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Health and Wellbeing Board

Date: **TUESDAY, 14 MARCH 2017**

Time: **2.30 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

Statutory Members (Voting)
Councillor Philip Corthorne MCIPD (Chairman)
Councillor David Simmonds CBE (Vice-Chairman)
Councillor Jonathan Bianco
Councillor Keith Burrows
Councillor Richard Lewis
Councillor Douglas Mills
Councillor Raymond Puddifoot MBE
Dr Ian Goodman, Chair - Hillingdon CCG
Stephen Otter, Chair - Healthwatch Hillingdon

Statutory Members (Non-Voting)
Statutory Director of Adult Social Services
Statutory Director of Children's Services
Statutory Director of Public Health

Co-Opted Members (Non-Voting)
The Hillingdon Hospitals NHS Foundation Trust
Central & North West London NHS Foundation Trust
Royal Brompton & Harefield NHS Foundation Trust
Hillingdon Clinical Commissioning Group (officer)
Hillingdon Clinical Commissioning Group (clinician)
LBH - Deputy Director: Public Safety & Environment

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Agenda

CHAIRMAN'S ANNOUNCEMENTS

1	Apologies for Absence	
2	Declarations of Interest in matters coming before this meeting	
3	To approve the minutes of the meeting on 8 December 2016	1 - 8
4	To confirm that the items of business marked Part I will be considered in public and that the items marked Part II will be considered in private	

Health and Wellbeing Board Reports - Part I (Public)

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Health and Wellbeing Board Reports - Part II (Private and Not for Publication)

The reports listed above in Part II are not made public because they contain exempt information under Part I of Schedule 12A to the Local Government (Access to Information) Act 1985 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it.

Minutes

HEALTH AND WELLBEING BOARD

8 December 2016

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

	Statutory Voting Board Members Present: Councillors Philip Corthorne (Chairman), Richard Lewis and Douglas Mills, Dr Ian Goodman and Stephen Otter **Statutory Non Voting Board Members Present**: Tony Zaman - Statutory Director of Adult Social Services and Statutory Director of Children's Services Dr Steve Hajioff - Statutory Director of Public Health **Co-opted Board Members Present:** Shane DeGaris - The Hillingdon Hospitals NHS Foundation Trust Maria O'Brien - Central and North West London NHS Foundation Trust (substitute) Nick Hunt - Royal Brompton and Harefield NHS Foundation Trust (substitute) Rob Larkman - Hillingdon Clinical Commissioning Group (officer) Nigel Dicker - LBH Deputy Director Residents Services **LBH Officers Present**: Nikki O'Halloran (Interim Senior Democratic Services Manager), Kevin Byrne (Head of Policy and Partnerships) and Gary Collier (Better Care Fund Programme Manager) **LBH Councillor Present:** Councillor Beulah East
31.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence were received from Councillors Bianco, Burrows, Puddifoot and Simmonds, and Mr Bob Bell (Mr Nick Hunt was present as his substitute) and Ms Robyn Doran (Ms Maria O'Brien was present as her substitute).
32.	**TO APPROVE THE MINUTES OF THE MEETING ON 29 SEPTEMBER 2016** *(Agenda Item 3)* Mr Stephen Otter was nominated as the Statutory Voting Member for Healthwatch Hillingdon and Mr Turkay Mahmoud was nominated as the Substitute Statutory Voting Member for Healthwatch Hillingdon. These nominations would be considered at the Council meeting on 19 January 2017. Ms Alison Seidler was appointed as the Non-Voting Co-opted Member (Clinician) for Hillingdon Clinical Commissioning Group. **RESOLVED: That:** **1. Council on 19 January 2017 consider the nominations for Mr Stephen Otter and Mr Turkay Mahmoud;** **2. Ms Alison Seidler be appointed as the Non-Voting Co-opted Member (Clinician) for Hillingdon Clinical Commissioning Group; and**

	3. the minutes of the meeting held on 29 September 2016 be agreed as a correct record.
33.	**TO CONFIRM THAT THE ITEMS OF BUSINESS MARKED PART I WILL BE CONSIDERED IN PUBLIC AND THAT THE ITEMS MARKED PART II WILL BE CONSIDERED IN PRIVATE** *(Agenda Item 4)* It was confirmed that Agenda Items 5 to 16 would be considered in public. Agenda Items 17 and 18 would be considered in private.
34.	**DEVELOPING HILLINGDON'S HEALTH & WELLBEING STRATEGY** *(Agenda Item 5)* It was noted that, at the Board's last meeting, officers had been asked to consider how to provide sharper focus to the report and to link it to the delivery of the local Sustainability and Transformation Plan. It was agreed that the Local ST Plan would be considered by the Board prior to its inclusion in the Health and Wellbeing Strategy. The Board also noted that Pharmacies were providing income generating services which were financially sustainable and which were reducing the footfall to GPs During the first half of 2016/17, 668 residents had accessed the H4All Wellbeing Service and 357 assessments had taken place using the Patient Activation Model (PAM) (which tested how motivated a person was to manage their long-term condition and helped to identify the level of support required from services). The Autism Plan had been drafted and was awaiting sign off from the CCG. With regard to the reduction in winter deaths, consideration would be given to breaking the figures down to show the impact of air quality. It was noted that the Council's Hospital Discharge Team had supported the early discharge of 157 people from Hillingdon Hospital and 62 from other hospitals during the first six months of 2016/2017. This Team was working with partners in a multi-disciplinary way. The Board was advised that subsequent iterations of the report would be presented in a different format to ensure that it reflected the progress on particular high profile issues and demonstrated links to others plans especially the STP. It was noted that the intention would be to eventually bring one overall strategy to the Board and then have one performance report based on the strategy. However, bringing together the different aspects of performance might take a little longer. **RESOLVED: That the Health and Wellbeing Board:** **1. notes the approach towards developing one overall Health and Wellbeing Strategy that will encompass delivery of the local Sustainability and Transformation Plan.** **2. notes progress against the existing plan.**
35.	**HILLINGDON'S JOINT STRATEGIC NEEDS ASSESSMENT** *(Agenda Item 6)* The Hillingdon Joint Health and Wellbeing Strategy had been developed in conjunction with Hillingdon CCG and was driven by the core offer from the Council and Public Health. It had identified emerging population trends which then helped to shape the

