000008	Blackburn with Darwen	00V	NHS Bury CCG	0.2%	0.2%
E06000008	Blackburn with Darwen	01A	NHS East Lancashire CCG	0.7%	1.6%
E06000009	Blackpool	00R	NHS Blackpool CCG	87.0%	97.5%
E06000009	Blackpool	02M	NHS Fylde & Wyre CCG	2.6%	2.5%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.6%
E08000001	Bolton	00V	NHS Bury CCG	1.3%	0.9%
E08000001	Bolton	00X	NHS Chorley and South Ribble CCG	0.2%	0.1%
E08000001	Bolton	01G	NHS Salford CCG	0.6%	0.5%
E08000001	Bolton	02H	NHS Wigan Borough CCG	0.8%	0.9%
E06000028 & E06000029	Bournemouth & Poole	11J	NHS Dorset CCG	45.7%	100.0%
E06000036	Bracknell Forest	10G	NHS Bracknell and Ascot CCG	82.1%	94.8%
E06000036	Bracknell Forest	99M	NHS North East Hampshire and Farnham CCG	0.6%	1.1%
E06000036	Bracknell Forest	10C	NHS Surrey Heath CCG	0.1%	0.1%
E06000036	Bracknell Forest	11C	NHS Windsor, Ascot and Maidenhead CCG	1.8%	2.2%
E06000036	Bracknell Forest	11D	NHS Wokingham CCG	1.4%	1.8%
E08000032	Bradford	02N	NHS Airedale, Wharfdale and Craven CCG	67.4%	18.7%
E08000032	Bradford	02W	NHS Bradford City CCG	99.4%	21.5%
E08000032	Bradford	02R	NHS Bradford Districts CCG	97.8%	58.4%
E08000032	Bradford	02T	NHS Calderdale CCG	0.1%	0.0%
E08000032	Bradford	02V	NHS Leeds North CCG	0.6%	0.2%
E08000032	Bradford	03C	NHS Leeds West CCG	1.7%	1.1%
E08000032	Bradford	03J	NHS North Kirklees CCG	0.1%	0.0%
E09000005	Brent	07M	NHS Barnet CCG	2.0%	2.1%
E09000005	Brent	07P	NHS Brent CCG	89.6%	87.2%
E09000005	Brent	07R	NHS Camden CCG	4.0%	2.7%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.2%	0.6%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	0.2%	0.1%
E09000005	Brent	08E	NHS Harrow CCG	5.7%	3.9%
E09000005	Brent	08Y	NHS West London (K&C & QPP) CCG	4.4%	2.8%
E06000043	Brighton and Hove	09D	NHS Brighton and Hove CCG	97.8%	99.7%
E06000043	Brighton and Hove	09G	NHS Coastal West Sussex CCG	0.1%	0.2%
E06000043	Brighton and Hove	99K	NHS High Weald Lewes Havens CCG	0.3%	0.2%
E06000023	Bristol, City of	11H	NHS Bristol CCG	94.7%	97.9%
E06000023	Bristol, City of	12A	NHS South Gloucestershire CCG	3.8%	2.1%
E09000006	Bromley	07N	NHS Bexley CCG	0.2%	0.1%
E09000006	Bromley	07Q	NHS Bromley CCG	94.9%	95.3%
E09000006	Bromley	07V	NHS Croydon CCG	1.1%	1.3%
E09000006	Bromley	08A	NHS Greenwich CCG	1.5%	1.2%
E09000006	Bromley	08K	NHS Lambeth CCG	0.0%	0.1%
E09000006	Bromley	08L	NHS Lewisham CCG	2.0%	1.8%
E09000006	Bromley	99J	NHS West Kent CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Y	NHS Aylesbury Vale CCG	91.2%	35.0%
E10000002	Buckinghamshire	06F	NHS Bedfordshire CCG	0.6%	0.5%
E10000002	Buckinghamshire	10H	NHS Chiltern CCG	96.1%	59.9%
E10000002	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E10000002	Buckinghamshire	08G	NHS Hillingdon CCG	0.8%	0.5%
E10000002	Buckinghamshire	04F	NHS Milton Keynes CCG	1.2%	0.6%
E10000002	Buckinghamshire	04G	NHS Nene CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.6%	0.8%
E10000002	Buckinghamshire	10T	NHS Slough CCG	2.8%	0.8%
E10000002	Buckinghamshire	11C	NHS Windsor, Ascot and Maidenhead CCG	1.3%	0.4%

E08000002	Bury	00T	NHS Bolton CCG	0.8%	1.2%
E08000002	Bury	00V	NHS Bury CCG	94.3%	94.3%
E08000002	Bury	01A	NHS East Lancashire CCG	0.1%	0.2%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	01M	NHS North Manchester CCG	2.0%	2.0%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.8%
E08000033	Calderdale	02R	NHS Bradford Districts CCG	0.4%	0.7%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.6%	98.8%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.4%	0.4%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.8%
E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	72.1%	96.6%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.9%	0.7%
E10000003	Cambridgeshire	99D	NHS South Lincolnshire CCG	0.4%	0.0%
E10000003	Cambridgeshire	07H	NHS West Essex CCG	0.2%	0.1%
E10000003	Cambridgeshire	07J	NHS West Norfolk CCG	1.5%	0.4%
E10000003	Cambridgeshire	07K	NHS West Suffolk CCG	4.0%	1.4%
E09000007	Camden	07M	NHS Barnet CCG	0.1%	0.2%
E09000007	Camden	07P	NHS Brent CCG	1.5%	2.2%
E09000007	Camden	07R	NHS Camden CCG	84.6%	88.4%
E09000007	Camden	09A	NHS Central London (Westminster) CCG	6.0%	5.1%
E09000007	Camden	08D	NHS Haringey CCG	0.5%	0.6%
E09000007	Camden	08H	NHS Islington CCG	3.4%	3.2%
E09000007	Camden	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.2%
E06000056	Central Bedfordshire	10Y	NHS Aylesbury Vale CCG	2.1%	1.5%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.8%	95.1%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.2%	0.5%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.8%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.4%	2.0%
E06000049	Cheshire East	01C	NHS Eastern Cheshire CCG	96.3%	50.6%
E06000049	Cheshire East	04J	NHS North Derbyshire CCG	0.4%	0.3%
E06000049	Cheshire East	05G	NHS North Staffordshire CCG	1.1%	0.6%
E06000049	Cheshire East	05N	NHS Shropshire CCG	0.1%	0.0%
E06000049	Cheshire East	01R	NHS South Cheshire CCG	98.6%	45.3%
E06000049	Cheshire East	01W	NHS Stockport CCG	1.6%	1.3%
E06000049	Cheshire East	02A	NHS Trafford CCG	0.2%	0.1%
E06000049	Cheshire East	02D	NHS Vale Royal CCG	0.7%	0.2%
E06000049	Cheshire East	02E	NHS Warrington CCG	0.7%	0.4%
E06000049	Cheshire East	02F	NHS West Cheshire CCG	2.0%	1.3%
E06000050	Cheshire West and Chester	01C	NHS Eastern Cheshire CCG	1.1%	0.7%
E06000050	Cheshire West and Chester	01F	NHS Halton CCG	0.2%	0.0%
E06000050	Cheshire West and Chester	01R	NHS South Cheshire CCG	0.5%	0.2%
E06000050	Cheshire West and Chester	02D	NHS Vale Royal CCG	99.3%	29.3%
E06000050	Cheshire West and Chester	02E	NHS Warrington CCG	0.4%	0.3%
E06000050	Cheshire West and Chester	02F	NHS West Cheshire CCG	96.8%	69.4%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.2%
E09000001	City of London	07R	NHS Camden CCG	0.2%	6.0%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.0%	0.8%
E09000001	City of London	07T	NHS City and Hackney CCG	1.9%	74.1%
E09000001	City of London	08H	NHS Islington CCG	0.1%	3.1%
E09000001	City of London	08Q	NHS Southwark CCG	0.0%	0.1%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.4%	15.8%
E06000052	Cornwall & Scilly	11N	NHS Kernow CCG	99.7%	99.4%
E06000052	Cornwall & Scilly	99P	NHS North, East, West Devon CCG	0.4%	0.6%
E06000047	County Durham	00D	NHS Durham Dales, Easington and Sedgefield CCG	97.4%	53.0%
E06000047	County Durham	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.1%	0.0%
E06000047	County Durham	13T	NHS Newcastle Gateshead CCG	0.7%	0.7%
E06000047	County Durham	00J	NHS North Durham CCG	96.6%	45.7%
E06000047	County Durham	00P	NHS Sunderland CCG	1.2%	0.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.0%	99.9%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.3%	0.1%
E09000008	Croydon	07Q	NHS Bromley CCG	1.5%	1.3%
E09000008	Croydon	07V	NHS Croydon CCG	95.6%	93.7%
E09000008	Croydon	09L	NHS East Surrey CCG	3.0%	1.3%
E09000008	Croydon	08K	NHS Lambeth CCG	2.7%	2.6%
E09000008	Croydon	08R	NHS Merton CCG	0.8%	0.4%
E09000008	Croydon	08T	NHS Sutton CCG	0.8%	0.4%
E09000008	Croydon	08X	NHS Wandsworth CCG	0.4%	0.4%
E10000006	Cumbria	01H	NHS Cumbria CCG	97.4%	100.0%
E10000006	Cumbria	01K	NHS Lancashire North CCG	0.2%	0.0%
E06000005	Darlington	00C	NHS Darlington CCG	98.2%	96.3%
E06000005	Darlington	00D	NHS Durham Dales, Easington and Sedgefield CCG	1.2%	3.1%
E06000005	Darlington	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.0%	0.1%
E06000005	Darlington	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.5%
E06000015	Derby	04R	NHS Southern Derbyshire CCG	50.1%	100.0%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	8.1%	1.4%
E10000007	Derbyshire	01C	NHS Eastern Cheshire CCG	0.3%	0.0%
E10000007	Derbyshire	03X	NHS Erewash CCG	92.2%	11.3%
E10000007	Derbyshire	03Y	NHS Hardwick CCG	94.6%	12.2%
E10000007	Derbyshire	04E	NHS Mansfield and Ashfield CCG	1.9%	0.5%
E10000007	Derbyshire	04J	NHS North Derbyshire CCG	98.3%	36.0%
E10000007	Derbyshire	04L	NHS Nottingham North and East CCG	0.2%	0.0%
E10000007	Derbyshire	04M	NHS Nottingham West CCG	5.0%	0.6%
E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.4%
E10000007	Derbyshire	04R	NHS Southern Derbyshire CCG	48.2%	33.0%
E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	14.1%	4.3%
E10000007	Derbyshire	04V	NHS West Leicestershire CCG	0.5%	0.2%
E10000008	Devon	11J	NHS Dorset CCG	0.3%	0.3%
E10000008	Devon	11N	NHS Kernow CCG	0.3%	0.2%
E10000008	Devon	99P	NHS North, East, West Devon CCG	70.0%	80.5%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E10000008	Devon	99Q	NHS South Devon and Torbay CCG	51.1%	18.7%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.4%	0.3%
E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.2%	0.5%

E08000017	Doncaster	02X	NHS Doncaster CCG	96.7%	97.8%
E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.3%
E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.1%
E10000009	Dorset	11J	NHS Dorset CCG	52.7%	95.9%
E10000009	Dorset	11X	NHS Somerset CCG	0.6%	0.7%
E10000009	Dorset	11A	NHS West Hampshire CCG	2.0%	2.5%
E10000009	Dorset	99N	NHS Wiltshire CCG	0.8%	0.9%
E08000027	Dudley	13P	NHS Birmingham Crosscity CCG	0.2%	0.5%
E08000027	Dudley	05C	NHS Dudley CCG	93.2%	90.9%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	4.0%	6.9%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.8%	1.5%
E08000027	Dudley	06D	NHS Wyre Forest CCG	0.6%	0.2%
E09000009	Ealing	07P	NHS Brent CCG	1.7%	1.5%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000009	Ealing	07W	NHS Ealing CCG	86.7%	90.8%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.7%	2.9%
E09000009	Ealing	08E	NHS Harrow CCG	0.3%	0.2%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.6%	0.5%
E09000009	Ealing	07Y	NHS Hounslow CCG	5.0%	3.7%
E09000009	Ealing	08Y	NHS West London (K&C & QPP) CCG	0.6%	0.4%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.4%	85.2%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	9.4%	8.0%
E06000011	East Riding of Yorkshire	03M	NHS Scarborough and Ryedale CCG	0.7%	0.2%
E06000011	East Riding of Yorkshire	03Q	NHS Vale of York CCG	6.4%	6.6%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.0%	0.6%
E10000011	East Sussex	09F	NHS Eastbourne, Hailsham and Seaford CCG	100.0%	34.5%
E10000011	East Sussex	09P	NHS Hastings and Rother CCG	99.7%	33.3%
E10000011	East Sussex	99K	NHS High Weald Lewes Havens CCG	98.1%	29.7%
E10000011	East Sussex	09X	NHS Horsham and Mid Sussex CCG	2.9%	1.2%
E10000011	East Sussex	99J	NHS West Kent CCG	0.8%	0.7%
E09000010	Enfield	07M	NHS Barnet CCG	1.1%	1.3%
E09000010	Enfield	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000010	Enfield	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E09000010	Enfield	07X	NHS Enfield CCG	95.5%	90.7%
E09000010	Enfield	08D	NHS Haringey CCG	7.8%	6.9%
E09000010	Enfield	06N	NHS Herts Valleys CCG	0.1%	0.2%
E09000010	Enfield	08H	NHS Islington CCG	0.2%	0.1%
E10000012	Essex	07L	NHS Barking and Dagenham CCG	0.1%	0.0%
E10000012	Essex	99E	NHS Basildon and Brentwood CCG	99.8%	18.3%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.4%	11.7%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.8%	0.7%
E10000012	Essex	08F	NHS Havering CCG	0.2%	0.0%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.4%
E10000012	Essex	06T	NHS North East Essex CCG	98.7%	22.4%
E10000012	Essex	08N	NHS Redbridge CCG	3.2%	0.6%
E10000012	Essex	99G	NHS Southend CCG	3.4%	0.4%
E10000012	Essex	07G	NHS Thurrock CCG	1.5%	0.2%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	07H	NHS West Essex CCG	97.3%	19.7%
E10000012	Essex	07K	NHS West Suffolk CCG	2.3%	0.4%
E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	39.6%	98.0%
E08000037	Gateshead	00J	NHS North Durham CCG	0.9%	1.1%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.7%
E08000037	Gateshead	00N	NHS South Tyneside CCG	0.3%	0.2%
E10000013	Gloucestershire	11M	NHS Gloucestershire CCG	97.6%	98.6%
E10000013	Gloucestershire	05F	NHS Herefordshire CCG	0.5%	0.1%
E10000013	Gloucestershire	10Q	NHS Oxfordshire CCG	0.2%	0.2%
E10000013	Gloucestershire	12A	NHS South Gloucestershire CCG	0.3%	0.1%
E10000013	Gloucestershire	05R	NHS South Warwickshire CCG	0.5%	0.2%
E10000013	Gloucestershire	05T	NHS South Worcestershire CCG	1.1%	0.5%
E10000013	Gloucestershire	99N	NHS Wiltshire CCG	0.2%	0.2%
E09000011	Greenwich	07N	NHS Bexley CCG	5.2%	4.3%
E09000011	Greenwich	07Q	NHS Bromley CCG	1.1%	1.3%
E09000011	Greenwich	08A	NHS Greenwich CCG	88.6%	89.9%
E09000011	Greenwich	08L	NHS Lewisham CCG	4.1%	4.5%
E09000012	Hackney	07R	NHS Camden CCG	0.8%	0.7%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.6%	94.6%
E09000012	Hackney	08D	NHS Haringey CCG	0.6%	0.7%
E09000012	Hackney	08H	NHS Islington CCG	4.1%	3.4%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.5%	0.5%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.7%
E06000006	Halton	01J	NHS Knowsley CCG	0.1%	0.2%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E06000006	Halton	02E	NHS Warrington CCG	0.6%	0.9%
E06000006	Halton	02F	NHS West Cheshire CCG	0.6%	1.2%
E09000013	Hammersmith and Fulham	07P	NHS Brent CCG	0.3%	0.5%
E09000013	Hammersmith and Fulham	07R	NHS Camden CCG	0.0%	0.1%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.4%	2.3%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.6%	1.2%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	90.9%	88.0%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.8%
E09000013	Hammersmith and Fulham	08Y	NHS West London (K&C & QPP) CCG	6.4%	7.2%
E10000014	Hampshire	10G	NHS Bracknell and Ascot CCG	0.6%	0.0%
E10000014	Hampshire	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000014	Hampshire	11J	NHS Dorset CCG	0.5%	0.3%
E10000014	Hampshire	10K	NHS Fareham and Gosport CCG	98.6%	14.5%
E10000014	Hampshire	09N	NHS Guildford and Waverley CCG	2.9%	0.5%
E10000014	Hampshire	10M	NHS Newbury and District CCG	5.9%	0.5%
E10000014	Hampshire	10N	NHS North & West Reading CCG	0.9%	0.0%
E10000014	Hampshire	99M	NHS North East Hampshire and Farnham CCG	76.4%	12.4%
E10000014	Hampshire	10J	NHS North Hampshire CCG	99.2%	15.9%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.5%	0.7%
E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.4%	14.6%