	Commissioning Intentions and highlighted emerging areas of focus. Although the report stated that the life expectancy of both men and women in Hillingdon was higher than the England average, it did not make a distinction between the north and south of the Borough. The number of TB cases in Hillingdon during 2012-2014 had been higher than the England and regional average. There had been an issue in the Borough regarding the availability of vaccines. Vaccines were commissioned by NHS England, Public Health England and the Council and re-commissioning work was currently underway. Consideration would be given to how this process could be accelerated. The Board was advised that GPs were incentivised to screen at risk patients for TB. Although the number of people diagnosed with diabetes in Hillingdon was higher than average, it was suggested that this was positive as it reflected a better standard of primary care. It was noted that the Safer Hillingdon Partnership would be leading on the development of a multi agency suicide strategy. **RESOLVED: That the Health and Wellbeing Board:** **1. notes the headlines from Hillingdon's Joint Strategic Needs Assessment (JSNA) which are being considered in developing updated commissioning plans.** **2. notes and comment on the proposed JSNA work priorities (as set out in Appendix 2 of the report) which ensures that it remains a key source of local intelligence to underpin effective service planning.**
36.	**SUSTAINABILITY AND TRANSFORMATION PLANS** *(Agenda Item 7)* It was becoming easier to visualise how the Sustainability and Transformation Plan (STP) would take shape and the prioritisation. However, local authorities had expressed concern regarding the lack of clarity in relation to emerging investment. The funding principles would be examined and consideration would need to be given to investment in transformational systems to improvement patient experiences such as intermediate care. Officers were asked to prepare a detailed Hillingdon STP Plan with specific actions drawn from Appendix B of the report. Options for consultation could then be considered by the Board at its meeting on 14 March 2017. The Implementation Business Case (ImBC) set out the investment of £½bn in North West London (NWL). With regard to the ImBC Strategic Outline Case, a capital bid for investment was being made to create additional capacity for hospitals and primary / community hubs (including A&E and maternity). It was noted that £70m was available for PC sites/GP premises in NWL and that, if successful in its bid, some £100m would be made available to Hillingdon. **RESOLVED: That the Health and Wellbeing Board:** **1. notes the NWL STP submission (Appendix 1 of the report) and, whilst continuing to offer broad support to the direction of the plan, registers concern regarding uncertainty on the funding arrangements and to seek reassurance on flexibility to deliver what works best for Hillingdon.**

	2. notes the Hillingdon STP (Appendix 2 of the report) and progress in implementing proposals to take it forwards into a full delivery plan linked to an eventual overall Health and Wellbeing Strategy. **3. asks officers to prepare, in the first place, a detailed Hillingdon STP Plan with specific details drawing from Appendix B of the report and options for consultation to be considered by the Board at its meeting on 14 March 2017.**
37.	**BETTER CARE FUND: PERFORMANCE REPORT** *(Agenda Item 8)* The BCF Policy Framework, setting out the national conditions that all Health and Wellbeing Board areas would be required to satisfy, was expected to be circulated after Christmas. Depending on the timings, consideration might then need to be given to delegations. It was noted that there had been some recording issues in relation to the number of delayed days in an acute setting as a result of difficulties in securing appropriate placements. Although a lot of encouraging work was underway in relation to BCF in relation to prevention and early intervention, it was agreed that the Corporate Director of Adults, Children and Young People's Services would provide a breakdown of the transfer delays to show the median as it was suspected that there might be a handful of individuals that skewed the results. With regard to delayed transfer of care (DTOC), it was noted that, although there had been 10 confirmed DTOCs at Hillingdon Hospital, it was thought that there were about 20-30 additional patients at the hospital who were medically fit but who were still unable to leave. It was noted that the CCG, Social Services and The Hillingdon Hospital NHS Foundation Trust (THH) had been working well in partnership to address this issue. Healthwatch Hillingdon had undertaken a review of hospital discharges and had found that a patient's personal circumstances could impact on delays in their discharge (for example, when an appropriate home could not be found). It was noted that the length of time that a discharge was delayed impacted on the whole pathway. A&E attendances had increased 8% on the previous year and, although emergency admissions had reduced as a result of the work of the Rapid Response Team, patients were staying longer in hospital. It was also noted that the number of blue light admissions had increased significantly (these tended to be for symptoms such as fast respiratory rate or fever). These increases had impacted on the hospital which was now under immense pressure. The Board was advised that THH had planned for an increase in paediatric admissions following closures at Ealing Hospital and that this had not impacted on the Trust's performance targets. It was suggested that the increase in A&E attendances had been as a result of a population increase in Hillingdon as well as some additional patients coming from Ealing. To mitigate the number of patients from Ealing attending Hillingdon Hospital, it was suggested that there be some form of communication to remind residents that Ealing A&E was still open. **That the Health and Wellbeing Board:** **a) notes the contents of the report.**

	b) provides feedback to officers on outline proposals for the 2017 to 2019 BCF plan contained within the report. **c) receives a breakdown of the transfer delays from the Council's Corporate Director of Adults, Children and Young People's Services.**
38.	**CAMHS PROGRESS REPORT** *(Agenda Item 9)* It was noted that, despite investment in the service, CAMHS had not been transformed and so, in its current form, would not be sustainable in the future. The report set out action that would be taken to address the issues and improve the CAMHS service. The Chairman had attended an event in October 2016 and had met with Council officers from Children and Young People's Services the previous week to discuss the timeframe for the implementation of the proposed improvements. The Board recognised that there had been some improvement in relation to waiting times, but also acknowledged that more improvement was needed. **RESOLVED: That the Health and Wellbeing Board:** **a) notes the progress in implementing the agreed 2016/17 Local Transformation Plan.** **b) notes proposals to develop a new approach to commissioning CAMHS services which are to be developed and are subject to approval by HCCG and the Council.** **c) continues to request regular performance updates against the partnership plan.**
39.	**PROGRESS UPDATE ON THE DEVELOPMENT OF AN ACCOUNTABLE CARE PARTNERSHIP (ACP) IN HILLINGDON** *(Agenda Item 10)* The report set out the actions being taken as well as the reasoning and benefits of these actions. The case for change highlighted that the funding gap and the increase in long term conditions necessitated the need for more integrated working which had then led to the creation of the Accountable Care Partnership (ACP). The ACP comprised four equal partners: The Hillingdon Hospitals NHS Foundation Trust (THH), CNWL, H4All CIC (a federation of voluntary sector partners) and Hillingdon's four GP networks (which would become Hillingdon GP federation from April 2017). The ACP had been named Hillingdon Health and Care Partners (HHCP). HHCP had been working with the Council, to ensure that social care pathways were available and managed, and commissioners to ensure that it received input on shaping the right model. A phased approach to a capitated budget was planned for those in the Borough aged 65+. It was anticipated that there would be 15 Care Connection Teams (CCTs) that would work with GPs to identify those people at greatest risk, proactively plan their care to reduce risk of emergency admission and to enable people to remain in their own home as long as possible. The proposed changes would require a culture shift for staff to ensure that they were more flexible in responding to the needs of patients. CCTs had already shown positive results and work was now underway to recruit to the remaining CCT vacant posts. It was anticipated that CCTs would be able to help patients navigate through the health system to receive the right care and support. HHCP had been one of the local priorities included within the Sustainability and Transformation Plan (STP) and meant that Hillingdon was ahead of other parts of North West London (NWL). It was noted that service users would be included on working

	groups and consideration was now being given to the inclusion of lay people on the Board. **RESOLVED: That the Health and Wellbeing Board:** **a) notes the update on the work that is going on in Hillingdon develop an Accountable Care Partnership (ACP), initially for older people** **b) notes the progress to date, the proposed actions going forward and the current challenges within the ACP work plan.** **c) has the opportunity to discuss and input ideas into the further development opportunities that may exist for this model within the Borough.**
40.	**HILLINGDON CCG UPDATE** *(Agenda Item 11)* It was noted that planning had gone well in relation to children's services and the Sustainability and Transformation Plan (STP). Furthermore, HCCG and CNWL had been successful in a joint bid to become a national early implementer of the new access targets for Improving Access to Psychological Therapies (IAPT). Whilst HCCG was hoping to hit all of its targets during 2016/2017, this would require all of its resources. As such, HCCG was unclear how it would bridge the funding gap in 2017/2018. The report highlighted three major areas which needed to be controlled: continuing healthcare beds; palliative care beds; and over activity at Harefield Hospital. It also stated that discussions were ongoing across London with regards to the next phase of the devolution proposal with key areas of focus being estates and integration. It was noted that work was underway to elect a new Vice Chair of HCCG. **RESOLVED: That the Health and Wellbeing Board note the update.**
41.	**HEALTHWATCH HILLINGDON UPDATE** *(Agenda Item 12)* Healthwatch Hillingdon had completed two major projects: 1. maternity - the feedback on this service had been good; and 2. hospital discharge - the feedback on this had not been good and highlighted that there would be a significant pressure through QIPP. Further information about these two reviews would be included in Healthwatch Hillingdon's report to the Health and Wellbeing Board on 14 March 2017. It was noted that the recruitment and retention of volunteers continued to be a challenge. Healthwatch Hillingdon had a small nucleus of volunteers and there were times when this experience had helped them in moving on to new jobs. The organisation would continue to advertise for new volunteers and consideration would be given to using Hillingdon People to support this recruitment. **RESOLVED: That the Health and Wellbeing Board note the report received.**
42.	**UPDATE: STRATEGIC ESTATE DEVELOPMENT** *(Agenda Item 13)* It was noted that the format of the report had been revised to include broader estates themes and any comments or feedback on these changes were welcomed. All s106

	health contributions with a deadline during 2016/2017 had been spent or allocated. Although this demonstrated that key players were working together, it belied the difficulties experienced when working with NHS Property Services (NHSPS) in relation to projects such as the Yiewsley Health Centre. Consideration was being given to how progress could be made on projects, such as the St Andrews development. A significant population growth was expected in Hayes and it was queried whether the Hesa Centre had sufficient capacity to cope with the expected increased demand. As the Hesa Centre was not likely to be big enough, HCCG was looking to put a contingency plan in place to deal with the excess. As well as having early sight of the issues so that they could be discussed, the Board agreed that it would be useful to have a map of the Borough with locations and public transport links included. **RESOLVED: That the Health and Wellbeing Board notes the progress being made towards the delivery of the CCGs strategic estates plans.**
43.	**HILLINGDON LOCAL SAFEGUARDING CHILDREN'S BOARD (LSCB) ANNUAL REPORT** *(Agenda Item 14)* It was noted that both of the reports of the Local Safeguarding Children Board (LSCB) and the Safeguarding Adult Partnership Board had focussed on limited resources. Consideration was being given to bringing the two Boards together as there were common attendees at both meetings. The LSCB had been streamlined and the task and finish groups that had been set up were working well. In light of the recent abuse allegations in relation to football clubs, concern was expressed in relation to the oversight that was provided for smaller groups and organisations. Outreach work was undertaken and all schools were provided with information but, given the recent high profile in the news, it was agreed that reminders would be sent out. The website pages would also be refreshed and information would continue to be periodically included in Hillingdon People to raise awareness. **RESOLVED: That the Health and Wellbeing Board notes the report.**
44.	**HILLINGDON SAFEGUARDING ADULT PARTNERSHIP BOARD ANNUAL REPORT** *(Agenda Item 15)* The Care Act 2014 had been a significant factor in the way adult safeguarding was regarded amongst both agencies and the public. A business unit had been put in place to develop performance and audit processes and ensure that training packages were available to all agencies, as well as provide project management support. **RESOLVED: That the Health and Wellbeing Board notes the report.**
45.	**BOARD PLANNER & FUTURE AGENDA ITEMS** *(Agenda Item 16)* Consideration was given to the Health and Wellbeing Board's Board Planner. It was noted that s106 information would in future be included in the report entitled Update: Strategic Estate Development. Detailed Sustainability and Transformation Plan (STP) information would be fitted into the existing STP report.

	RESOLVED: That the Health and Wellbeing Board notes the Board Planner, as amended.
46.	**TO APPROVE THE PART II MINUTES OF THE MEETING ON 29 SEPTEMBER 2016** *(Agenda Item 17)* It was noted that the consultation on the proposal to withdraw paediatric cardiac services from Royal Brompton and Harefield NHS Foundation Trust had been delayed until the new year. No practical steps would be able to be taken regarding any changes until April 2019 at the earliest. **RESOLVED: That the Part II minutes of the meeting held on 29 September 2016 be agreed as a correct record.**
47.	**UPDATE ON CURRENT AND EMERGING ISSUES AND ANY OTHER BUSINESS THE CHAIRMAN CONSIDERS TO BE URGENT** *(Agenda Item 18)* The Board considered a number of issues including available/possible health sites in Hillingdon, joined up strategic planning and the Accountable Care Partnership. **RESOLVED: That the discussion be noted.**
	The meeting, which commenced at 2.30 pm, closed at 4.00 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on 01895 250472. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

HILLINGDON'S HEALTH AND WELLBEING STRATEGY AND SUSTAINABILITY AND TRANSFORMATION DELIVERY PLAN

Relevant Board Member(s)	Councillor Philip Corthorne Dr Ian Goodman
Organisation	London Borough of Hillingdon Hillingdon CCG
Report author	Kevin Byrne, LBH Policy and Partnerships Sarah Walker, HCCG Transformation
Papers with report	Annex 1. Hillingdon STP delivery plan. Annex 2. Emerging Governance Structure