E10000014	Hampshire	10X	NHS Southampton CCG	5.5%	1.1%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.7%	0.0%
E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.0%
E10000014	Hampshire	99N	NHS Wiltshire CCG	1.3%	0.5%
E10000014	Hampshire	11D	NHS Wokingham CCG	0.6%	0.0%
E09000014	Haringey	07M	NHS Barnet CCG	1.1%	1.6%
E09000014	Haringey	07R	NHS Camden CCG	0.5%	0.5%
E09000014	Haringey	07T	NHS City and Hackney CCG	3.0%	3.1%
E09000014	Haringey	07X	NHS Enfield CCG	1.3%	1.4%
E09000014	Haringey	08D	NHS Haringey CCG	87.7%	91.6%
E09000014	Haringey	08H	NHS Islington CCG	2.3%	1.9%
E09000015	Harrow	07M	NHS Barnet CCG	4.3%	6.3%
E09000015	Harrow	07P	NHS Brent CCG	3.7%	5.0%
E09000015	Harrow	07W	NHS Ealing CCG	1.3%	1.9%
E09000015	Harrow	08E	NHS Harrow CCG	90.0%	84.3%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.4%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.7%	1.9%
E09000015	Harrow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%
E06000001	Hartlepool	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.1%	0.4%
E06000001	Hartlepool	00K	NHS Hartlepool and Stockton-On-Tees CCG	32.6%	99.6%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	4.0%	3.3%
E09000016	Havering	08F	NHS Havering CCG	92.0%	95.9%
E09000016	Havering	08M	NHS Newham CCG	0.0%	0.1%
E09000016	Havering	08N	NHS Redbridge CCG	0.5%	0.6%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.1%
E06000019	Herefordshire, County of	11M	NHS Gloucestershire CCG	0.3%	0.9%
E06000019	Herefordshire, County of	05F	NHS Herefordshire CCG	98.1%	97.3%
E06000019	Herefordshire, County of	05N	NHS Shropshire CCG	0.3%	0.5%
E06000019	Herefordshire, County of	05T	NHS South Worcestershire CCG	0.8%	1.3%
E10000015	Hertfordshire	10Y	NHS Aylesbury Vale CCG	0.4%	0.0%
E10000015	Hertfordshire	07M	NHS Barnet CCG	0.2%	0.0%
E10000015	Hertfordshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000015	Hertfordshire	06H	NHS Cambridgeshire and Peterborough CCG	2.1%	1.6%
E10000015	Hertfordshire	10H	NHS Chiltern CCG	0.1%	0.0%
E10000015	Hertfordshire	06K	NHS East and North Hertfordshire CCG	96.8%	46.6%
E10000015	Hertfordshire	07X	NHS Enfield CCG	0.3%	0.0%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.5%	0.1%
E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.1%	50.9%
E10000015	Hertfordshire	08G	NHS Hillingdon CCG	2.3%	0.6%
E10000015	Hertfordshire	06P	NHS Luton CCG	0.4%	0.0%
E10000015	Hertfordshire	07H	NHS West Essex CCG	0.7%	0.2%
E09000017	Hillingdon	10H	NHS Chiltern CCG	0.1%	0.1%
E09000017	Hillingdon	07W	NHS Ealing CCG	5.2%	6.9%
E09000017	Hillingdon	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000017	Hillingdon	08E	NHS Harrow CCG	2.2%	1.8%
E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.3%	90.0%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.0%	0.9%
E09000018	Hounslow	07W	NHS Ealing CCG	5.8%	8.0%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.0%	0.6%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.0%	87.1%
E09000018	Hounslow	09Y	NHS North West Surrey CCG	0.3%	0.4%
E09000018	Hounslow	08P	NHS Richmond CCG	5.3%	3.6%
E09000018	Hounslow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07R	NHS Camden CCG	4.4%	4.9%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.4%	0.4%
E09000019	Islington	07T	NHS City and Hackney CCG	3.2%	4.1%
E09000019	Islington	08D	NHS Haringey CCG	1.3%	1.7%
E09000019	Islington	08H	NHS Islington CCG	89.8%	89.0%
E09000020	Kensington and Chelsea	07P	NHS Brent CCG	0.0%	0.1%
E09000020	Kensington and Chelsea	07R	NHS Camden CCG	0.2%	0.4%
E09000020	Kensington and Chelsea	09A	NHS Central London (Westminster) CCG	4.1%	5.1%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	0.9%	1.2%
E09000020	Kensington and Chelsea	08Y	NHS West London (K&C & QPP) CCG	64.1%	93.2%
E10000016	Kent	09C	NHS Ashford CCG	100.0%	8.3%
E10000016	Kent	07N	NHS Bexley CCG	1.1%	0.2%
E10000016	Kent	07Q	NHS Bromley CCG	0.8%	0.2%
E10000016	Kent	09E	NHS Canterbury and Coastal CCG	100.0%	14.1%
E10000016	Kent	09J	NHS Dartford, Gravesham and Swanley CCG	98.3%	16.5%
E10000016	Kent	09L	NHS East Surrey CCG	0.1%	0.0%
E10000016	Kent	08A	NHS Greenwich CCG	0.1%	0.0%
E10000016	Kent	09P	NHS Hastings and Rother CCG	0.3%	0.0%
E10000016	Kent	99K	NHS High Weald Lewes Havens CCG	0.6%	0.0%
E10000016	Kent	09W	NHS Medway CCG	6.0%	1.1%
E10000016	Kent	10A	NHS South Kent Coast CCG	100.0%	13.0%
E10000016	Kent	10D	NHS Swale CCG	99.9%	7.1%
E10000016	Kent	10E	NHS Thanet CCG	100.0%	9.3%
E10000016	Kent	99J	NHS West Kent CCG	98.7%	30.4%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.5%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	90.6%	98.5%
E09000021	Kingston upon Thames	08J	NHS Kingston CCG	87.1%	95.8%
E09000021	Kingston upon Thames	08R	NHS Merton CCG	1.0%	1.2%
E09000021	Kingston upon Thames	08P	NHS Richmond CCG	0.7%	0.8%
E09000021	Kingston upon Thames	99H	NHS Surrey Downs CCG	0.9%	1.5%
E09000021	Kingston upon Thames	08T	NHS Sutton CCG	0.1%	0.1%
E09000021	Kingston upon Thames	08X	NHS Wandsworth CCG	0.3%	0.5%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02R	NHS Bradford Districts CCG	1.0%	0.8%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.3%	0.6%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.5%	54.8%
E08000034	Kirklees	03C	NHS Leeds West CCG	0.3%	0.2%
E08000034	Kirklees	03J	NHS North Kirklees CCG	99.0%	42.4%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.5%	1.2%
E08000011	Knowsley	01F	NHS Halton CCG	1.1%	0.9%
E08000011	Knowsley	01J	NHS Knowsley CCG	86.9%	88.2%

E08000011	Knowsley	99A	NHS Liverpool CCG	2.5%	8.0%
E08000011	Knowsley	01T	NHS South Sefton CCG	0.2%	0.1%
E08000011	Knowsley	01X	NHS St Helens CCG	2.3%	2.9%
E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000022	Lambeth	07V	NHS Croydon CCG	0.7%	0.8%
E09000022	Lambeth	08K	NHS Lambeth CCG	86.8%	92.7%
E09000022	Lambeth	08R	NHS Merton CCG	1.2%	0.7%
E09000022	Lambeth	08Q	NHS Southwark CCG	1.8%	1.6%
E09000022	Lambeth	08X	NHS Wandsworth CCG	3.6%	3.8%
E10000017	Lancashire	02N	NHS Airedale, Wharfdale and Craven CCG	0.2%	0.0%
E10000017	Lancashire	00Q	NHS Blackburn with Darwen CCG	11.0%	1.5%
E10000017	Lancashire	00R	NHS Blackpool CCG	13.0%	1.8%
E10000017	Lancashire	00T	NHS Bolton CCG	0.3%	0.0%
E10000017	Lancashire	00V	NHS Bury CCG	1.4%	0.2%
E10000017	Lancashire	00X	NHS Chorley and South Ribble CCG	99.8%	14.5%
E10000017	Lancashire	01H	NHS Cumbria CCG	1.4%	0.6%
E10000017	Lancashire	01A	NHS East Lancashire CCG	98.9%	30.0%
E10000017	Lancashire	02M	NHS Fylde & Wyre CCG	97.4%	11.9%
E10000017	Lancashire	01E	NHS Greater Preston CCG	100.0%	17.1%
E10000017	Lancashire	01D	NHS Heywood, Middleton and Rochdale CCG	0.9%	0.2%
E10000017	Lancashire	01J	NHS Knowsley CCG	0.1%	0.0%
E10000017	Lancashire	01K	NHS Lancashire North CCG	99.8%	12.8%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.0%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.5%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	97.1%	8.8%
E10000017	Lancashire	02H	NHS Wigan Borough CCG	0.8%	0.2%
E08000035	Leeds	02W	NHS Bradford City CCG	0.6%	0.0%
E08000035	Leeds	02R	NHS Bradford Districts CCG	0.7%	0.3%
E08000035	Leeds	02V	NHS Leeds North CCG	96.4%	24.3%
E08000035	Leeds	03G	NHS Leeds South and East CCG	98.5%	31.9%
E08000035	Leeds	03C	NHS Leeds West CCG	97.9%	42.7%
E08000035	Leeds	03J	NHS North Kirklees CCG	0.3%	0.0%
E08000035	Leeds	03Q	NHS Vale of York CCG	0.6%	0.2%
E08000035	Leeds	03R	NHS Wakefield CCG	1.5%	0.6%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	2.5%	2.2%
E06000016	Leicester	04C	NHS Leicester City CCG	92.5%	95.2%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.6%	2.6%
E10000018	Leicestershire	03V	NHS Corby CCG	0.6%	0.0%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.3%	40.1%
E10000018	Leicestershire	04C	NHS Leicester City CCG	7.5%	4.2%
E10000018	Leicestershire	04N	NHS Rushcliffe CCG	5.4%	1.0%
E10000018	Leicestershire	04Q	NHS South West Lincolnshire CCG	5.7%	1.1%
E10000018	Leicestershire	04R	NHS Southern Derbyshire CCG	0.6%	0.5%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	52.7%
E09000023	Lewisham	07Q	NHS Bromley CCG	1.3%	1.5%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000023	Lewisham	08A	NHS Greenwich CCG	2.2%	2.0%
E09000023	Lewisham	08K	NHS Lambeth CCG	0.2%	0.3%
E09000023	Lewisham	08L	NHS Lewisham CCG	92.1%	92.5%
E09000023	Lewisham	08Q	NHS Southwark CCG	3.7%	3.7%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.2%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.2%	0.0%
E10000019	Lincolnshire	03T	NHS Lincolnshire East CCG	99.2%	32.1%
E10000019	Lincolnshire	04D	NHS Lincolnshire West CCG	98.5%	30.4%
E10000019	Lincolnshire	04H	NHS Newark & Sherwood CCG	2.4%	0.4%
E10000019	Lincolnshire	03H	NHS North East Lincolnshire CCG	2.7%	0.6%
E10000019	Lincolnshire	03K	NHS North Lincolnshire CCG	2.6%	0.6%
E10000019	Lincolnshire	99D	NHS South Lincolnshire CCG	90.6%	19.5%
E10000019	Lincolnshire	04Q	NHS South West Lincolnshire CCG	93.2%	16.2%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.5%	2.8%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.3%	96.2%
E08000012	Liverpool	01T	NHS South Sefton CCG	3.3%	1.0%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.3%	4.5%
E06000032	Luton	06P	NHS Luton CCG	97.2%	95.5%
E08000003	Manchester	00V	NHS Bury CCG	0.3%	0.1%
E08000003	Manchester	00W	NHS Central Manchester CCG	93.7%	36.9%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	01M	NHS North Manchester CCG	85.1%	30.3%
E08000003	Manchester	00Y	NHS Oldham CCG	0.9%	0.4%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%
E08000003	Manchester	01N	NHS South Manchester CCG	93.9%	28.2%
E08000003	Manchester	01W	NHS Stockport CCG	1.5%	0.8%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	4.3%	1.8%
E06000035	Medway	09J	NHS Dartford, Gravesham and Swanley CCG	0.2%	0.2%
E06000035	Medway	09W	NHS Medway CCG	94.0%	99.5%
E06000035	Medway	10D	NHS Swale CCG	0.1%	0.0%
E06000035	Medway	99J	NHS West Kent CCG	0.2%	0.3%
E09000024	Merton	07V	NHS Croydon CCG	0.5%	0.8%
E09000024	Merton	08J	NHS Kingston CCG	3.5%	3.0%
E09000024	Merton	08K	NHS Lambeth CCG	0.9%	1.4%
E09000024	Merton	08R	NHS Merton CCG	87.7%	81.5%
E09000024	Merton	08T	NHS Sutton CCG	3.4%	2.7%
E09000024	Merton	08X	NHS Wandsworth CCG	6.5%	10.5%
E06000002	Middlesbrough	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.2%	0.2%
E06000002	Middlesbrough	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.3%
E06000002	Middlesbrough	00M	NHS South Tees CCG	52.0%	99.5%
E06000042	Milton Keynes	06F	NHS Bedfordshire CCG	1.5%	2.5%
E06000042	Milton Keynes	04F	NHS Milton Keynes CCG	95.5%	96.1%
E06000042	Milton Keynes	04G	NHS Nene CCG	0.6%	1.4%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	58.0%	95.0%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	6.0%	4.2%
E08000021	Newcastle upon Tyne	00L	NHS Northumberland CCG	0.8%	0.8%
E09000025	Newham	07L	NHS Barking and Dagenham CCG	0.5%	0.3%