1. HEADLINE INFORMATION

Summary	The Board has asked that the next iteration of Hillingdon's Joint Health and Wellbeing Strategy take into account the significant effort across partners that went into developing the Hillingdon STP and that delivery of the STP should be encompassed within delivery of the JHWB Strategy - with the aim of one strategy and one performance report. This paper provides the Board with a draft delivery plan for the Hillingdon Sustainability and Transformation Plan (STP) together with timescales and proposals for governance. This will form part of the next Hillingdon Joint Health and Wellbeing Strategy.
Contribution to plans and strategies	Producing a Joint Health and Wellbeing Strategy is a statutory requirement placed on Health and Wellbeing Boards by the Health and Social Care Act 2012. The Hillingdon STP has been developed as a partnership plan reflecting priorities across health and care services. The Hillingdon STP is also closely aligned to the NWL STP to ensure that delivery meets the needs of local people and supports development of solutions in the best interests of health and care in Hillingdon.
Financial Cost	There are no costs arising directly from this report.
Ward(s) affected	All

2. RECOMMENDATIONS

That the Health and Wellbeing Board:

1) **notes the update on taking forward decisions made by the Board regarding developing the next Hillingdon Joint Health and Wellbeing Strategy to encompass STP delivery.**
2) **provides comments on the draft Hillingdon ST delivery plan, including timescales and proposals for governance as at Annexes 1 & 2.**

3. INFORMATION

Background Information

At its last meeting on 8th December, the Board agreed that its ambition should be to work towards agreeing one overall Borough Strategy and one performance report, whilst recognising that external reporting requirements, especially from NHSE, required separate reporting templates. This meant that in practice achieving this intention would take a little time. In particular the Board considered Hillingdon's JHWB Strategy should encompass the Sustainability and Transformation Plan for Hillingdon and its delivery plan priorities.

Hillingdon's current Joint Health and Wellbeing Strategy (2014-17) was agreed by the Board in December 2014. The Board has received regular performance updates against the published strategy and plan at each Board meeting since together with an update on outcome indicators relevant to the strategy in the form of a scorecard.

Joint Strategic Needs Assessment

The Board also received a paper (8th December) on the Joint Strategic Needs Assessment which starts the next planning cycle to inform the priorities for the JHWB strategy. This identified some challenges to improve health and wellbeing. These include:

- Historically higher levels of violent crime in Hillingdon.
- Higher rates of sexually transmitted infections and tuberculosis.
- People diagnosed with diabetes in Hillingdon is higher than average.
- The percentage of physically active adults is lower than England.

The biggest cause of death in Hillingdon continues to be cardio-vascular disease (heart disease and stroke), cancer and respiratory diseases. Diabetes is a significant cause of illness (morbidity) and predisposes to other diseases e.g. heart disease and stroke, kidney disease and blindness.

Certain lifestyle factors will increase the risk of ill-health, including smoking, poor diet, lack of regular exercise and higher levels of alcohol consumption and/or binge drinking. The estimated 2015 prevalence of smoking in Hillingdon (16.9%) was the same as the estimated proportion for England (16.9%).

Age and other related conditions also affect health and wellbeing. Many people aged 65 and over are diagnosed with one or more long term conditions, of whom over half are typically diagnosed with multiple long term conditions which increases dependency on care and support. Other conditions include learning disability and child and adult mental health, including dementia.

Developing a new Joint Health and Wellbeing Strategy

Hillingdon's current Joint Health and Wellbeing Strategy (2014-17) is structured as follows :

1. Foreword - from HWB Chairman.
2. Health and Wellbeing Board - overview of role and purpose.
3. What is the Joint Health and Wellbeing Strategy? - clarification of purpose of strategy.
4. Our common principles- "I statements " - what we want residents to be able to say.
5. About Hillingdon: our borough and our residents - headline information on the key characteristics of Hillingdon and its population.
6. Priority areas for action as identified via JSNA including current needs and progress in delivering improvements, namely:
    a. Improving Health and Wellbeing and reducing inequalities
    b. Prevention and early intervention
    c. Developing integrated, high quality social care and health services within the community or at home
    d. A positive experience of care
7. Delivery Plan - which has formed the basis of reporting performance against the strategy.

This content requires review and updating to reflect changes that have occurred since 2014. The five STP delivery areas provide a robust framework and the ten Hillingdon STP transformation workstreams provide a firm foundation (see below). There is further work to do to ensure that this does encompass all areas that require action so as to develop the overarching strategy to cover areas identified through the JSNA and the transformation work identified through the Hillingdon STP.

An officer group will be established across functions to review the approach and develop a narrative for the strategy and report back to next Health and Wellbeing Board.

Hillingdon Sustainability and Transformation Delivery Plan

The Hillingdon STP has been developed to transform local health and care services and to address the projected funding gap of at least £120m (excluding children's social care) that is likely to be experienced between 2016 and 2021. The NWL and Hillingdon STPs identify five STP Delivery Areas (DA) to align system transformation efforts and to meet the service and funding challenge:

- DA1 - Radically upgrading prevention and wellbeing.
- DA2 - Eliminating unwarranted variation and improving LTC management.
- DA3 - Achieving better outcomes and experiences for older people.
- DA4 - Improving outcomes for children and adults with mental health needs.
- DA5 - Ensuring we have safe, high quality, sustainable acute services.

In addition the Hillingdon plan identifies 10 transformation workstreams to be the focus of activity, there are also a number of current and ongoing projects and task and finish groups that fit together within this structure. The table below maps these against the five Delivery Areas:

5 Delivery Areas	DA1 Radically upgrading prevention and wellbeing **Prevention, Wellbeing & CYP**	DA2 Eliminating unwarranted variation and improving LTC management **Primary Care & LTC**	DA3 Achieving better outcomes and experiences for older people **Older People & ACP**	DA4 Improving outcomes for children and adults with MH needs **Mental Health**	DA5 Ensuring we have safe high quality sustainable acute services **Sustainable Acute Services**	**Enablers**
10 Hillingdon Transformation Streams	Prevent disease & ill health	Integrated LTC Support Services	Older People Care Transformation	Supporting SMI and LD	Local Services Transformation	Workforce Digital / IT Estates Statutory Targets Provider Market Medicines Management
		Transforming Cancer Care	End of Life Service Integration		Urgent & Emergency Care Integration	
	Integrated Care for C&YP	New Model of Primary Care				

The Board will note that the proposals for the Better Care Fund Plan from 2017 for two years are contained in the separate paper to today's Board as they still require submission and reporting separately to NHSE. They are, however, integral to the delivery of Hillingdon's STP so the BCF paper also sets out how the BCF will contribute to delivery of the STP five delivery areas. It contains proposed actions and some of the detailed decisions that will be required over the period on new ways of working, establishing lead commissioner arrangements and strengthening the pooled budget approach.

The draft plan at **Annex 1** outlines the proposed programme of work for system transformation. Projects are grouped to the five delivery areas with estimated timeframes for taking forward each of the key components, and an approximation of the programme value attached to each area of work. It also identifies areas of significant system-wide and integrated working.

Further strategic planning and analysis is in train (via the Health Impact Assessment (HIA) process) to review, within the context of the NWL STP and JSNA, local progress in 16/17 and plans in 17/18 and 18/19, progress against targets. In this way, the HIA will inform system leaders of areas for future focus. The findings of this work will be consolidated into a 2020/21 vision and delivery agenda.

The Board is invited to provide feedback on this delivery plan, which if agreed will now form the basis for programme management and reporting, shown in Annex 2.

Emerging governance structure for STP delivery

To enable the Hillingdon STP to be mobilised towards delivery it is proposed that Hillingdon's Health and Wellbeing Board takes overall strategic oversight and is supported by the Hillingdon Transformation Board which would provide strategic direction and hold the system to account for delivery to plan. The existing STP partners group could then continue to develop STP plans, as well as take on a programme management function to monitor progress within transformation groups and agree reporting upwards. Each workstream/project in the delivery plan has an SRO and CRO who are supported by project staff. **Annex 2** illustrates the emerging governance structure, as well as mapping the current transformation and supporting working groups to the five NWL STP Delivery Areas.

The Board is asked to agree the broad approach to ST governance at Annex 2.

Financial Implications

The high level estimates set out in the NWL STP October submission identified the revised funding gap arising from the option to 'do nothing' over the period 2016/21 and how using new funding through the STP provided by the government will transform services and close any funding gaps over the next 5 financial years. The financial analysis set out in the detailed plans were calculated at a strategic level and were based upon a number of assumptions and models that have been reworked by finance officers from both Health and Local Government to ensure that the financial costs and investments can be fully evidenced.

A high level exercise was undertaken to identify the financial impact of the 'Do nothing' option for the Hillingdon based STP plan, for the period 2016/2021. The future funding gap for Health split out across the different types of provision and for Adult Social Care is currently estimated at £120m as set out in the table below:

Period 2016/2021	**Hillingdon £m**
CCG	(39)
Primary Care	(2)
Social Care	(34)
Acute and Community Care	(45)
Special Commissioning	0
Total	**(120)**

The detailed assumptions underpinning these forecasts are as follows:

- For the health economy , the increased health needs of a growing and ageing population means that the forecast increase in demand and the resulting cost of delivering services will increase faster than the actual population growth. There are also financial pressures arising from inflation, increased A&E attendances, increased prescribing costs for new treatments and a range of pressures across a number of other services.

- For Adult Social Care the 'do nothing' funding gap comprises the demographic growth for Older People, People with disabilities and mental health conditions, the impact of the National Living Wage on Home Care and Residential and Nursing Accommodation provider costs. As at October 2016, this has been estimated locally as £34m over the next 5 financial years. The updated 'do nothing' forecast funding gap for Social Care now includes a corporate share of the financial savings over the 5 year period that Adult Social Care Services will need to make to contribute to councils statutory requirement to set a balanced budget.

The proposed projects for Hillingdon are set out in Annex 1 and will be developed in more detail with business cases they will be subject to a robust analysis of any investment proposals and efficiency savings that can be delivered to ensure that any financial benefits are realistic and achievable over the 5 year period. The programme values set out in Annex 1 are currently indicative estimates.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

The STP is designed to improve health and care systems in Hillingdon.

Consultation Carried Out or Required

Hillingdon STP engagements and consultations build on our local approach of continuous dialogue with the public and partners as a platform for the co-design and co-production of health and wellbeing plans. We have embedded inclusion of patient, public, provider and other stakeholder input to the initial stages of research, development and testing of system transformation projects. We reflect here on the work done in the CAMHS co-design/service user engagement, interviews to understand the impact of the Empowered Patient Programme, hosting an annual Health Conference, and engaging personally with interested individual members of the public. Hillingdon has also previously received acknowledgement from NHS England of the 'outstanding' engagement done locally, the success of which lies in the integrated working of all Hillingdon health, care and wellbeing organisations. In these ways, we comply with and actively work beyond the guidance set out by NHS England on patient and public participation in commissioning under section13Q of the National Health Service Act 2006.

Policy Overview Committee comments

None at this stage.

5. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

Corporate Finance has reviewed this report, noting that the local Hillingdon STP plan outlines an approach to bridging the budget gap for both Health and Adult Social Care by 2020/21.

Hillingdon's share of this budget gap is reflected in the Council's own Medium Term Financial Forecast. Subject to acceptance of the NWL bid by Department of Health, savings identified will be fully costed and reflected in the MTFF alongside any additional funding available to support local Social Care services. Decisions regarding implementation of the Social Care Precept in Hillingdon remain the prerogative of the Council.

Hillingdon Council Legal comments

The Borough Solicitor confirms that there are no specific legal implications arising from this report.