E09000025	Newham	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.0%
E09000025	Newham	08M	NHS Newham CCG	96.9%	97.9%
E09000025	Newham	08N	NHS Redbridge CCG	0.2%	0.2%
E09000025	Newham	08V	NHS Tower Hamlets CCG	0.2%	0.2%
E09000025	Newham	08W	NHS Waltham Forest CCG	1.7%	1.4%
E10000020	Norfolk	06H	NHS Cambridgeshire and Peterborough CCG	0.7%	0.7%
E10000020	Norfolk	06M	NHS Great Yarmouth and Waveney CCG	47.5%	12.3%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.1%	0.0%
E10000020	Norfolk	06V	NHS North Norfolk CCG	100.0%	18.8%
E10000020	Norfolk	06W	NHS Norwich CCG	100.0%	23.7%
E10000020	Norfolk	99D	NHS South Lincolnshire CCG	0.2%	0.0%
E10000020	Norfolk	06Y	NHS South Norfolk CCG	98.8%	25.3%
E10000020	Norfolk	07J	NHS West Norfolk CCG	98.5%	18.5%
E10000020	Norfolk	07K	NHS West Suffolk CCG	2.6%	0.7%
E06000012	North East Lincolnshire	03T	NHS Lincolnshire East CCG	0.8%	1.2%
E06000012	North East Lincolnshire	03H	NHS North East Lincolnshire CCG	95.9%	98.7%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.1%	0.2%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.1%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.1%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.1%
E06000013	North Lincolnshire	04D	NHS Lincolnshire West CCG	1.0%	1.4%
E06000013	North Lincolnshire	03H	NHS North East Lincolnshire CCG	1.4%	1.4%
E06000013	North Lincolnshire	03K	NHS North Lincolnshire CCG	97.2%	96.8%
E06000024	North Somerset	11E	NHS Bath and North East Somerset CCG	1.7%	1.6%
E06000024	North Somerset	11H	NHS Bristol CCG	0.3%	0.6%
E06000024	North Somerset	11T	NHS North Somerset CCG	99.1%	97.7%
E06000024	North Somerset	11X	NHS Somerset CCG	0.0%	0.2%
E08000022	North Tyneside	13T	NHS Newcastle Gateshead CCG	1.0%	2.5%
E08000022	North Tyneside	99C	NHS North Tyneside CCG	93.1%	96.4%
E08000022	North Tyneside	00L	NHS Northumberland CCG	0.7%	1.1%
E10000023	North Yorkshire	02N	NHS Airedale, Wharfdale and Craven CCG	32.4%	8.3%
E10000023	North Yorkshire	01H	NHS Cumbria CCG	1.2%	1.0%
E10000023	North Yorkshire	00C	NHS Darlington CCG	1.3%	0.2%
E10000023	North Yorkshire	02X	NHS Doncaster CCG	0.2%	0.1%
E10000023	North Yorkshire	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.1%
E10000023	North Yorkshire	01A	NHS East Lancashire CCG	0.1%	0.0%
E10000023	North Yorkshire	02Y	NHS East Riding of Yorkshire CCG	1.3%	0.7%
E10000023	North Yorkshire	03D	NHS Hambleton, Richmondshire and Whitby CCG	98.7%	22.9%
E10000023	North Yorkshire	03E	NHS Harrogate and Rural District CCG	99.9%	26.3%
E10000023	North Yorkshire	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.0%
E10000023	North Yorkshire	02V	NHS Leeds North CCG	3.0%	1.0%
E10000023	North Yorkshire	03G	NHS Leeds South and East CCG	0.5%	0.2%
E10000023	North Yorkshire	03M	NHS Scarborough and Ryedale CCG	99.3%	19.2%
E10000023	North Yorkshire	03Q	NHS Vale of York CCG	32.6%	18.7%
E10000023	North Yorkshire	03R	NHS Wakefield CCG	2.0%	1.2%
E10000021	Northamptonshire	10Y	NHS Aylesbury Vale CCG	0.1%	0.0%
E10000021	Northamptonshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000021	Northamptonshire	06H	NHS Cambridgeshire and Peterborough CCG	1.6%	1.9%
E10000021	Northamptonshire	03V	NHS Corby CCG	99.1%	9.6%
E10000021	Northamptonshire	05A	NHS Coventry and Rugby CCG	0.3%	0.2%
E10000021	Northamptonshire	03W	NHS East Leicestershire and Rutland CCG	1.9%	0.8%
E10000021	Northamptonshire	04F	NHS Milton Keynes CCG	3.2%	1.2%
E10000021	Northamptonshire	04G	NHS Nene CCG	98.8%	85.0%
E10000021	Northamptonshire	10Q	NHS Oxfordshire CCG	1.2%	1.1%
E10000021	Northamptonshire	99D	NHS South Lincolnshire CCG	0.9%	0.2%
E06000057	Northumberland	01H	NHS Cumbria CCG	0.0%	0.1%
E06000057	Northumberland	13T	NHS Newcastle Gateshead CCG	0.3%	0.4%
E06000057	Northumberland	00J	NHS North Durham CCG	0.2%	0.2%
E06000057	Northumberland	99C	NHS North Tyneside CCG	0.9%	0.6%
E06000057	Northumberland	00L	NHS Northumberland CCG	98.0%	98.7%
E06000018	Nottingham	04K	NHS Nottingham City CCG	89.7%	94.8%
E06000018	Nottingham	04L	NHS Nottingham North and East CCG	4.7%	2.1%
E06000018	Nottingham	04M	NHS Nottingham West CCG	5.7%	1.6%
E06000018	Nottingham	04N	NHS Rushcliffe CCG	4.1%	1.5%
E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	97.5%	13.5%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.7%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	03X	NHS Erewash CCG	7.8%	0.9%
E10000024	Nottinghamshire	03Y	NHS Hardwick CCG	5.1%	0.6%
E10000024	Nottinghamshire	04D	NHS Lincolnshire West CCG	0.4%	0.1%
E10000024	Nottinghamshire	04E	NHS Mansfield and Ashfield CCG	98.1%	22.5%
E10000024	Nottinghamshire	04H	NHS Newark & Sherwood CCG	97.6%	15.5%
E10000024	Nottinghamshire	04K	NHS Nottingham City CCG	10.3%	4.4%
E10000024	Nottinghamshire	04L	NHS Nottingham North and East CCG	95.0%	17.3%
E10000024	Nottinghamshire	04M	NHS Nottingham West CCG	89.3%	10.2%
E10000024	Nottinghamshire	04N	NHS Rushcliffe CCG	90.5%	13.6%
E10000024	Nottinghamshire	04Q	NHS South West Lincolnshire CCG	0.7%	0.1%
E10000024	Nottinghamshire	04R	NHS Southern Derbyshire CCG	0.6%	0.4%
E10000024	Nottinghamshire	04V	NHS West Leicestershire CCG	0.1%	0.0%
E08000004	Oldham	01D	NHS Heywood, Middleton and Rochdale CCG	1.4%	1.3%
E08000004	Oldham	01M	NHS North Manchester CCG	2.6%	2.1%
E08000004	Oldham	00Y	NHS Oldham CCG	94.7%	96.3%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E10000025	Oxfordshire	10Y	NHS Aylesbury Vale CCG	6.2%	1.8%
E10000025	Oxfordshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000025	Oxfordshire	04G	NHS Nene CCG	0.1%	0.1%
E10000025	Oxfordshire	10M	NHS Newbury and District CCG	0.1%	0.0%
E10000025	Oxfordshire	10N	NHS North & West Reading CCG	2.0%	0.3%
E10000025	Oxfordshire	10Q	NHS Oxfordshire CCG	97.3%	96.6%
E10000025	Oxfordshire	05R	NHS South Warwickshire CCG	0.7%	0.3%
E10000025	Oxfordshire	12D	NHS Swindon CCG	2.6%	0.8%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	22.6%	96.1%
E06000031	Peterborough	99D	NHS South Lincolnshire CCG	5.2%	3.9%
E06000026	Plymouth	99P	NHS North, East, West Devon CCG	29.3%	100.0%
E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.4%	1.3%

E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.5%	98.4%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.3%	0.3%
E06000038	Reading	10N	NHS North & West Reading CCG	61.2%	36.6%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.2%	0.6%
E06000038	Reading	10W	NHS South Reading CCG	79.9%	60.1%
E06000038	Reading	11D	NHS Wokingham CCG	3.1%	2.7%
E09000026	Redbridge	07L	NHS Barking and Dagenham CCG	5.6%	3.8%
E09000026	Redbridge	08F	NHS Havering CCG	0.9%	0.8%
E09000026	Redbridge	08M	NHS Newham CCG	1.5%	1.8%
E09000026	Redbridge	08N	NHS Redbridge CCG	92.6%	88.7%
E09000026	Redbridge	08W	NHS Waltham Forest CCG	3.4%	3.2%
E09000026	Redbridge	07H	NHS West Essex CCG	1.8%	1.7%
E06000003	Redcar and Cleveland	03D	NHS Hambleton, Richmondshire and Whitby CCG	1.0%	1.0%
E06000003	Redcar and Cleveland	00M	NHS South Tees CCG	47.7%	99.0%
E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.4%	0.4%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	5.0%	7.1%
E09000027	Richmond upon Thames	08J	NHS Kingston CCG	1.6%	1.5%
E09000027	Richmond upon Thames	08P	NHS Richmond CCG	92.2%	90.3%
E09000027	Richmond upon Thames	99H	NHS Surrey Downs CCG	0.0%	0.1%
E09000027	Richmond upon Thames	08X	NHS Wandsworth CCG	0.3%	0.6%
E08000005	Rochdale	00V	NHS Bury CCG	0.6%	0.5%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.6%	96.6%
E08000005	Rochdale	01M	NHS North Manchester CCG	1.8%	1.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.8%	0.9%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.4%	3.2%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	0.9%	0.4%
E08000018	Rotherham	02X	NHS Doncaster CCG	1.1%	1.3%
E08000018	Rotherham	03L	NHS Rotherham CCG	97.9%	93.5%
E08000018	Rotherham	03N	NHS Sheffield CCG	0.7%	1.6%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.3%
E06000017	Rutland	03V	NHS Corby CCG	0.3%	0.6%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	9.8%	85.6%
E06000017	Rutland	99D	NHS South Lincolnshire CCG	2.7%	12.0%
E06000017	Rutland	04Q	NHS South West Lincolnshire CCG	0.4%	1.5%
E08000006	Salford	00T	NHS Bolton CCG	0.2%	0.3%
E08000006	Salford	00V	NHS Bury CCG	1.8%	1.4%
E08000006	Salford	00W	NHS Central Manchester CCG	0.3%	0.3%
E08000006	Salford	01M	NHS North Manchester CCG	2.1%	1.7%
E08000006	Salford	01G	NHS Salford CCG	93.9%	95.1%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.1%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.2%
E08000028	Sandwell	13P	NHS Birmingham Crosscity CCG	2.8%	6.2%
E08000028	Sandwell	04X	NHS Birmingham South and Central CCG	0.2%	0.2%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.8%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	54.3%	89.2%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.6%	1.3%
E08000028	Sandwell	06A	NHS Wolverhampton CCG	0.3%	0.3%
E08000014	Sefton	01J	NHS Knowsley CCG	1.8%	1.0%
E08000014	Sefton	99A	NHS Liverpool CCG	2.9%	5.2%
E08000014	Sefton	01T	NHS South Sefton CCG	96.1%	51.9%
E08000014	Sefton	01V	NHS Southport and Formby CCG	97.0%	41.9%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.3%	0.1%
E08000019	Sheffield	02P	NHS Barnsley CCG	0.8%	0.4%
E08000019	Sheffield	03Y	NHS Hardwick CCG	0.4%	0.0%
E08000019	Sheffield	04J	NHS North Derbyshire CCG	0.7%	0.3%
E08000019	Sheffield	03L	NHS Rotherham CCG	0.3%	0.1%
E08000019	Sheffield	03N	NHS Sheffield CCG	98.6%	99.2%
E06000051	Shropshire	05F	NHS Herefordshire CCG	0.5%	0.3%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.4%	0.3%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.5%	95.4%
E06000051	Shropshire	01R	NHS South Cheshire CCG	0.5%	0.3%
E06000051	Shropshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.2%	0.9%
E06000051	Shropshire	05T	NHS South Worcestershire CCG	1.0%	1.0%
E06000051	Shropshire	05X	NHS Telford and Wrekin CCG	2.4%	1.4%
E06000051	Shropshire	02F	NHS West Cheshire CCG	0.2%	0.1%
E06000051	Shropshire	06D	NHS Wyre Forest CCG	0.7%	0.3%
E06000039	Slough	10H	NHS Chiltern CCG	3.2%	6.7%
E06000039	Slough	10T	NHS Slough CCG	96.6%	92.9%
E06000039	Slough	11C	NHS Windsor, Ascot and Maidenhead CCG	0.4%	0.4%
E08000029	Solihull	13P	NHS Birmingham Crosscity CCG	2.0%	6.8%
E08000029	Solihull	04X	NHS Birmingham South and Central CCG	0.3%	0.3%
E08000029	Solihull	05A	NHS Coventry and Rugby CCG	0.0%	0.1%
E08000029	Solihull	05J	NHS Redditch and Bromsgrove CCG	0.4%	0.3%
E08000029	Solihull	05P	NHS Solihull CCG	83.8%	91.7%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.4%	0.5%
E08000029	Solihull	05H	NHS Warwickshire North CCG	0.2%	0.2%
E10000027	Somerset	11E	NHS Bath and North East Somerset CCG	3.1%	1.1%
E10000027	Somerset	11J	NHS Dorset CCG	0.5%	0.7%
E10000027	Somerset	11T	NHS North Somerset CCG	0.9%	0.3%
E10000027	Somerset	99P	NHS North, East, West Devon CCG	0.3%	0.5%
E10000027	Somerset	11X	NHS Somerset CCG	98.5%	97.3%
E10000027	Somerset	99N	NHS Wiltshire CCG	0.1%	0.0%
E06000025	South Gloucestershire	11E	NHS Bath and North East Somerset CCG	0.6%	0.4%
E06000025	South Gloucestershire	11H	NHS Bristol CCG	4.7%	8.2%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.8%	1.8%
E06000025	South Gloucestershire	12A	NHS South Gloucestershire CCG	95.0%	89.4%
E06000025	South Gloucestershire	99N	NHS Wiltshire CCG	0.0%	0.1%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.1%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.3%	99.2%
E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E06000045	Southampton	10X	NHS Southampton CCG	94.5%	99.6%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.4%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.6%	4.5%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.6%	95.5%
E09000028	Southwark	07R	NHS Camden CCG	0.5%	0.4%