Corporate Property and Construction

Not applicable

6. BACKGROUND PAPERS

Previous Board papers regarding STP development

Annex 1 - Hillingdon STP 2017/201 delivery Plan

Key

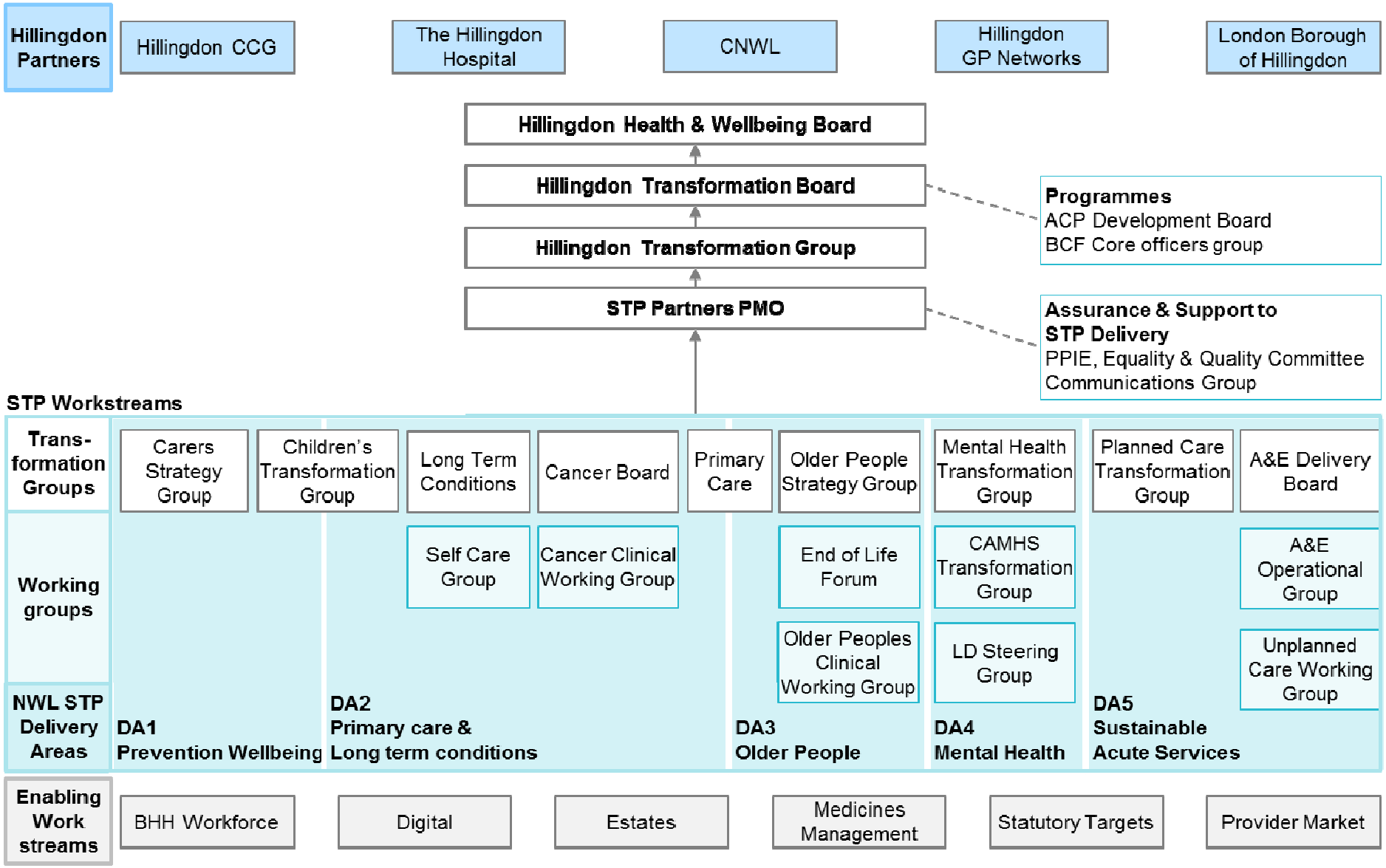
Bold Project title	Area of significant system-wide/integrated working
	Research, planning, development and testing stage
	Service roll-out with incremental in-year benefits
	Full implementation & benefits realisation anticipated

Hillingdon STP Workstreams

Theme	Project	Programme Value	16/17	17/18	18/19	19/20	20/21
Prevent disease & ill health	**Hillingdon Prevention Strategy**	£25m					
	Hillingdon Carers Strategy						
	Hillingdon Physical Activity Strategy						
	Personal Health Budgets Strategy						
	Better Care Fund (BCF) 2017-19 Plan						
	Wellbeing Programme & Training in Schools						
C&YP	**Children & Young People Single Point of Access / Pathway**	£26m					
	Consultant Led Paediatric Service						
	Community pathways for acutely sick children						
	Paediatric Asthma Programme						
	Critical Care Level 1 THH						
	Maternity Public Engagement and Education						
	Community Clinics						
Primary Care Model	Strategic Commissioning Framework	£69m					
	Phase 1 – Embedding unplanned care, care homes, LTCs & enhanced access model in Primary Care						
	Phase 2 – Embedding MH support and improving Acute flows						
LTC	**Long Term Conditions Strategy**	£100m					
	LTC Psychological Support Service						
	Integrated Services Programme - Hillingdon (Respiratory, Cardiology (HF), Diabetes, AF & Stroke) - BHH RightCare Programme (Diabetes, MSK, Cancer, Respiratory)						
	Empowered Patient Programme & Patient Activation (PAM)						
Cancer	**Cancer National Vanguard Strategy**	£13m					
	Cancer Strategy						
	Cancer Diagnosis Capacity in Community						
Older People Care Model	**Coordinate My Care Proactive Care Management**	Tbc					
	Care Connection Team	Tbc					
	New Model of Care – Care Homes	Tbc					
	Better Care Fund (BCF) 17/19 - (Care markets focus)	tbc					
	Accountable Care Partnership	£97m					
EoL	**End of Life Care Strategy & Single Point of Access (SPA)**	£12m					

Theme	Project	Programme Value	16/17	17/18	18/19	19/20	20/21
Support SMI & LD	**Crisis Care** (Urgent, emergency, rapid response) **Autism Spectrum Strategy** **NWL Transforming Care Partnership Programme** Integrated Community Mental & Physical Health Care Strategy Care model development and delivery Mental Health – LikeMinded Programme Children & Adult Mental Health Services (CAMHS) 5 Yr Plan	£30m					
Local Services and Planned Care	7 Day Services **Hillingdon Local Services Strategy** **Consultant Led Paediatric Service** NWL Referrals Criteria & Management protocol CATs service development and enhancement	£78m					
UEC	Urgent & Emergency Care Strategy Ambulatory & Emergency Care Pathways **111 & Primary Care Triage Model** Discharge to Assess Integrate Intermediate Care Services and Homesafe Follow-up in the Community (readmissions)	£26m					

Annex 2 - Hillingdon STP Emerging Governance Structure



The draft proposed roles for the governance structure are outlined in the table below.

Group	Role & responsibility
Hillingdon partners	Hillingdon organisations involved in the commissioning/provision of health and care services
Health & Wellbeing Board	Provides strategic oversight of delivery against the plan
Hillingdon Transformation Board	Monitors progress against the plan and provides guidance to strategic planning
Hillingdon Transformation Group	Discussion and clearing group proactively engaged in championing delivery at pace and scale, as well as helping unblock systemic issues to delivery
STP Partners PMO	Core programme team to develop strategic plans for approval to drive a programme of work that aligns to the NWL and Hillingdon plan, that is delivered at pace and scale, and to assure consistency of approach across the programme of work as well as unblocking working issues to delivery
Transformation Groups	Provide strategic direction for associated projects including
Working Groups	Responsible for content development and implementation of projects as well as operational problem solving
PPIE, Equality & Quality Committee	Provide assurance of patient and public engagement, as well as equality and quality assurance
Communications Group	Supporting coherent, joined up dialogue with residents and staff
ACP Development Board	A programme of work encompassing a number of workstream areas impacting how services are commissioned/provided
BCF Core Officers Group	A programme of work directing investment within the BCF portfolio areas and impacting how services are commissioned/provided

BETTER CARE FUND: PERFORMANCE REPORT (OCTOBER - DECEMBER 2016)

Relevant Board Member(s)	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 Caroline Morison, HCCG
Papers with report	Appendix 1) BCF Monitoring report - Month 7 -9: October - December 2016 Appendix 2) BCF Metrics Scorecard Appendix 3) Hillingdon Hospital Discharges Day by Day (October - December 2014/15 to 2016/17) Appendix 3A) Hillingdon Hospital Discharges Before Midday (October - December 2014/15 to 2016/17)

HEADLINE INFORMATION

Summary	This report provides the Board with the third performance report on the delivery of the 2016/17 Better Care Fund plan.
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 £22,531k for 2016/17 as at month 9.
Ward(s) affected	All

RECOMMENDATION

That the Health and Wellbeing Board notes the contents of the report.