E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.0%	1.3%
E09000028	Southwark	08K	NHS Lambeth CCG	6.6%	7.6%
E09000028	Southwark	08L	NHS Lewisham CCG	1.9%	1.8%
E09000028	Southwark	08Q	NHS Southwark CCG	94.5%	88.9%
E09000028	Southwark	08X	NHS Wandsworth CCG	0.0%	0.1%
E08000013	St. Helens	01F	NHS Halton CCG	0.2%	0.1%
E08000013	St. Helens	01J	NHS Knowsley CCG	2.6%	2.3%
E08000013	St. Helens	01X	NHS St Helens CCG	91.1%	96.5%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.6%	1.1%
E10000028	Staffordshire	13P	NHS Birmingham Crosscity CCG	0.5%	0.4%
E10000028	Staffordshire	04Y	NHS Cannock Chase CCG	99.3%	14.9%
E10000028	Staffordshire	05C	NHS Dudley CCG	1.4%	0.5%
E10000028	Staffordshire	05D	NHS East Staffordshire CCG	91.9%	14.5%
E10000028	Staffordshire	01C	NHS Eastern Cheshire CCG	0.6%	0.1%
E10000028	Staffordshire	04J	NHS North Derbyshire CCG	0.7%	0.2%
E10000028	Staffordshire	05G	NHS North Staffordshire CCG	95.1%	23.5%
E10000028	Staffordshire	05N	NHS Shropshire CCG	1.1%	0.4%
E10000028	Staffordshire	01R	NHS South Cheshire CCG	0.5%	0.1%
E10000028	Staffordshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	96.2%	23.7%
E10000028	Staffordshire	04R	NHS Southern Derbyshire CCG	0.5%	0.3%
E10000028	Staffordshire	05V	NHS Stafford and Surrounds CCG	99.5%	16.6%
E10000028	Staffordshire	05W	NHS Stoke on Trent CCG	8.9%	2.9%
E10000028	Staffordshire	05X	NHS Telford and Wrekin CCG	1.0%	0.2%
E10000028	Staffordshire	05Y	NHS Walsall CCG	1.6%	0.5%
E10000028	Staffordshire	05H	NHS Warwickshire North CCG	1.2%	0.2%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.8%	0.9%
E10000028	Staffordshire	06D	NHS Wyre Forest CCG	0.2%	0.0%
E08000007	Stockport	00W	NHS Central Manchester CCG	0.7%	0.6%
E08000007	Stockport	01C	NHS Eastern Cheshire CCG	1.6%	1.1%
E08000007	Stockport	01N	NHS South Manchester CCG	2.9%	1.7%
E08000007	Stockport	01W	NHS Stockport CCG	95.2%	96.5%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E06000004	Stockton-on-Tees	00C	NHS Darlington CCG	0.4%	0.2%
E06000004	Stockton-on-Tees	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.3%	0.5%
E06000004	Stockton-on-Tees	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.1%
E06000004	Stockton-on-Tees	00K	NHS Hartlepool and Stockton-On-Tees CCG	66.8%	98.7%
E06000004	Stockton-on-Tees	00M	NHS South Tees CCG	0.3%	0.5%
E06000021	Stoke-on-Trent	05G	NHS North Staffordshire CCG	3.4%	2.7%
E06000021	Stoke-on-Trent	05V	NHS Stafford and Surrounds CCG	0.5%	0.3%
E06000021	Stoke-on-Trent	05W	NHS Stoke on Trent CCG	91.1%	97.0%
E10000029	Suffolk	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.2%
E10000029	Suffolk	06M	NHS Great Yarmouth and Waveney CCG	52.5%	16.5%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.8%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.3%	0.6%
E10000029	Suffolk	06Y	NHS South Norfolk CCG	1.2%	0.4%
E10000029	Suffolk	07K	NHS West Suffolk CCG	91.0%	29.6%
E08000024	Sunderland	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.7%	0.7%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.8%
E08000024	Sunderland	00J	NHS North Durham CCG	2.3%	2.0%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.4%	0.2%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	96.2%
E10000030	Surrey	10G	NHS Bracknell and Ascot CCG	1.7%	0.2%
E10000030	Surrey	07Q	NHS Bromley CCG	0.4%	0.1%
E10000030	Surrey	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000030	Surrey	09H	NHS Crawley CCG	6.6%	0.7%
E10000030	Surrey	07V	NHS Croydon CCG	1.2%	0.4%
E10000030	Surrey	09L	NHS East Surrey CCG	96.6%	14.1%
E10000030	Surrey	09N	NHS Guildford and Waverley CCG	94.0%	16.9%
E10000030	Surrey	09X	NHS Horsham and Mid Sussex CCG	1.6%	0.3%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.5%	0.1%
E10000030	Surrey	08J	NHS Kingston CCG	4.4%	0.7%
E10000030	Surrey	08R	NHS Merton CCG	0.2%	0.0%
E10000030	Surrey	99M	NHS North East Hampshire and Farnham CCG	23.0%	4.2%
E10000030	Surrey	10J	NHS North Hampshire CCG	0.1%	0.0%
E10000030	Surrey	09Y	NHS North West Surrey CCG	99.5%	29.6%
E10000030	Surrey	08P	NHS Richmond CCG	0.5%	0.0%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	99H	NHS Surrey Downs CCG	97.1%	23.9%
E10000030	Surrey	10C	NHS Surrey Heath CCG	99.0%	7.6%
E10000030	Surrey	08T	NHS Sutton CCG	1.2%	0.2%
E10000030	Surrey	99J	NHS West Kent CCG	0.2%	0.0%
E10000030	Surrey	11C	NHS Windsor, Ascot and Maidenhead CCG	7.7%	1.0%
E09000029	Sutton	07V	NHS Croydon CCG	1.0%	1.9%
E09000029	Sutton	08J	NHS Kingston CCG	3.3%	3.2%
E09000029	Sutton	08K	NHS Lambeth CCG	0.1%	0.2%
E09000029	Sutton	08R	NHS Merton CCG	6.2%	6.5%
E09000029	Sutton	99H	NHS Surrey Downs CCG	1.4%	2.0%
E09000029	Sutton	08T	NHS Sutton CCG	94.5%	86.0%
E09000029	Sutton	08X	NHS Wandsworth CCG	0.1%	0.2%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.0%	0.2%
E06000030	Swindon	12D	NHS Swindon CCG	96.3%	98.4%
E06000030	Swindon	99N	NHS Wiltshire CCG	0.6%	1.4%
E08000008	Tameside	00W	NHS Central Manchester CCG	0.5%	0.5%
E08000008	Tameside	01M	NHS North Manchester CCG	6.4%	5.5%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.8%
E08000008	Tameside	01W	NHS Stockport CCG	1.6%	2.1%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.1%	88.1%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.8%	3.0%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.7%	97.0%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.2%	0.2%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.2%
E06000034	Thurrock	08F	NHS Havering CCG	0.1%	0.2%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.4%	99.3%
E06000027	Torbay	99Q	NHS South Devon and Torbay CCG	48.9%	100.0%
E09000030	Tower Hamlets	07R	NHS Camden CCG	1.1%	0.9%
E09000030	Tower Hamlets	09A	NHS Central London (Westminster) CCG	0.3%	0.2%

E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	0.8%	0.8%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.3%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.9%	97.7%
E08000009	Trafford	00W	NHS Central Manchester CCG	4.7%	4.3%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.1%
E08000009	Trafford	01N	NHS South Manchester CCG	3.2%	2.2%
E08000009	Trafford	02A	NHS Trafford CCG	95.3%	93.2%
E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%
E08000036	Wakefield	02P	NHS Barnsley CCG	0.8%	0.6%
E08000036	Wakefield	03G	NHS Leeds South and East CCG	1.0%	0.8%
E08000036	Wakefield	03C	NHS Leeds West CCG	0.1%	0.2%
E08000036	Wakefield	03J	NHS North Kirklees CCG	0.6%	0.3%
E08000036	Wakefield	03R	NHS Wakefield CCG	94.6%	98.1%
E08000030	Walsall	13P	NHS Birmingham Crosscity CCG	1.8%	4.7%
E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.7%	0.3%
E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.6%	3.1%
E08000030	Walsall	05Y	NHS Walsall CCG	92.4%	90.7%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.3%	1.2%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.3%	0.3%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.1%	1.5%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.4%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.3%	96.8%

E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000032	Wandsworth	08J	NHS Kingston CCG	0.1%	0.0%
E09000032	Wandsworth	08K	NHS Lambeth CCG	2.7%	2.9%
E09000032	Wandsworth	08R	NHS Merton CCG	3.0%	1.8%
E09000032	Wandsworth	08P	NHS Richmond CCG	1.3%	0.7%
E09000032	Wandsworth	08X	NHS Wandsworth CCG	88.8%	93.6%
E09000032	Wandsworth	08Y	NHS West London (K&C & QPP) CCG	0.5%	0.3%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.2%	2.0%
E06000007	Warrington	02E	NHS Warrington CCG	97.8%	97.0%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.2%
E10000031	Warwickshire	13P	NHS Birmingham Crosscity CCG	0.1%	0.2%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.6%	21.4%
E10000031	Warwickshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000031	Warwickshire	04G	NHS Nene CCG	0.2%	0.2%
E10000031	Warwickshire	10Q	NHS Oxfordshire CCG	0.3%	0.3%
E10000031	Warwickshire	05J	NHS Redditch and Bromsgrove CCG	0.8%	0.2%
E10000031	Warwickshire	05P	NHS Solihull CCG	0.6%	0.3%
E10000031	Warwickshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	0.8%	0.3%
E10000031	Warwickshire	05R	NHS South Warwickshire CCG	96.1%	45.6%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.8%	30.9%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E06000037	West Berkshire	10M	NHS Newbury and District CCG	93.1%	66.2%
E06000037	West Berkshire	10N	NHS North & West Reading CCG	35.7%	23.7%
E06000037	West Berkshire	10J	NHS North Hampshire CCG	0.7%	0.9%
E06000037	West Berkshire	10Q	NHS Oxfordshire CCG	0.2%	1.1%
E06000037	West Berkshire	10W	NHS South Reading CCG	9.1%	7.6%
E06000037	West Berkshire	99N	NHS Wiltshire CCG	0.1%	0.4%
E06000037	West Berkshire	11D	NHS Wokingham CCG	0.1%	0.1%
E10000032	West Sussex	09D	NHS Brighton and Hove CCG	1.2%	0.4%
E10000032	West Sussex	09G	NHS Coastal West Sussex CCG	99.5%	57.7%
E10000032	West Sussex	09H	NHS Crawley CCG	93.4%	13.9%
E10000032	West Sussex	09L	NHS East Surrey CCG	0.3%	0.0%
E10000032	West Sussex	09N	NHS Guildford and Waverley CCG	3.1%	0.8%
E10000032	West Sussex	99K	NHS High Weald Lewes Havens CCG	1.0%	0.2%
E10000032	West Sussex	09X	NHS Horsham and Mid Sussex CCG	95.6%	25.8%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.2%	1.0%
E10000032	West Sussex	99H	NHS Surrey Downs CCG	0.5%	0.2%
E09000033	Westminster	07P	NHS Brent CCG	1.3%	2.0%
E09000033	Westminster	07R	NHS Camden CCG	2.9%	3.1%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	81.6%	71.1%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000033	Westminster	08Y	NHS West London (K&C & QPP) CCG	23.5%	23.7%
E08000010	Wigan	00T	NHS Bolton CCG	0.1%	0.1%
E08000010	Wigan	01G	NHS Salford CCG	1.1%	0.8%
E08000010	Wigan	01X	NHS St Helens CCG	3.9%	2.3%
E08000010	Wigan	02E	NHS Warrington CCG	0.4%	0.2%
E08000010	Wigan	02G	NHS West Lancashire CCG	2.7%	0.9%
E08000010	Wigan	02H	NHS Wigan Borough CCG	96.7%	95.6%
E06000054	Wiltshire	11E	NHS Bath and North East Somerset CCG	0.7%	0.3%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.3%	0.5%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.6%
E06000054	Wiltshire	10M	NHS Newbury and District CCG	0.9%	0.2%
E06000054	Wiltshire	11X	NHS Somerset CCG	0.3%	0.4%
E06000054	Wiltshire	12A	NHS South Gloucestershire CCG	0.9%	0.5%
E06000054	Wiltshire	12D	NHS Swindon CCG	1.0%	0.5%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.1%
E06000054	Wiltshire	99N	NHS Wiltshire CCG	96.7%	97.0%
E06000040	Windsor and Maidenhead	10G	NHS Bracknell and Ascot CCG	12.3%	10.9%
E06000040	Windsor and Maidenhead	10H	NHS Chiltern CCG	0.6%	1.2%
E06000040	Windsor and Maidenhead	09Y	NHS North West Surrey CCG	0.2%	0.5%
E06000040	Windsor and Maidenhead	10Q	NHS Oxfordshire CCG	0.0%	0.2%
E06000040	Windsor and Maidenhead	10T	NHS Slough CCG	0.6%	0.5%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.1%	0.0%
E06000040	Windsor and Maidenhead	11C	NHS Windsor, Ascot and Maidenhead CCG	88.9%	85.5%
E06000040	Windsor and Maidenhead	11D	NHS Wokingham CCG	1.2%	1.2%
E08000015	Wirral	02F	NHS West Cheshire CCG	0.4%	0.3%
E08000015	Wirral	12F	NHS Wirral CCG	99.7%	99.7%
E06000041	Wokingham	10G	NHS Bracknell and Ascot CCG	3.2%	2.7%
E06000041	Wokingham	10N	NHS North & West Reading CCG	0.1%	0.0%
E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.5%
E06000041	Wokingham	10W	NHS South Reading CCG	11.1%	9.0%
E06000041	Wokingham	11D	NHS Wokingham CCG	93.5%	87.9%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.4%	1.7%
E08000031	Wolverhampton	05L	NHS Sandwell and West Birmingham CCG	0.1%	0.3%
E08000031	Wolverhampton	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.7%	1.4%
E08000031	Wolverhampton	05Y	NHS Walsall CCG	3.9%	4.0%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	93.7%	92.7%
E10000034	Worcestershire	13P	NHS Birmingham Crosscity CCG	0.5%	0.6%
E10000034	Worcestershire	04X	NHS Birmingham South and Central CCG	2.6%	1.1%
E10000034	Worcestershire	05C	NHS Dudley CCG	0.8%	0.4%
E10000034	Worcestershire	11M	NHS Gloucestershire CCG	0.5%	0.6%
E10000034	Worcestershire	05F	NHS Herefordshire CCG	1.0%	0.3%
E10000034	Worcestershire	05J	NHS Redditch and Bromsgrove CCG	95.9%	27.9%
E10000034	Worcestershire	05N	NHS Shropshire CCG	0.3%	0.1%
E10000034	Worcestershire	05P	NHS Solihull CCG	0.5%	0.2%
E10000034	Worcestershire	05R	NHS South Warwickshire CCG	2.3%	1.1%
E10000034	Worcestershire	05T	NHS South Worcestershire CCG	97.1%	48.8%
E10000034	Worcestershire	06D	NHS Wyre Forest CCG	98.5%	18.8%
E06000014	York	03E	NHS Harrogate and Rural District CCG	0.1%	0.1%
E06000014	York	03Q	NHS Vale of York CCG	60.4%	99.9%

HILLINGDON
LONDON

Health Impact Assessment

STEP A) Description of what is to be assessed and its relevance to health

What is being assessed? Please tick

Review of a service ☐ Staff restructure ☐ Decommissioning a service ☐

Changing a policy ☐ Tendering for a new service ☐ A strategy or plan

The Better Care Fund (BCF) Plan is a mechanism for providing better outcomes for residents and patients through closer integration between health and social care. This assessment updates the one undertaken for the 2015/16 BCF plan.

The focus of Hillingdon's plan in 2016/17, as in 2015/16, is the 65 and over population and there is a specific focus on:

- All of Hillingdon's residents aged 85 and over
- Frail older people aged 75 and over with two or more conditions
- Older people who are at risk of dementia
- Older people who are at risk of falling for a first time.

However, there are aspects of the 2016/17 plan that are extended to a broader population, e.g. scheme 6, which is intended to address the needs of all adults in supported living and scheme 7 which considers the needs of Carers of all ages.

There are eight schemes within the 2016/17 BCF and these are:

- ***Scheme 1*** - Proactive early identification of people with susceptibility to falls, dementia, stroke and/or social isolation
- ***Scheme 2*** - Better care for people at the end of their life
- ***Scheme 3*** - Rapid response and integrated intermediate care
- ***Scheme 4*** - Seven day working initiative
- ***Scheme 5*** - Integrated community-based care and support
- ***Scheme 6*** - Care home and supported living market development
- ***Scheme 7*** - Supporting Carers
- ***Scheme 8*** - Living well with dementia

Annex 1 provides a summary of each of the schemes.

What is the lead organisation for the service to be assessed? EG Hillingdon CCG or London Borough of Hillingdon

The plan is jointly led by HCCG and Hillingdon Council (LBH)

Who is accountable for the service? E.g. Head of Service or Corporate Director

Chief Operating Officer, HCCG Director of Adults and Children and Young people's Services, LBH

Date assessment completed and approved by accountable person

Date assessment completed: 10th March 2016 Date assessment approved:

Names and job titles of people carrying out the assessment

Sally Chandler - CEO, Hillingdon Carers (post meeting input) Gary Collier - Better Care Fund Programme Manager, LBH Claire Eves - Head of Adult Services, CNWL Graham Hawkes - CEO, Hillingdon Healthwatch Jo Manley - Hillingdon ACP Programme Director Peter Okali - CEO, Age UK Hillingdon/H4All Shikha Sharma - Consultant in Public Health Jane Walsh - Older People's Commissioner, HCCG

A.1) What are the main aims and intended benefits of what you are assessing?

The following aims and objectives of the BCF Plan have been agreed with service users and partners: • We will build on our present initiatives around admissions avoidance and supported discharge. • Hillingdon's residents will experience a shared set of responsibilities exhibited by all the organisations working in health and care. • Residents will be able to access the services appropriate to their needs on each day of the week. • Our workforce will be better equipped and better skilled to face this challenge: to residents, they will appear as a single system, with an open culture that celebrates success. • We will work together to proactively identify the health and care needs of older frail residents and will aim to better manage the care needs of younger people who may be susceptible to frailty as they get older. • We will aim to reduce levels of health inequality in Hillingdon. • We will work with care home providers to ensure that local supply is suitable to

meet the needs of Hillingdon's older residents now and in the future.

- We will be better at predicting future health and care needs – both across the population and for individual residents.

The key benefits of the plan are:

a. A reduction in the number of non-elective admissions (NELs) attributed to the 65 and over population by 663 during 2016/17. This is s contribution to the overall CCG target for 2016/17;
b. A reduction in the number of permanent admissions of older people (65 + and over) to care homes, per 100,000 population;
c. Increase in the proportion of older people (65 + and over) who were still at home 91 days after discharge from hospital into reablement services;
d. Reduction in delayed transfers of care (delayed days) from hospital per 100,000 population (18 +).

A.2) Who are the service users or staff affected by what you are assessing?

The service users, residents and patients affected by the BCF Plan are Hillingdon's 65 and over population and their Carers. People affected would also include adults with learning disabilities and adults living with mental health conditions who are living in a supported living environment or who could benefit from this model.

A.3) Who are the stakeholders in this assessment and what is their interest in it?

Stakeholders	Interest
Residents and patients	People directly affected by the Plan
Carers	People directly affected by the Plan
GP Networks	Involved in delivery of the schemes
Hillingdon Hospital Trust	Involved in delivery of the schemes
CNWL	Involved in delivery of the schemes
Third sector (voluntary and community)	Involved in delivery of the schemes

A.4) Which health-related issues are relevant to the assessment? in the box.

Employment or financial well-being		Self-care	
Access to healthcare (primary, secondary, specialised)		Social inclusion	
Environmental exposures (eg noise, air quality, green space)		Mental wellness	

Lifestyle (e.g. diet, physical activity, smoking, alcohol)		Health inequalities	
Infectious disease		Community Safety (eg crime, road safety, defensible space)	
Scope of health care services		Other – please state	

STEP B) Consideration of information; data, research, consultation, engagement

B.1) Consideration of information and data - what have you got and what is it telling you?

Overview

The 65 + population accounted for 40% of all non-elective admissions in 2014/15. The 75 + population account for 70% of the non-elective health spend and it is estimated that 35% of this is avoidable or deferrable.

Population 65 +

Hillingdon's Joint Strategic Needs Assessment (JSNA) shows that there are a total of 34,385 people over the age of 65 in Hillingdon, out of which 14,797 (43%) are men, and 19,588 (57%) are women. Older People's (65+) population is predicted to increase by 7.1% in the next 5 years compared with 5% overall increase in Hillingdon's population. This is approximately the same increase as the neighbouring boroughs of Hounslow and Harrow, but slightly higher than Ealing where there is a projected increase of 5% over the next 5 years. In addition the projected increase for Hillingdon is also in line with the projected increase for the London region.

Population 85 +

The biggest percentage increases in Hillingdon is expected to occur in those aged between 65 - 69 and 85 and over. The projected overall increase in the population of persons aged 85+ is 8% in the next five years compared with 5% in Hillingdon's total population. Currently, the total number of people aged 85+ is 4,716, out of which 1,529 (32.4%) are men and 3,187 (67.6%).

Population 65 + and Ethnicity

A key feature of Hillingdon's demography is that ethnic diversity is concentrated in the younger age groups. For each of the five year age bands for people aged 65 and over there is an increasing proportion of White British. It is expected that the lack of diversity within these older age groups will change over the coming decades as the younger age groups grow older.

Long-term Conditions

Within the next 5 years, there is a projected increase of 9% in the number of people aged 65 and over with a limiting long-term illness. This figure is slightly higher than the projections for Ealing and the London region, but close to the percentage increases projected for Hounslow and Harrow. Overall Hillingdon has the highest projected increase in relation to the London region and the forenamed neighbours.

The latest official data on dementia prevalence data (Joint Commissioning Panel for Mental Health, 2013) suggests that at mid-year 2014 there were 2,574 people in the borough living with dementia. This is projected to grow by 13.5% to 2,975 by 2021. The Projecting Older People's Population Information (POPPI) service developed by the Institute of Public Care (IPC) in partnership with Oxford Brookes University suggests that there are currently 2,670 people living with dementia and predicts an increase of 12% to 3,037 by 2020.

The Royal Society of Psychiatrists' 2009 study *Dementia and People with Learning Disabilities: Guidance on the assessment, diagnosis, treatment and support of people learning disabilities who develop dementia* shows that there is an increased susceptibility amongst this population group to develop dementia once they reach the age of 50. The following figures suggest that the risk is up to four times greater than the general population:

- 1 in 10 of those aged 50 to 64
- 1 in 7 of those aged 65 to 74
- 1 in 4 of those aged 75 to 84
- Nearly three-quarters of those aged 85 or over.

Research undertaken in partnership with the Alzheimers' Society estimates that 1 in 10 people with a learning disability will go on to develop dementia between the ages of 50 and 65 and approximately 50% of those aged 85 and over. For people living with Down's syndrome 1 in 50 are estimated to develop dementia in their 30s and 50% of those aged 60 and over will develop it. The Projecting Adult Needs and Service Information (PANSI) suggests that there are currently 5,393 adults in Hillingdon with a learning disability and that this will increase by 6% to 5,749 in the period up to 2020. There are approximately 117 people who have Down's syndrome in Hillingdon.

POPPI projections suggest that the number of people aged 65 and over with a body mass index of 30 + was 10,094 in 2015 and that this will increase by 8% to 10,943 by 2020. The numbers of older people living with types 1 & 2 diabetes are projected to increase by nearly 10% from 4,805 in 2015 to 5,307 in 2020.

Stroke

In 2013/14 there were 3,246 people who had been diagnosed with a stroke in Hillingdon. In the same period there were 310 admissions recorded on the Sentinel Stroke National Audit Programme. Atrial fibrillation is a known risk factor for stroke. The diagnosed prevalence in Hillingdon is 1.1% and the estimated prevalence is 2.0%. There could be an additional 2,500 people with undiagnosed atrial fibrillation in Hillingdon.

Falls and Fractures

The consequences of falls have a significant impact on both NHS and social care services. Falling can precipitate loss of confidence, the need for regular social care support at home, or even admission to a care home. Fractures of the hip require major surgery and inpatient care in acute and often rehabilitation settings, on-going recuperation and support at home from NHS community health and social care teams. In addition, hip fractures are the event that prompts entry to a care home in up to 10% of cases. Indeed, fractures of any kind frequently require a care package for older people to support them at home.

In the UK, 35% of over-65s experience one or more falls each year. About 45% of people aged over 80 who live in the community fall each year. Between 10% and 25% of such fallers will sustain a serious injury.

757 patients aged 65 years or over were admitted as an emergency admission to The Hillingdon Hospital (THH) as a result of a fall in 2012/13. The total cost was £1,767,175. The average cost per patient for the acute inpatient stay was £2,334. 146 patients aged 65 years or over were admitted to THH with a fractured neck of femur as a result of a fall in 2012/13. The average cost of the acute inpatient stay was £5,762.

Life Expectancy

Life expectancy in Hillingdon is estimated at 79.4 years for males and 83.5 years for females (data from 2008-12). This is similar to the averages for London and England & Wales.

There are inequalities within the Borough at ward level. The gap in male life expectancy between Eastcote and East Ruislip and Botwell is 6.7 years and the gap in female life expectancy between Eastcote & East Ruislip and Botwell is 8.5 years.

Sedantary Lifestyle

Health Survey for England 2008 Volume 1 Physical activity and fitness shows that approximately 50% of Hillingdon's population aged 65 - 74 year olds spend 6 or more hours sedentary time day during the week and over 50% at weekends. For the over 75s it is 62% for both week days and at weekends.

Older People Living Alone

The 2011 census identified that 31% of older people lived alone. POPPI projections suggest that there are currently 14,094 older people living alone and that this will increase by approximately 10% to 15,580 by 2020. This does not necessarily mean that an older person living on their own is socially isolated but it can act as an indicator.

The study *Preventing Suicide in England - a cross-governmental outcomes strategy to save lives* (DH 2012) shows that living alone and becoming socially isolated and experiencing bereavement are contributory factors that can lead to suicide. Available

figures show that the number of suicides amongst the 65 + age group in Hillingdon is small, e.g. 5 in 2010, 4 in 2011 and 3 in 2012, but they predominantly occur amongst men.

Supported Living Schemes

There are currently 15 schemes comprising of 106 self-contained flats for people with learning disabilities and a further scheme comprising of 14 self-contained flats due to open in 2018. There are an additional 60 rooms in 12 shared houses with the objective being to step-down people to the least restrictive environment.

There are also 48 self-contained flats in four supported living schemes for adults of working age with mental health needs and a further scheme comprising of 12 self-contained flats is due to open in 2018.

Two extra care sheltered housing schemes for the 55 and over population comprising of 95 self-contained flats for rent were opened in 2011 and 2012 respectively and two further schemes comprising of a total of 146 self-contained flats are due to open in 2018.

Consultation

B.2) Did you carry out any consultation or engagement as part of this assessment?

Please tick NO YES ☐

If no, explain why:
The timescale for delivering the HIA did not permit wider consultation to be undertaken. However, the development of the 2016/17 BCF Plan is consistent with feedback from consultation previously undertaken for the development of the 2015/16 plan and feedback from stakeholders through a range of fora.

If yes, what did you do or are planning to do? What were the outcomes?

B.3) Provide any other information to consider as part of the assessment

MTFF/QIPP context

The Council is required to find £13.3m of savings in 2016/17.
The HCCG is required to find £8.6m of savings in 2016/17.

National policy context

The Better Care Fund has been introduced as part of national policy as a tool to implement the new general duty under the 2014 Care Act to integrate services between health and social care. The intention behind integration is to achieve efficiencies through better coordination and provide patients and residents with an

improved experience of care and support. In the 2015 Autumn Statement the Government announced its intention that the BCF would be the mechanism to deliver full integration between health and social care by 2020.

A further objective is that there are timely and appropriate interventions by the statutory agencies working with primary care and the third sector to prevent non-elective attendances at A & E that are avoidable as well as avoidable hospital admissions. Integration through the BCF is also intended to be used as a mechanism for preventing escalation in the needs of older people that result in a loss of independence and the need for more expensive forms of intervention by health and social care.

C) Assessment

What did you find in B1? Who is affected? Is there, or likely to be, an impact on certain groups?

C.1) Describe any **NEGATIVE** impacts (actual or potential):

Health-related issues	Impact on this issue and actions you need to take
Employment or financial wellbeing	The 2016 assessment review confirmed that there were no negative impacts on this health-related issue arising from the proposed 2016/17 plan. There could be a potential negative impact on staff as a result of the development of further integration options (structural as well as functional) for early supported discharge and intermediate care services. This will be mitigated through the application of good employment practice procedures. The seven day working scheme (*scheme 4*) could also result in staff coming under pressure, real or perceived, to work extended hours to ensure that services are available. This will again be mitigated through the application of good employment practice procedures.
Access to healthcare	The 2015/16 assessment considered whether the BCF Plan would lead to resources being diverted from other user groups. It was identified that as the funding going into the 2015/16 BCF plan was predominantly existing money that was already being used to support older people, there should not have been any effect on other user groups. There is no evidence from the experience of the 2015/16 plan that there has been any diversion of resources for the reasons stated above. Additional demands on health services could arise from the pro-

	active early identification work proposed to be undertaken as part of *schemes 1 and 5*. The compensation for this is the potential for avoiding or delaying increased costs as a result of a more anticipatory model of care. The assessment team identified a potential concern about clinical treatment decisions being influenced negatively by the early identification of a person as being within the last year of life. This is mitigated by the benefits of early identification for enabling advanced planning to take place and therefore reducing the likelihood of crisis situations occurring that will inevitably be distressing for everyone involved. In addition, the multi-agency advanced planning process should also mitigate against the concerns mentioned above from occurring. *Scheme 6* includes the development of wrap-around services to support the independence of residents in supported living schemes, such as extra care sheltered for older people, could result in initial cost pressures. The scheme also includes a similar approach with care homes. It is expected that any financial outlay will be matched by reductions in A & E attendances and emergency admissions. The outcomes of the scheme both in terms of resource outlay and reductions in avoidable demand on hospital resources will be monitored and reported to the Health and Wellbeing Board. The Plan is aligned with the key integration enablers such as care and support planning being delivered by GP networks, shifting to planning for anticipated needs with GPs as lead professional. This will result in more services being delivered from local GP practices and may create access issues for some people who might otherwise have gone to Hillingdon Hospital. However, the compensation is the probable increased access and convenience that there will be for others as a result of health services being delivered closer to home. For those for whom transport may be an issue this is being addressed through amendments to provider contracts to ensure that patient transport is provided where needed. The GP Networks are at different levels of development which means that they may not all be in a position to be as responsive to needs identified from the proactive work within the BCF Plan as would be desirable. The extent to which this is an issue will need to be kept under review as the different schemes are rolled out and their full implications become apparent. The implementation of a communications plan will help with the delivery of the 2016/17 plan as well as assisting in shaping the 2017/18 – 2019/20 plan, which will be developed early in the new financial year.

Self-care	The assessment team identified that the proposed work under the 2016/17 plan to support people to self-manage their long-term conditions was predicated on the assumption that when people have access to all the relevant information that they will make reasonable decisions. It was acknowledged that people with capacity had the right to make 'bad' decisions and that an objective of the plan was to ensure that people had access to information and support to enable them to make informed decisions.
Social inclusion **Mental wellness** **Lifestyle** **Infectious disease** **Health inequalities**	No negative impacts were identified from the eight schemes within the 2016/17 plan on these health-related issues by the assessing team.
Scope of healthcare services	The proactive approach to identification of need required under *schemes 1 and 5* and the expanded remit of *scheme 7* which includes all carers and not just adult carers of other adults, which is covers legal duties under the 2014 Children and Families Act and the 2014 Care Act, may lead to the identification of health needs for which the appropriate services may not currently be in place and which may therefore have additional resource implications. There is no evidence that this occurred in 2015/16 but it is a potential issue as the work under the schemes becomes more embedded and the effects of demographic pressures are felt. This would potentially be compensated for by the cost avoidance arising from the reduction in need resulting from the earlier intervention. The individual benefits of the schemes versus additional resource requirements will be kept under review as part of the BCF monitoring process.

C.2) Describe any **POSITIVE** impacts

The assessing team felt that the comments raised as part of the 2015/16 plan assessment were still valid. Additions have been made to those comments where the team felt that this was appropriate in view of the content of the 2016/17 proposed plan.