INFORMATION

1. This is the third performance report to the HWBB on the delivery of Hillingdon's Better Care Fund (BCF) Plan for 2016/17 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 the Council's 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:

- *Emergency admissions* - In Q3 there were 2,478 emergency (also known as non-elective) admissions to hospital of people aged 65 and over, which is marginally above the ceiling for the quarter of 2,432. On a straightline projection this would suggest an outturn for 2016/17 of 9,913 admissions against a ceiling of 9,700.

- *Falls-related emergency admissions* - There were 190 falls-related admissions during Q3 against a ceiling of 180 for the quarter. The projected outturn of 806 admissions would exceed the ceiling for 2016/17 of 720 but would be similar to 2015/16 activity.

- *Emergency admissions from care homes* - 2016/17 to the end of Q3 has seen a 22% drop in the number of the emergency admissions from care homes supported by Hillingdon GPs, e.g. 401 admissions compared to 514 in the same period in 2016/17. This suggests that initiatives to support local care homes supported by Hillingdon GPs are being successful. However, this does not reflect attendances and admissions to Hillingdon Hospital from care homes outside of the borough or those care homes in the borough supported by GPs from outside of the borough.

- *Delayed transfers of care (DTOC)* - There were 2,122 delayed days during Q3, which was above the ceiling of 1,350. This activity was attributed to 36 people in an acute setting and 14 people in non-acute, primarily with CNWL. The projected outturn for 2016/17 based on Q1 to Q3 activity is 7,983 delayed days against a ceiling of 4,117 for the year.

- *Permanent admissions to care homes* - There were 40 permanent admissions of older people to care homes in Q3, which suggests that the outturn for 2016/17 is going to be below the ceiling for the year of 150.

- *Still at home 91 days after discharge from hospital to reablement* - The average number of older people aged 65 and over still at home 91 days after discharge from hospital to reablement during Q3 was 94.2% against a target for 2016/17 of 93.8%.

- *Seven day working* - There has been an increase in the number of people admitted to Hillingdon Hospital for planned procedures being discharged at weekends and an increase in the percentage of people being discharged on Saturdays before midday but there is little change to the discharge pattern for people admitted as emergencies.

- *Connect to Support* - 3,576 individuals accessed Connect to Support and completed 4,975 sessions reviewing the information & advice pages and/or details of available services and support. This represents an increase of 2,286 people and 3,037 sessions on the same period in 2015/16 and suggests that promotional activities are starting to have an impact.

- *Disabled Facilities Grants* - In Q3 31 people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs).

Delayed Transfers of Care

4. There were a total number of 5,987 delayed days between Q1 and Q3. The number of people to which delayed days in acute hospitals are attributed will be reported verbally to the

Board. The delayed days in non-acute beds during this period were attributed to 38 people (27 with CNWL).

5. The Q2 report to the December Board meeting identified the key reasons for Hillingdon's DTOC position, which remain unchanged and these include:

- Increasing complexity of need of people admitted to hospital;
- Inefficient post-admission processes, such as an inconsistently applied approach to discharge planning;
- A local health and care system that remains complex and fragmented; and
- A lack of care home market capacity and willingness to address the placement needs of people with complex needs, including challenging behaviours.

6. There is confidence amongst partners that the DTOC definition is being appropriately applied, which suggests that there was under-reporting in 2015/16.

7. Although Hillingdon Hospital has had its own transformation programme in place during 2016/17 that was looking at how to improve patient flow through the hospital, in Q2 the Trust requested support from NHS Improvement (NHSI)'s Emergency Care Improvement Programme (ECIP). In recent months ECIP has been supporting the Trust to diagnose, review and facilitate improving patient flow across the whole hospital. ECIP has also been looking at the whole system with a view to reducing the length of stay of people admitted to the Hospital who are medically fit to leave. Actions arising from ECIP's work with Hillingdon's emergency care system will be reflected in the Hospital Discharge Action Plan and overseen by a multi-agency task and finish group called the Joint Hospital Discharge Pathway Group. The escalation route from this group is to the A & E Delivery Board and the Health and Wellbeing Board.

<u>2016/17 BCF Plan Evaluated</u>

8. A key achievement of the 2016/17 BCF plan has been the continued improvement in the working relationship between health and care professionals, which is of significant importance to the delivery of better outcomes for residents. Other achievements include:

- *Online information portal* - The online system called Connect to Support (C2S) is intended to enable residents to identify the services that are available to meet their needs and promotional activity has significantly increased the numbers accessing the system;

- *H4All Wellbeing Service* - This innovative service intended to prevent the needs of older people living with long-term conditions escalating so as to result in a loss of independence and increase demand on health and care services became operational and is starting to show positive results;

- *Coordinate My Care (CMC)* - Adult Social Care has gained read and write access to this advanced care planning tool that is used in London to ensure the coordination of care for people at end of life;

- *Hospital discharge* - A new patient information booklet has been produced that should contribute to a reduction in the number of DTOCs attributed to the patient/family choice reason. Partners have also worked together to establish bed-based discharge to assess arrangements in local care homes in order to relieve pressure on Hillingdon Hospital. Increased investment by the CCG has funded an additional consultant geriatrician post that will help to support community health teams to support discharge and prevent readmission.

Hillingdon Hospital has established and recruited to nine Patient Flow Coordinator posts that will help to ensure a more consistent discharge process across wards;

- *Seven day working* - Additional medical cover has enabled the Hawthorn Intermediate Care Unit (HICU) to accept referrals seven days a week;

- *Carers' hub contract* - A new contract delivering a single point of access for Carers of all ages started. This is provided by the consortium Hillingdon Carers' Partnership and led by Hillingdon Carers;

- *Dementia Resource Centre* - Planning consent was given for Grassy Meadow Court extra care sheltered housing scheme in which will be located the Dementia Resource Centre. When open in 2018 this will provide support to people living with dementia and their Carers;

- *Dementia training* - The Alzheimer's Society was funded through the BCF to deliver *Introduction to Dementia* training to staff working in GP surgeries as well as the Council's contact centre and libraries.