Health-related issues	**Impact on this issue and actions you need to take**
Employment or	*Scheme 7*: The broadening of the definition of who is considered

financial well-being.	to be a carer and the extension of support to carers in their own right creates opportunities for those in work to be able to retain their employment for longer. This has positive implications for their mental and financial well-being and also for duration of the period for which they are willing and able to undertake a caring role. *Scheme 1:* Should lead to early identification of carers who may be in employment and provision of timely support following a Carer's assessment may enable them to continue in employment for longer with the benefits as described above. *Schemes 1 and 8*: Early identification of people living with dementia may help to ensure early access to appropriate treatments that may enable them to retain employment longer. This becomes more of an issue for older people with changes to the retirement age as well as the abolition of the mandatory retirement age.
Access to healthcare	*Scheme 1*: Early identification of people at risk of falls, dementia and/or social isolation will ensure timely access to appropriate healthcare as well as other care and support services. This will allow for more effective care planning where required and prevent deterioration in need that can lead to a loss of independence and more expensive healthcare interventions. Expanding the scope of the scheme to cover people with susceptibilities to stroke potentially could help prevent one of the main causes of disability amongst older people. *Scheme 2:* This will support people to die in their preferred place of care, which is generally at home. As well as being a more comforting environment for the person in the last days of their life (as well as their family). The scheme will lead to a more effective coordination of the required services. The scheme will lead to a more effective coordination of the required services. *Scheme 5:* Integrated Community-based Care and Support should result in the health needs of residents being addressed at a more local level. Taken in conjunction with the other schemes within the BCF Plan and other integrated care system enablers such as improved care planning, care navigation and multi-disciplinary team working, the result should be a more efficient use of resources.
Self-care	*Schemes 1, 2, 3* and 5 promote self-care as a means of putting individuals more in control of managing their own health and care needs, thus preventing or delaying a

	deterioration in their needs and the loss of independence that can arise from this. The H4All Health and Wellbeing Service should have a significant impact in empowering people to take more control and navigate the health and care system in a better way. *Scheme 6* also promotes the supported living model to enable people to live more independently in the community with care and support based on a reablement model.
Social inclusion	*Scheme 1* seeks to identify people at risk of social isolation and present them with options to engage with their local communities. This could include opportunities to volunteer with third sector organisations. The expended remit of *scheme 7* to include all Carers increases the scope for ensuring that Carers of all ages can have a life of their own, which will extend the time that they are willing and able to continue in their caring role.
Mental wellness	*Scheme 1*: Early identification of those living with dementia can help to ensure timely access to treatment that may arrest the progress of the condition. Access to advice about changes in lifestyle habits that may contribute to and otherwise accelerate progress could also have the same effect. Engaging with people who are socially isolated can help prevent adverse health impacts, such as depression, that can also lead to other physical health problems. *Scheme 2*: Better management of the end of life pathway should relieve some of the stress experienced both by the person at the end of their life and also their family. The study *Preventing Suicide in England - a cross-governmental outcomes strategy to save lives* (DH 2012) shows that living alone and becoming socially isolated and also bereavement are contributory factors in leading to suicides. Living with a long-term condition is also a contributory risk factor. Available figures show that the number of suicides amongst the 65 + age group is small, e.g. 5 in 2010, 4 in 2011 and 3 in 2012, and these predominantly occur amongst men. *Schemes 1, 2* and *8* in particular would seek to address some of the issues that can lead to suicide. The creation of a specific scheme focusing on the needs of people living with dementia (scheme 8) will help to promote the parity of esteem between physical and mental

	health whilst addressing the specific needs of patients living with this condition and supporting their Carers.
Lifestyle	*Schemes 1, 3 and 5* will identify particular lifestyle issues, e.g. diet, smoking, alcohol abuse, through visits to patients' homes. The result will be referrals to appropriate professionals and/or third sector organisations to provide advice and support.
Infectious disease	Key objectives of the BCF Plan are to prevent non-elective admissions and to reduce Length of Stay (LOS) in the event of an admission. Achieving this will help to prevent the risk of hospital acquired infections. *Scheme 6*: Training and support provided to care homes should help to improve standards and reduce the number of care home acquired infections acquired by residents that can lead to hospital admission and a rapid deterioration in mental wellbeing as well as physical health.
Health inequalities	The BCF Plan seeks to address health inequalities faced by Hillingdon's more vulnerable older population. However, given the disparity in social and economic wellbeing between older people in the north of the borough and those in the relatively more deprived, more culturally diverse wards in the south, particular consideration will have to be given as to how communities will be accessed. It is envisaged that this will be accomplished by close working with faith and other community-based groups. The provision of Personal Health budgets for people meeting Continuing Health Care (CHC) thresholds and Personal Budgets for people meeting the National Adult Social Care eligibility criteria provides opportunities for a more personalised approach to addressing need that would reflect cultural and religious diversity. Promotion of Personal Health Budgets is addressed within *scheme 5* of the plan. Proposals within *scheme 6* of the plan to provide wrap-around support for supported living schemes will also help to address health inequalities experienced by people with learning disabilities and people living with mental health conditions as well as maximising their independence within the least restrictive care setting.

D) Conclusions

The assessment has shown that the health implications of the 2016/17 BCF Plan are overwhelmingly positive for the residents of Hillingdon, which should consequently result in financial benefits for the local health and social care economy.

There were concerns that not all of the GP Networks to be able to respond to the needs identified from the implementation of the Plan, e.g. supporting care homes and supported living schemes. This is something that will have to be kept under review as the schemes within the plan are rolled out. Inclusion of GP and consultant geriatrician representatives on the project group for the development of the care and support specification for the extra care sheltered housing schemes in the borough should help to mitigate this and an on-going dialogue in respect of medical support for care homes.

The assessment also identified that there may be access issues for some residents, as more health services are delivered locally from GP practices. The conclusion was that more people were likely to benefit from local provision and that individual solutions would need to be identified to address the needs of those who are disadvantaged. Transport-related access issues were also being addressed through provider service specifications.

Key areas that need further consideration are:

- The suitability of existing services to meet the needs of people identified from the more proactive case finding approach set out in *scheme 1*.
- A number of the schemes require proposals to be developed during 2016/17 for potential delivery in 2017/18, e.g. intermediate care integration options under scheme 3, and specific assessments will be required in these circumstances.

The impact of all of the schemes will be monitored as part of the governance process for the BCF Plan.

Signed and dated:…….

Name and position:…….

Scheme Number	Scheme Title	Scheme Aim(s)
1.	Proactive early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.	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.	Better care for people at the end of their life	To realign and better integrate the services provided to people towards the end of their life. To develop the ethos of 'a good death' for people and for their families and carers within the provision of adult services.
3.	Rapid Response and integrated intermediate care	Prevention of admission to acute care following an event or 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.
4.	Seven day working	To improve quality and patient safety through reducing inconsistent care provision by: • Enabling discharge from the acute trust seven days a week for people admitted for either planned or unplanned procedures; • Enabling access to community services seven days a week thereby preventing unnecessary emergency department attendances and admission and reducing length of stay

		for people admitted to hospital for either planned or unplanned procedures; • **Reducing the uneven rate of hospital discharge across the week.**
5.	**Integrated Community-based Care and Support**	**To ensure that community based resources work as effectively and as efficiently as possible with primary care for the benefit of patients.**
6.	**Care Home and Supported Living Market Development**	**Through market reshaping secure:** • **A vibrant, quality care home market that meets current and future local need; and** • **An appropriate mix of supported living provision that provides people with a realistic alternative to care home admission.**
7.	**Supporting Carers**	The aims of this scheme are that Carers are able to say: • "I am physically and mentally well and treated with dignity" • "I am not forced into financial hardship by my caring role" • "I enjoy a life outside of caring" • "I am recognised, supported and listened to as an experienced carer"
8.	**Living well with dementia**	The aim of this scheme is that people with dementia and their family carers are enabled to live well with dementia.

HILLINGDON
LONDON

NHS
Hillingdon
Clinical Commissioning Group

Equality Impact Analysis: Better Care Fund Plan 2016/17

Equality Impact Analysis is the method used by the Hillingdon Clinical Commissioning Group (HCCG) and Hillingdon Council (LBH) to demonstrate that it is giving due regard to equality when developing and implementing changes to services, strategy, policy and/or practice.

The purpose of this equality analysis is to:

1. Identify unintended consequences and mitigate them as far as is possible,
2. To actively consider how the CCG and LBH can support the advancement of equality and fostering of good relations
3. Reduce health inequalities across the Borough of Hillingdon

Section 1: General information

Background:

The Better Care Fund (BCF) Plan is a mechanism for providing better outcomes for residents and patients through closer integration between health and social care. This assessment updates the one undertaken for the 2015/16 BCF plan.

The focus of Hillingdon's plan in 2016/17, as in 2015/16, is the 65 and over population and there is a specific focus on:

- All of Hillingdon's residents aged 85 and over
- Frail older people aged 75 and over with two or more conditions
- Older people who are at risk of dementia
- Older people who are at risk of falling for a first time.

However, there are aspects of the 2016/17 plan that are extended to a broader population, e.g. scheme 6, which is intended to address the needs of all adults in supported living and scheme 7 which considers the needs of Carers of all ages.

There are eight schemes within the 2016/17 BCF and these are:

- ***Scheme 1*** - Proactive early identification of people with susceptibility to falls, dementia, stroke and/or social isolation
- ***Scheme 2*** - Better care for people at the end of their life
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- ***Scheme 5*** - Integrated community-based care and support

- ***Scheme 6*** - Care home and supported living market development
- ***Scheme 7*** - Supporting Carers
- ***Scheme 8*** - Living well with dementia

Annex 1 provides a summary of each of the schemes.

Responsible officer completing this assessment:

Gary Collier - Better Care Fund Programme Manager

Date completed:

10th March 2016

Relevant documents:

Name of document	Year	Owner(s)	Public document
Better Care Fund Plan Narrative	2016	CCG/LBH	Yes
Better Care Fund Annex 1	2014	CCG/LBH	Yes
Better Care Fund Planning Template	2014	CCG/LBH	Yes

Responsible Clinical Lead

Dr Kuldhir Johal HCCG Governing Body and Older People's Model of Care Delivery Group co-chair

Supporting team

Kevin Byrne - Head of Policy and Partnerships, LBH
John Higgins – Head of Safeguarding, Quality and Partnerships, LBH
Joan Veysey - Deputy Chief Operating Officer, HCCG
Jane Walsh - Commissioner Older People's Services, HCCG

Section 2: Data gathering

What are the aims of the policy?

The following aims and objectives of the BCF Plan have been agreed with service users and partners:

1. We will build on our present initiatives around admissions avoidance and supported discharge.
2. Hillingdon's residents will experience a shared set of responsibilities exhibited by all the organisations working in health and care.
3. Residents will be able to access the services appropriate to their needs on each day of the week.
4. Our workforce will be better equipped and better skilled to face this challenge: to residents, they will appear as a single system, with an open culture that celebrates success.

5. We will work together to proactively identify the health and care needs of older frail residents and will aim to better manage the care needs of younger people who may be susceptible to frailty as they get older.

6. We will aim to reduce levels of health inequality in Hillingdon.

7. We will be better at predicting future health and care needs – both across the population and for individual residents.

What health and social care outcomes do HCCG and the Council hope to achieve?

a. A reduction in the number of non-elective admissions (NELs) attributed to the 65 and over population by 663 during 2016/17. This is a contribution to the overall CCG target for 2016/17;
b. A reduction in the number of permanent admissions of older people (65 + and over) to care homes, per 100,000 population;
c. Increase in the proportion of older people (65 + and over) who were still at home 91 days after discharge from hospital into reablement services;
d. Reduction in delayed transfers of care (delayed days) from hospital per 100,000 population (18 +).

Are there any factors that might prevent these outcomes being achieved?

The following are factors that could impact on these outcomes being achieved:
a. Continuing increase in the level of NEL activity;
b. Impact of severe weather;
c. Lack of suitably qualified staff;
d. Private care provider business failure.
e. Lack of available providers who can support people with complex needs.

What relevant quantitative and qualitative data do you have?

Overview

40% of our non-elective activity in 2014/15 and 39% during Quarters 1 to 3 2015/16 was attributed to the 65 and over population, this group accounted for 56% of the total health emergency admission spend (54% Q1 to 3 2015/16). In 2014/15 the 42% (39% Q1 to 3 2015/16) of emergency admission spend was on the 75 and over population, which accounted for 29% of admissions in 2014/15 (27% Q1 to 3 2015/16). We estimate that some 35% of emergency admission for the 75 and over population group are avoidable or deferrable, which is based on the proportion of admissions resulting in a length of stay of between 0 and 2 days.

Population 65 +

Hillingdon's Joint Strategic Needs Assessment (JSNA) shows that in 2016 there are approximately 39,400 people aged 65 and over in Hillingdon, out of which 17,730 (45%) are men, and 21,670 (55%) are women. Older People's (65+) population is predicted to increase by 7.3% in the next 4 years to 2020, which compares with a 5% overall increase in Hillingdon's population. This is approximately the same increase as the neighbouring boroughs of Hounslow and Harrow, but slightly higher than Ealing where there is a projected increase of 5% over the next 5 years. In addition the projected increase for Hillingdon is also in line with the projected increase for the London region.

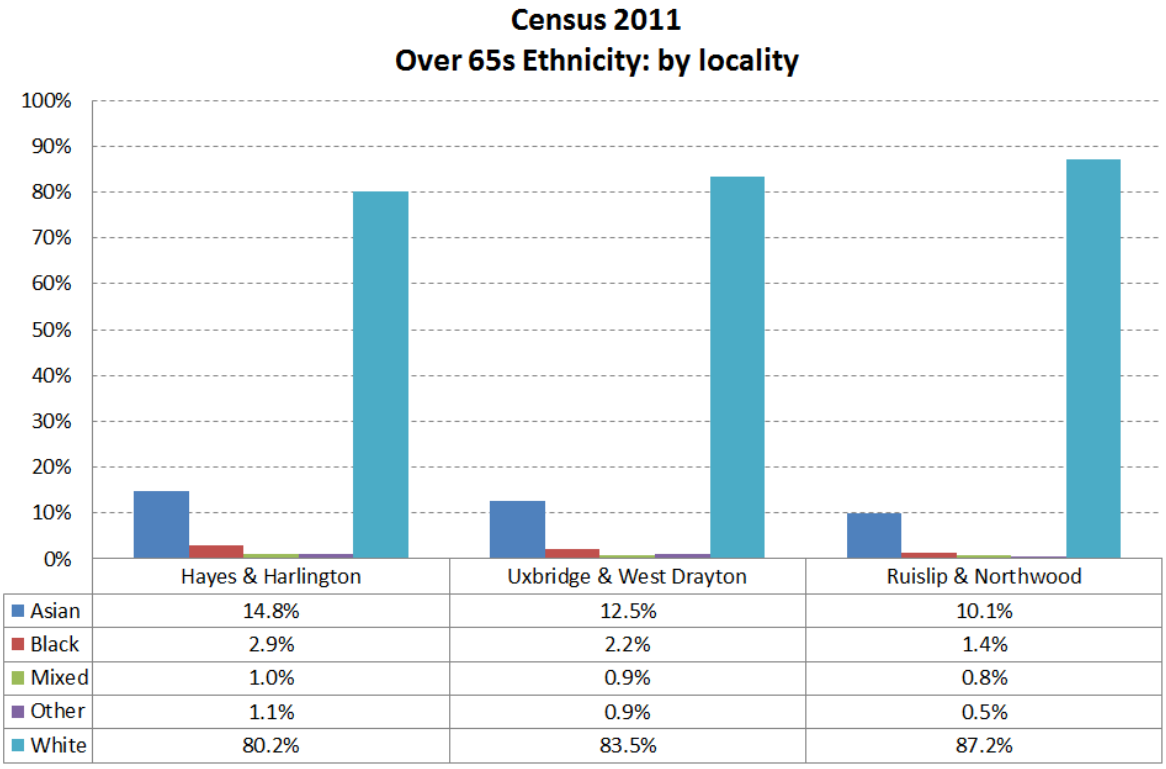
Population 85 +

The biggest percentage increases in Hillingdon is expected to occur in those aged between 65 - 69 and 85 and over. The projected overall increase in the population of people aged 85 and over is 17% between 2016 and 2021 from 5,443 to 6,561. 37.6% (2,049) of the 85 and over population are males and 62.3% (3,933) are females.

Population 65 + and Ethnicity

A key feature of Hillingdon's demography is that ethnic diversity is concentrated in the younger age groups. For each of the five year age bands for people aged 65 and over there is an increasing proportion of White British. It is expected that the lack of diversity within these older age groups will change over the coming decades as the younger age groups grow older.

The graph below shows the distribution by ethnicity of Hillingdon's older people population.



	Hayes & Harlington	Uxbridge & West Drayton	Ruislip & Northwood
Asian	14.8%	12.5%	10.1%
Black	2.9%	2.2%	1.4%
Mixed	1.0%	0.9%	0.8%
Other	1.1%	0.9%	0.5%
White	80.2%	83.5%	87.2%

Long-term Conditions

Within the next 5 years, there is a projected increase of 9% in the number of people aged 65 and over with a limiting long-term illness. This figure is slightly higher than the projections for Ealing and the London region, but close to the percentage increases projected for Hounslow and Harrow. Overall Hillingdon has the highest projected increase in relation to the London region and the forenamed neighbours.

The latest official data on dementia prevalence data (Joint Commissioning Panel for Mental Health, 2013) suggests that at mid-year 2014 there were 2,574 people in the borough living with dementia. This is projected to grow by 13.5% to 2,975 by 2021. The Projecting Older People's Population Information (POPPI) service developed by the Institute of Public Care (IPC) in partnership with Oxford Brookes University suggests that there are currently 2,670 people living with dementia and predicts an increase of 12% to 3,037 by 2020.

The Royal Society of Psychiatrists' 2009 study *Dementia and People with Learning Disabilities: Guidance on the assessment, diagnosis, treatment and support of people learning disabilities who develop dementia* shows that there is an increased susceptibility amongst this population group to develop dementia once they reach the age of 50. The following figures suggest that the risk is up to four times greater than the general population:

- 1 in 10 of those aged 50 to 64
- 1 in 7 of those aged 65 to 74
- 1 in 4 of those aged 75 to 84
- Nearly three-quarters of those aged 85 or over.

Research undertaken in partnership with the Alzheimers' Society estimates that 1 in 10 people with a learning disability will go on to develop dementia between the ages of 50 and 65 and approximately 50% of those aged 85 and over. For people living with Down's syndrome 1 in 50 are estimated to develop dementia in their 30s and 50% of those aged 60 and over will develop it. The Projecting Adult Needs and Service Information (PANSI) suggests that there are currently 5,393 adults in Hillingdon with a learning disability and that this will increase by 6% to 5,749 in the period up to 2020. There are approximately 117 people who have Down's syndrome in Hillingdon.

POPPI projections suggest that the number of people aged 65 and over with a body mass index of 30 + was 10,094 in 2015 and that this will increase by 8% to 10,943 by 2020. The numbers of older people living with types 1 & 2 diabetes are projected to increase by nearly 10% from 4,805 in 2015 to 5,307 in 2020.

Stroke

In 2013/14 there were 3,246 people who had been diagnosed with a stroke in Hillingdon. In the same period there were 310 admissions recorded on the Sentinel Stroke National Audit Programme. Atrial fibrillation is a known risk factor for stroke. The diagnosed prevalence in Hillingdon is 1.1% and the estimated prevalence is 2.0%. There could be an additional 2,500 people with undiagnosed atrial fibrillation in Hillingdon.

Falls and Fractures

The consequences of falls have a significant impact on both NHS and social care services. Falling can precipitate loss of confidence, the need for regular social care support at home, or even admission to a care home. Fractures of the hip require major surgery and inpatient care in acute and often rehabilitation settings, on-going recuperation and support at home from NHS community health and social care teams. In addition, hip fractures are the event that prompts entry to a care home in up to 10% of cases. Indeed, fractures of any kind frequently require a care package for older people to support them at home.

In the UK, 35% of over-65s experience one or more falls each year. About 45% of people aged over 80 who live in the community fall each year. Between 10% and 25% of such fallers will sustain a serious injury.

757 patients aged 65 years or over were admitted as an emergency admission to The Hillingdon Hospital (THH) as a result of a fall in 2012/13. The total cost was £1,767,175. The average cost per patient for the acute inpatient stay was £2,334. 146 patients aged 65 years or over were admitted to THH with a fractured neck of femur as a result of a fall in 2012/13. The average cost of the acute inpatient stay was £5,762.

Life Expectancy

Life expectancy in Hillingdon is estimated at 79.4 years for males and 83.5 years for females (data from 2008-12). This is similar to the averages for London and England & Wales.

There are inequalities within the Borough at ward level. The gap in male life expectancy between Eastcote and East Ruislip and Botwell is 6.7 years and the gap in female life expectancy between Eastcote & East Ruislip and Botwell is 8.5 years.

Sedantary Lifestyle

Health Survey for England 2008 Volume 1 Physical activity and fitness shows that approximately 50% of Hillingdon's population aged 65 - 74 year olds spend 6 or more hours sedentary time day during the week and over 50% at weekends. For the over 75s it is 62% for both week days and at weekends.

Older People Living Alone

The 2011 census identified that 31% of older people lived alone. POPPI projections suggest that there are currently 14,094 older people living alone and that this will increase by approximately 10% to 15,580 by 2020. This does not necessarily mean that an older person living on their own is socially isolated but it can act as an indicator.

The study *Preventing Suicide in England - a cross-governmental outcomes strategy to save lives* (DH 2012) shows that living alone and becoming socially isolated and experiencing bereavement are contributory factors that can lead to suicide. Available figures show that the number of suicides amongst the 65 + age group in Hillingdon is small, e.g. 5 in 2010, 4 in 2011 and 3 in 2012, but they predominantly occur amongst men.

Carers

Carers are people who provide care and support to vulnerable relatives or friends for no financial payment and should not be confused with care workers, who are paid for the work they do.

The 2011 census shows that there were at least 25,702 Carers in Hillingdon; in fact, this figure was and is probably much higher when taking into consideration the fact that some people who are providing care to their partner or other relatives do not identify themselves as Carers. These 'hidden Carers' may not be accessing the support and advice that is available to them.

The table below provides a breakdown of the age of Carers as identified by the 2011 census.

Age Breakdown of Carers in Hillingdon	
Carer Age Group	**Number**
0 - 24	2,450
25 - 64	18,609
65 +	4,643
TOTAL	**25,702**

The census showed that 11,158 Carers were male and of these 2,264 were aged 65 and over. This compares to 14,544 Carers who were female, 2,379 of which were aged 65 and over.

The census also showed that 36% of the Carers aged 65 and above were providing 50 hours a week or more unpaid care and of those 17% identified themselves as having bad or very bad health.

According to estimates within the Institute of Public Care's 2009 Estimating the prevalence of severe learning disability in adults - working paper 1, there should currently be approximately 400 people living with parents and this should rise to approximately 440 in 2020. Of the 220 people with learning disabilities currently being supported by the Council who live with parents or other relatives who are identified as their main Carers. 77 of these Carers are aged 65 and over and of these 11 are aged 75 and over. This illustrates both the importance of supporting older Carers and the need to plan for a time when they will be unable to continue their caring role because of the effects of old age.

What Older People Want

The 2006 Wanless review, *Securing Good Care for Older People*, showed that only 11% of older people wished to have their care needs met in a care home should these arise, with the preferred options either being to remain in their own home cared for by relatives or friends (62%) or trained care workers (56%). An analysis of Strategic Housing Market Assessment (SHMA) surveys of over 13,500 households aged 50 and over suggests that up to 20% of all older households would consider moving to retirement housing and the application of the Retirement Housing Group (RHG) model suggests that up to 20% of people aged 75 and over would do so if it was available. The key messages from national studies are reinforced by messages received from our local older people population through fora such as the Older People's Assembly.

Supported Living Schemes

There are currently 15 schemes comprising of 106 self-contained flats for people with learning disabilities and a further scheme comprising of 14 self-contained flats due to open in 2018. There are an additional 60 rooms in 12 shared houses with the objective being to step-down people to the least restrictive environment.

There are also 48 self-contained flats in four supported living schemes for adults of working age with mental health needs and a further scheme comprising of 12 self-contained flats is due to open in 2018.

Two extra care sheltered housing schemes for the 55 and over population comprising of 95 self-contained flats for rent were opened in 2011 and 2012 respectively and two further schemes comprising of a total of 146 self-contained flats are due to open in 2018.

Did you carry out any consultation or engagement as part of this assessment or previously?

Yes

Who was consulted or engaged?

The following were involved in the assessment process:

- Sally Chandler - CEO, Hillingdon Carers (post meeting input)
- Claire Eves - Head of Adult Services, CNWL
- Graham Hawkes - CEO, Hillingdon Healthwatch
- Jo Manley - Hillingdon ACP Programme Director

- Peter Okali - CEO, Age UK Hillingdon/H4All
- Shikha Sharma - Conslutant in Public Health
- Vicky Trott - Senior Policy Officer (Equalities & Diversity), LBH
- Jane Walsh - Older People's Commissioner, HCCG

The timescale for delivering the EIA did not permit wider consultation to be undertaken. However, the development of the 2016/17 BCF Plan is consistent with feedback from consultation previously undertaken for the development of the 2015/16 plan and feedback from stakeholders through a range of fora. The 2016/17 plan proposals have been raised with the multi-agency Older People's Model of Care Delivery Group, the Disabled Tenants' and Residents' Association and the Older People's Assembly.

From the consultation what feedback did you receive?

Feedback reflected in response to analysis of impact on protected characteristics.

What changes have been made as a result of the feedback you have received?

Feedback reflected in response to analysis of impact on protected characteristics.

Section 3: Impact

Consider the information gathered in section 2 of this assessment form and assess:

1. Where you think that the strategy could have a **NEGATIVE** impact on any of the equality groups, i.e. it could disadvantage them

2. Where you think that the strategy could have a **POSITIVE** impact on any of the equality groups like promoting equality and equal opportunities or improving relations within equality groups

3. Where you think that this strategy has a **NEUTRAL** effect on any of the equality groups listed below i.e. it has no effect currently on equality groups.

The assessing team felt that the comments raised as part of the 2015/16 plan assessment were still valid. Additions have been made to those comments where the team felt that this was appropriate in view of the content of the 2016/17 proposed plan.

Do you think that the policy impacts on people because of their **age?**

1. Age	Positive	Negative	Neutral	Reasons for your decision
Young (Children and young people, working age)			√	The focus of the BCF Plan is older people. The needs of Carers aged under 60 are considered under equalities characteristic 8: Carers.
Older (Working age, 60+, and	√			The key objective of the BCF Plan is to keep older people out of hospital or ensure a reduction in length of stay where an admission is unavoidable. The Plan seeks to promote independence and

retirement age)				maximise the quality of life for Hillingdon's older people population. However, the intention behind scheme 2 is embed the principle of a good death where older people are at the end of life.

Do you think that the policy impacts on **carers**? (e.g. adults providing care for other adults free of charge)

2. Carers	Positive	Negative	Neutral	Reasons for your decision
	√			The BCF Plan recognises the importance of supporting Carers and the majority of the resources committed under *scheme 7* are dedicated to that purpose, the remit of which has been expanded in the 2016/17 plan to include Carers of all ages. The following summarises other key benefits for Carers deriving from the schemes: *Scheme 1*: Early identification and case management support empower Carers to make informed choices, thus preventing decisions being made in crisis situations; *Scheme 2*: better end of life management helps to reduce stress for the Carer and provides continuing support on the passing of the person at end of life, therefore helping to address their mental wellbeing; Scheme 3: short term post discharge support from professionals and/or third sector will provide assurance for Carers and help to build their confidence about being able to manage the needs of the person they are caring for; Scheme 4: by ensuring steady flow of activity should reduce readmissions and the stress that this can cause to Carers; *Scheme 5*: Carers should experience a more seamless service as a result of the more widespread use of care planning and effective, joined up use of services to address needs; *Scheme 6*: Application of *Dignity Challenge* principles will see Carers treated as true partners in care provision; Scheme 8: Carers should benefit from the delivery of the proposed actions with this scheme.

Do you think that the policy impacts on people with a **disability?**

3. Disability	Positive	Negative	Neutral	Reasons for your decision
Visually impaired	√			All schemes should have a positive impact on people with sensory impairments and physical disabilities through the identification of people

Hearing impaired	√			susceptible to falls, dementia and/or stroke and assisting in preventing these occurring (*scheme 1*); provision of rehabilitation and reablement for those experiencing an acute episode (*scheme 3*); reducing length of stay and therefore avoiding hospital acquired infections (*scheme 4*); supporting people locally with an integrated response to their health and wellbeing needs (*scheme 5*); preventing admission to hospital from care homes where residents experience an exacerbation (*scheme 6*) by providing professional clinical support to care home staff; promoting greater independence in the least restrictive care setting through the development of supported living models with appropriate wrap-around care and support provision (including medical) (scheme 6); and addressing safeguarding issues and effectively managing the provider market (*scheme 6*).
Physically disabled	√			
Learning disability	√			*Schemes 1, 3, 4* and *5* could lead to the identification of older people with learning disabilities not known to services, i.e. people with learning disabilities from Black, Asian and minority ethnic communities, where there can be stigma attached to having this type of disability. *Scheme 6* will have a positive effect by ensuring the sustainability of the supported living model. A key benefit to this user group will come under *scheme 7* through identification and the provision of support to older Carers. The susceptibility of people with learning disabilities to develop dementias at a much younger age than the general population will be addressed through *scheme 8*.
Mental health	√			*Scheme 1*: Early identification of living with dementia can help to ensure timely access to treatment that may arrest the progress of the condition. Access to advice about changes in lifestyle habits that may contribute to and accelerate progress could also have the same effect. Engaging with people who are socially isolated can help prevent adverse health impacts, such as depression, that can also lead to other physical health problems. *Scheme 2*: Better management of the end of life pathway should relieve some of the stress

				experienced both by the person at the end of their life and also their family. The study *Preventing Suicide in England - a cross-governmental outcomes strategy to save lives* (DH 2012) shows that living alone and becoming socially isolated and also bereavement are contributory factors in leading to suicides. Available figures show that the number of suicides amongst the 65 + age group is small, e.g. 5 in 2010, 4 in 2011 and 3 in 2012, and these predominantly occur amongst men. *Schemes 1 and 2* in particular would seek to address some of the issues that can lead to suicide. The support to Carers deriving from *scheme 7* should help to address stress and anxiety that they face as a result of their caring role. The specific dementia scheme is intended to address the needs of people will organic mental health conditions to maximise their independence for as long as possible.
Other (HIV positive, multiple sclerosis, cancer, diabetes, epilepsy)	√			Risk stratification that is reflected in *scheme 5* will identify people with long-term conditions and ensure that they are linked into the appropriate GP network, which should ensure access to appropriate treatment and information and advice about self-care. This means that the Plan as a whole should have a beneficial impact

Do you think that the policy affects **men and women** in different ways?

4. Gender	Positive	Negative	Neutral	Reasons for your decision
Male	√			As men tend to be more reticent about discussing health needs or problems, *scheme 1* has the potential to be of particular benefit to them.
Female	√			More women than men are likely to benefit from the BCF Plan but this is largely due to the fact that they live longer rather than there being anything intrinsically discriminatory about the nature of the schemes.

Do you think that the policy impacts on people because of their **Gender identity (e.g. People in pre or post operation stage and/or where a person/s identify themselves as one gender but require**

access to their biological gender?

5. Gender Identity	Positive	Negative	Neutral	Reasons for your decision
Pre operation	√ Scheme 1		√ Other Schemes	*Scheme 1* may have a positive impact by identifying older people whose social isolation may relate to their gender identity but other schemes are considered to be neutral at this stage.

Do you think that the policy impacts on people because of **pregnancy or maternity?**

6. Pregnancy or maternity	Positive	Negative	Neutral	Reasons for your decision
			√	None of the schemes were considered to have a positive or negative impact on this characteristic, especially as the focus of the plan is the 65 and over population.

Do you think that the policy impacts on people on the grounds of their **race/ethnicity**?

7. Race	Positive	Negative	Neutral	Reasons for your decision
Promoting equality of opportunity	√			The principle behind *scheme 1* of making every visit count will enable risks relating to the needs of the seldom seen, seldom heard groups to be identified and addressed that may not be the case now. The implementation of the Health and Wellbeing Service in particular will establish links with community groups and facilitate more effective sign-posting to appropriate cultural and faith groups. *Scheme 2*: Identification of preferred place of care (PPC) at end of life and aligning workforce to provide seamless care will prevent distress occurring during handover periods and eliminate any de facto discrimination that may currently be occurring. Identification of PPC also recognises that for some cultures this may actually be hospital. Early identification of people within the last year of life will enable more personalised advanced planning arrangements to either avoid crises or to be able to respond to them in a way that is more sensitive to the needs and wishes of the person at end of life and their families. *Scheme 3*: Neutral as there are no identifiable features of this scheme that would have a
Eliminating unlawful discrimination	√			

				positive or negative effect on the population based on their race or ethnic origin. *Scheme 4*: Neutral as there are no identifiable features of this scheme that would have a positive or negative effect on the population based on their race or ethnic origin. *Scheme 5*: Improved linkages between primary care and community services are likely to have a positive benefit for people from seldom seen, seldom heard groups. The use of assistive technology benefits all communities by providing reassurance to service users and patients and their families that there will be a response in a crisis regardless of ethnicity and language. Risk stratification will proactively identify some groups who do not ordinarily access health services whose needs have escalated to the point where they are at risk of a significant loss of independence and high demand on health and care services, e.g. men and particularly men from East African communities. This is a potential positive impact. For people who meet the national eligibility criteria for adult social care or the Continuing Health Care criteria personal budgets in the form of Direct Payments or Personal Health Budgets (PHB) respectively, will enable residents to secure more personalised care services. *Scheme 6*: More proactive support for care homes is likely to eliminate discrimination faced by residents based on their race as a result of difficulties in expressing wishes or expressing concerns. *Scheme 7*: Identification of hidden Carers could particularly benefit people from BAME communities who do not identify themselves as Carers. This could potentially benefit those communities who may not traditionally access health and care services for whatever reason. *Scheme 8*: Having a dementia specific scheme is a positive as, in conjunction with schemes 5 and 6, it provides the opportunity to address stigma attached to dementia within some

				ethnic groups as well as addressing the needs that may arise for people living with dementia who may revert to their mother tongue. This is much more likely to be an issue in the south of the borough, which is much more diverse than the north.
Promoting good race relations			√	There may be positive benefits for the promotion of good race relations emanating from positive impacts on *Promoting equality of opportunity* and *Eliminating unlawful discrimination* but there is no evidence to suggest that the schemes will otherwise have a neutral impact at this stage.

Do you think that the policy impacts on people because of their **religion or faith?**

8. Religion or Faith	Positive	Negative	Neutral	Reasons for your decision
	√ Scheme 1		√ Other Schemes	Scheme 1 could have a positive effect for people because of their religion for the reasons set out above. Scheme 4 provides opportunities to work more flexibly to reflect religious beliefs but other schemes are likely to be neutral.

Do you think that the policy impacts on people because of their **sexual orientation?**

9. Sexual Orientation	Positive	Negative	Neutral	Reasons for your decision
Lesbian	√ Scheme 1		√ Other Schemes	*Scheme 1* may have a positive impact by identifying older people whose social isolation may relate to their sexual orientation but other schemes are considered to be neutral at this stage.
Gay				
Heterosexual				
Bisexual				
Transsexual				

Do you think that the policy impacts on any **other** people? (e.g. Homeless, veterans, ex-offenders, substance abuse)

10. Other (Please list)	Positive	Negative	Neutral	Reasons for your decision
				No benefits or disbenefits for other groups were considered as part of the assessment.

Section 4: Evaluation / On-going monitoring

If the service this policy refers to already exists please fill out sections 4A and then proceed to section 5. If the service in this policy is a new service please complete section 4B and then proceed to section 5.

Section 4A: Better Care Fund: Existing service

What systems are currently in place to monitor/ record the profile of service users? [e.g. patient or user survey that collects ethnic background]
Community providers collate information in relation to the profile of patients as well as from a patient satisfaction survey.

Equalities information against the protected characteristics are mandatory fields within the Adult Social Care case management system and all providers are required to report against these.

How often is this information collected?
For each episode of care

As a result of this policy will you monitor any additional equality profile information? If yes what additional information will you gather?
The information currently collated will be reviewed and if there are any gaps these can be addressed. Appropriate data collection will be ensured for schemes in development.

As a result of this policy will the CCG and/or the Council increase the frequency of which it collects the above data? If yes, what will the increase be? [e.g. monthly to weekly]
No

Who in the CCG and the Council reviews the data collected? Will they continue to review the data? If not who will monitor the information?
The data is reviewed by the HCCG, included in quarterly reports, during provider contract meetings.

Data is reviewed in the Council by the Performance and Intelligence Team and also the Category Management Team for providers.

Section 4B [Better Care Fund Plan: New Services]

What equality information will be collected that will assist in evidencing that the service is being accessed and meeting the needs of protected groups identified in section 3?

Equalities information and patient satisfaction surveys are required from providers of services and the data is reviewed by the HCCG, included in quarterly reports from the provider.

Equalities information against the protected characteristics are mandatory fields within the Adult Social Care case management system and all providers are required to report against these.

The information below is also collected as part of the BCF Plan metrics.

Service User Experience Metric

Adult Social Care Survey Q12 - In the past year, have you generally found it easy or difficult to find information and advice about support services or benefits?

Social Care-related Quality of Life

Social care-related quality of life. Adult Social Care Survey:

- ***Control - Q3a***: Which if the following statements best describes how much control you have over your daily life?
- ***Personal care - Q4a***: Thinking about keeping clean and presentable in appearance, which of the following statements best describes your situation?
- ***Food and nutrition - Q5a***: Thinking about the food and drink you get, which of the following statements best describes your situation?
- ***Accommodation - Q6a***: Which of the following statements best describes how clean and comfortable your home/care home is?
- ***Safety - Q7a***: Which of the following statements best describes how safe you feel?
- ***Social participation - Q8a***: Thinking about how much contact you've had with people you like, which of the following statements best describes your situation?
- ***Occupation - Q9a***: Which of the following statements best describes how you spend your time?
- ***Dignity - Q11***: Which of the following statements best describes how the way you are helped and treated makes you think and feel about yourself?

Each question has four possible answers, which are equated with having:

- No unmet needs
- Needs adequately met
- Some needs met
- No needs met

How often will this data be collected?

Equalities information is reported six monthly for the Council and quarterly for the HCCG.
The Adult Social Care Survey is undertaken annually and the audited results issued by the Department of Health in June of the following financial year. This means for BCF Plan purposes this information will not be available until June 2016.

Who in the CCG or Council will monitor this information?

Information will be monitored by the HCCG's Patient Public Involvement Equality Committee and by the Quality, Safety and Clinical Risk Committee.

Performance and Intelligence Team in the Council.

Section 5: Assessment

From your responses gathered in section 3 what actions will be taken to reduce inequalities identified in this EIA?

No inequalities were identified as a result of the assessment. However, particular attention will need to be given to how schemes develop to address the greater diversity in the south of the borough. The 2016/17 does contain areas for development in-year and these may require specific assessments to

support decisions during the year.

Is the policy directly or indirectly discriminatory under the equalities legislation?
No

If the policy is indirectly discriminatory can it be justified under the relevant legislation?

Not applicable.

Section 5: Publish Assessment Results

In order demonstrate openness about the way Hillingdon Clinical Commissioning Groups policies, services and partnerships and those of the Council are developed and our commitment to promoting equality and diversity, results of the impact assessment will be published on to the public facing website. www.hillingdonccg.nhs.uk . The assessment will also be available on the Council's website with all the BCF plan-related documents.

Is there any reason why this Equality Impact Assessment should not be published, please use this space to state your reasons:

None known

Section 6: Sign off

Section 7: Glossary

Listed below are definitions of key words that will provide additional guidance in relation to meeting requirements of an Equality Impact Assessment.

Adverse Impact
This is a significant difference in patterns of representation or outcomes between equalities groups, with the difference amounting to a detriment for one or more equalities groups.

Definition of Disability
The Equality Act, 2010 defines Disability as being:

“an impairment which has a substantial, long term adverse effect on person’s ability to carry out normal day-to-day activities”.

Differential Impact
Suggests that a particular group has been affected differently by a policy, in either a positive, neutral or negative way.

Direct Discrimination
That is treating people less favourably than others as it would apply to age, disability, gender, race, religion and belief, sexual orientation. There is no justification for direct discrimination

Ethnic monitoring
A process for collecting, storing and analysing data about individuals' ethnic (or racial) background and linking this data and analysis with planning and implementing policies.

Functions
The full range of activities carried out by a public authority to meet its public sector equalities duties.

Indirect discrimination
Applying a provision, criterion or practice that disadvantages people as applies to age, disability, gender, race, religion and belief, sexual orientation and can't be justified as a proportionate means of achieving a legitimate aim. The concept of 'provision, criterion or practice' covers the way in which an intention or policy is actually carried out, and includes attitudes and behaviour that could amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and stereotyping. To find discrimination it will be sufficient to show that a practice is likely to affect the group in question adversely.

BCF Scheme Summaries

Scheme Number	Scheme Title	Scheme Aim(s)
1.	Proactive early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.	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.	Better care for people at the end of their life	To realign and better integrate the services provided to people towards the end of their life. To develop the ethos of 'a good death' for people and for their families and carers within the provision of adult services.
3.	Rapid Response and integrated intermediate care	Prevention of admission to acute care following an event or 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.
4.	Seven day working	To improve quality and patient safety through reducing inconsistent care provision by: • Enabling discharge from the acute trust seven days a week for people admitted for either planned or unplanned procedures; • Enabling access to community services seven days a week thereby preventing unnecessary emergency department attendances and admission

		and reducing length of stay for people admitted to hospital for either planned or unplanned procedures; • **Reducing the uneven rate of hospital discharge across the week.**
5.	**Integrated Community-based Care and Support**	**To ensure that community based resources work as effectively and as efficiently as possible with primary care for the benefit of patients.**
6.	**Care Home and Supported Living Market Development**	**Through market reshaping secure:** • **A vibrant, quality care home market that meets current and future local need; and** • **An appropriate mix of supported living provision that provides people with a realistic alternative to care home admission.**
7.	**Supporting Carers**	The aims of this scheme are that Carers are able to say: • "I am physically and mentally well and treated with dignity" • "I am not forced into financial hardship by my caring role" • "I enjoy a life outside of caring" • "I am recognised, supported and listened to as an experienced carer"
8.	**Living well with dementia**	The aim of this scheme is that people with dementia and their family carers are enabled to live well with dementia.

CABINET FORWARD PLAN

Contact Officer: Charles Francis
Telephone: 01895 556454

REASON FOR ITEM

The Committee is required to consider the Forward Plan and provide Cabinet with any comments it wishes to make before the decision is taken.

OPTIONS OPEN TO THE COMMITTEE

1. Decide to comment on any items coming before Cabinet

2. Decide not to comment on any items coming before Cabinet

INFORMATION

1. The Forward Plan is updated on the 15th of each month. An edited version to include only items relevant to the Committee's remit is attached below. The full version can be found on the front page of the 'Members' Desk' under 'Useful Links'.

SUGGESTED COMMITTEE ACTIVITY

1. Members decide whether to examine any of the reports listed on the Forward Plan at a future meeting.

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Ref	Upcoming Decisions	Further details	Ward(s)	Final decision by Full Council	Cabinet Member(s) Responsible	Officer Contact for further information	Consultation on the decision	NEW ITEM	Public / Private Decision & reasons
	SI = Standard Item each month				Council Departments: RS = Residents Services	SC = Social Care	AD = Administration		FD= Finance
Cabinet - 21 April 2016									
104	**Carers Support Services**	Cabinet will consider a tender for services for Carers. The new contract will be for an integrated service which will combine the redelivery of respite, carers' assessment, information, advice, benefits advice, support and short break activities that the Council funds directly. The proposed contract period is for five years with options to extend for a further two years.	All		Cllr Philip Corthorne	SC / FD - John Higgins / Elizabeth Harris			Private (3)
105	**Better Care Fund Plan 2016/17 Section 75 Agreement**	Approval will be sought to enter into an agreement with Hillingdon Clinical Commissioning Group under section 75 of the National Health Service Act, 2006 to give legal effect to the financial arrangements contained in the 2016/17 Better Care Fund Plan, following consideration by the Health and Wellbeing Board.	All		Cllr Ray Puddifoot MBE & Cllr Philip Corthorne	SC - Gary Collier	Health and Wellbeing Board		Public
Cabinet Member Decisions - April 2016									
110	**Contractors for Supported Housing Developments**	Delegated approval by Cabinet has been granted to Members to appoint Design and Build Contractors for the new Parkview and Grassy Meadow Extra Care Housing developments.	Townfield / Yiewsley		Cllr Ray Puddifoot MBE & Cllr Jonathan Bianco	RS - Jenny Evans	Public consultation	NEW	Private (3)
SI	**Standard Items taken each month by the Cabinet Member**	Cabinet Members make a number of decisions each month on standard items - details of these standard items are listed at the end of the Forward Plan.	Various		All	AD - Democratic Services	Various		Public
Cabinet - 19 May 2016									
108	**Integrated Advocacy Service**	Cabinet will consider a tender for integrated advocacy services. The new contract will be for services which will combine statutory Care Act Advocacy, Independent Mental Health Advocacy, Independent Mental Capacity Advocacy and some non statutory General Advocacy. The proposed contract is for three years with an option to extend for a further 3 years.	All		Cllr Philip Corthorne	SC / FD - Ella Trafankowska		NEW	Private (3)

Ref	Upcoming Decisions	Further details	Ward(s)	Final decision by Full Council	Cabinet Member(s) Responsible	Officer Contact for further information	Consultation on the decision	NEW ITEM	Public / Private Decision & reasons
	SI = Standard Item each month				Council Departments: RS = Residents Services	SC = Social Care	AD = Administration		FD= Finance
115	**Best Interest Assessment Service**	Cabinet will consider a 2 years +1 +1 contract for a Best Interest Assessment Service. This service will provide an end to end single point of contact for BIAs. The appointment of independent assessors is made under the Care Act 2014, Mental Capacity Act 2005 and the Mental Health Act 2007.	All		Cllr Philip Corthorne	FD / RS - John Higgins / Nermine Taylor		NEW	Private (3)
78	**Carers Strategy - progress update**	Cabinet will receive an annual update on progress implementing the Carers' Strategy and Delivery Plan.	All		Cllr Philip Corthorne	AD - Vicky Trott	Carers, Carers Champion		Public
85	**Older People's Plan update**	Cabinet will receive it's twice yearly update on progress on the Older People's Plan (May and November annually).	All		Cllr Ray Puddifoot MBE / Cllr Philip Corthorne	AD - Vicky Trott	Older People, Leader's Initiative		Public

WORK PROGRAMME 2015/16

Contact Officer: Charles Francis
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REASON FOR ITEM

This report is to enable the Committee to review meeting dates and forward plans. This is a standard item at the end of the agenda.

OPTIONS AVAILABLE TO THE COMMITTEE

1. To confirm dates for meetings

2. To make suggestions for future working practices and/or reviews.

INFORMATION

All meetings to start at 7.00pm

Meetings	Room
2 July 2015	**CR 5**
30 July 2015	**CR 5**
3 September 2015	**CR 5**
6 October 2015	**CR 6**
4 November 2015	**CR 6**
20 January 2016	**CR 6**
23 February 2016	**CR3/3a**
24 March 2016	**CR 6**
20 April 2016	**CR 6**

Social Services, Housing and Public Health Policy Overview Committee

2015/16 - DRAFT Work Programme

Meeting Date	Item
2 July 2015	Major Reviews Topics 2015/16
	Work programme for 2015/16
	Cabinet Forward Plan

30 July 2015	Budget Planning Report for SS,Hsg&PH
	Scoping Report for Major Review
	Work Programme
	Cabinet Forward Plan

3 September 2015	Major Review - Witness Session 1
	Cabinet Forward Plan
	Annual Complaints Report
	Adults Safeguarding
	Work Programme

6 October 2015	Major Review - Witness Session 2
	Update on previous review recommendations (Shared Lives Review)
	Cabinet Forward Plan
	Work Programme

4 November 2015	Major Review - Witness Session 3
	Public Health Report - (deferred to 20 January 2016)
	Cabinet Forward Plan
	Work Programme

20 January 2016	Budget Proposals Report for 2016/17
	Major Review - Draft Final Report - (deferred to February)
	Consideration of second review
	Public Health Report
	Work Programme
	Cabinet Forward Plan

23 February 2016	Cabinet Forward Plan
	Major Review - Draft Final Report
	Second Review - Scoping report
	Work Programme

24 March 2016	Cabinet Forward Plan
	Work Programme
	Witness Session

20 April 2016	Cabinet Forward Plan
	Witness Session
	Loneliness update

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