9. The Board and HCCG Governing Body agreed a number of metrics as a means of measuring the success of the 2016/17 plan. These included the four national metrics mandated by NHS England (NHSE) and eight local measures referred to as relationship maturity metrics. Paragraph 3 of this report highlights that the projected outturn for two of the national metrics will be missed, e.g. emergency admissions reduction and DTOCs. For DTOCs the target will be missed by a considerable margin. Performance against targets for the other two national metrics, e.g. permanent admissions to care homes and the people still at home 91 days after discharge to reablement, are on track to be achieved.

10. The relationship maturity metrics are set out in **Appendix 1** (table 4) but the following are examples and reflect an intention to have in place by 31/03/17:

- The preferred integration option and procurement route for intermediate care services;
- The preferred integration option and procurement route for end of life services;
- The model of wrap-around services for care homes and supported living schemes.

11. Five of the eight relationship maturity metrics are showing slippage, which reflects the challenges with the delivery of the 2016/17 plan, e.g. that it requires partners to make decisions on more ambitious models of integration within the context of a very difficult financial situation and a highly complex local health and care system, as well as the need to navigate the governance processes of sovereign partner organisations. This was less of an issue with the 2015/16 plan as this largely reflected work that was already in progress and for which business cases had been agreed. In addition, the ambition for 2015/16 was limited as it was the first plan and partners agreed to minimise risk.

12. In conclusion, although this report highlights some of the evident achievements in 2016/17, it is has been more of a positional year that has enabled relationships to develop to create the opportunity for greater integration to deliver the objectives within the STP and better outcomes for residents from 2017/18. This is subject to agreement on the level of ambition by the Board and HCCG Governing Body. The suggested priorities for the 2017/19 BCF Plan are set out in a separate report on the agenda for the Board's March meeting.

13. The Board may also wish to note that the joint work between partners has helped to prevent demand on Hillingdon Hospital being much greater than that experienced during the review

period. For example, in the period April to December 2016 there has been a 7% increase in the number of attendances at the Hospital of people aged 65 and over compared to the same period in 2015/16 but a 4% drop in admissions. The key issue that has not been addressed is the 24% increase in bed days during this period and this is reflected in the suggested priorities for the 2017/19 BCF plan.

Financial Implications

14. The Quarter 3 performance report for the Better Care Fund shows a forecast net underspend for 2016/17 of £229k an increase of £25k from Quarter 2 arising from a favourable movement on the budget for community equipment for both organisations of £153k. The demand management work undertaken during the last financial year and continuing into this year to manage the community equipment budget is now delivering an improved financial outcome. There are a number of minor movements within the LBH - Protecting Social Care funding due increased demand on placement budgets offset by staffing underspends mainly within the Reablement Service.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

15. The monitoring of the BCF ensures effective governance of delivery via the Health and Wellbeing Board.

Consultation Carried Out or Required

16. The 2015/16 BCF Plan was developed with key stakeholders in the health and social care sector and through engagement with residents and the 2016/17 plan represents a logical progression of that plan and an extension in some areas, e.g. care home and home care market development. Hillingdon Hospital, CNWL and H4All have been consulted in the drafting of this report.

Policy Overview Committee Comments

17. None at this stage.

CORPORATE IMPLICATIONS

Corporate Finance Comments

18. Corporate Finance has reviewed the report and notes the financial position as set out in the financial implications above.

Hillingdon Council Legal Comments

19. 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.

Appendix 1

BCF Monitoring Report

Programme: Hillingdon Better Care Fund	
Date: March 2017	**Period covered:** Oct - Dec 2016 - Month 7 - 9
Core Group Sponsors: Caroline Morison/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 the Council's Cabinet/HCCG Governing Body.

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

A. Financials

Key components of BCF Pooled Fund 2016/17 (Revenue Funding unless classified as Capital)	Approved Pooled Budget	Forecast Outturn	Variance as at Month 9	Variance as at Month 6	Movement from Month 6
	£000's	£000's	£000's	£000's	£000's
HCCG Commissioned Services funding	11,965	11,854	(110)	(100)	(10)
LBH - Protecting Social Care Funding	7,109	6,989	(119)	(104)	(15)
LBH - Protecting Social Care Capital Funding	3,457	3,457	0	0	0
Overall BCF Total funding	**22,531**	**22,301**	**(229)**	**(204)**	**(25)**

1.1 The financial position at Quarter 3 for the BCF shows a forecast underspend of £229k, increasing from £204k at Quarter 2, mainly due to unfilled vacancies within the Council's Reablement team continued efficiencies with the provision of community equipment offset by pressures arising from the increased cost of placements.

B. Outcomes for Residents: Performance Metrics

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

1.3 **Emergency admissions target (known as non-elective admissions)** - In Q3 there were 2,478 emergency (also known as non-elective) admissions to hospital of people aged 65 and over, which is above the ceiling for the quarter of 2,432. 1,829 of the admissions (nearly 74%) were to Hillingdon Hospital. Although activity is above the ceiling for the quarter it is marginally lower than the same period in 2015/16 when there were 2,560 emergency admissions.

1.4 **Delayed transfers of care (DTOCS) -** There were 2,122 delayed days during Q3, which was above the ceiling of 1,350. The Q3 2016/17 position represents a significant increase on the same period in 2015/16 when the outturn was 1,369 delayed days.

1.5 If activity during Q1 and 3 continues at the same level during the remainder of 2016/17 then the projected outturn for the year could be 7,983 against a ceiling of 4,117.

1.6 Table 2 provides a breakdown of the delayed days during Q3 2016/17.

Table 2: Q1 - 3 DTOC Breakdown			
Delay Source	**Acute**	**Non-acute**	**Total**
NHS	2,271	1,794	4,065
Social Care	773	558	1,331
Both NHS & Social Care	12	579	591
Total	**3,056**	**2,931**	**5,987**

1.7 65% (1,366) of the delayed days concerned people with mental health needs in non-acute beds and of these nearly 52% (703) arose due to difficulties in securing suitable placements. Nearly 99% (1,346) of the non-acute delayed days concerned people in beds provided by CNWL.

1.8 Nearly 59% (3,862) of all delayed days during the period Q1 to Q2 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.

1.9 Table 3 shows the breakdown of delayed days by NHS trust for the Q1 to Q3 period.

Table 3: Distribution of Delayed Days by NHS Trust

Trust	Number of Delayed Days (Q1-3)
Bucks Healthcare	26
Chelsea & Westminster	1
CNWL	2,749
Hillingdon Hospitals	2,178
Imperial College, London	55
Luton & Dunstable	11
North West London (Northwick Park and Ealing)	513
Royal Brompton and Harefield	31
Royal Orthopaedic Hospital	24
United Lincolnshire Hospitals	25
University College	24
West Hertfordshire (Watford General)	261
West London Mental Health Trust	88
TOTAL	**5,987**

1.10 **Care home admission target** - During Q3 there were 40 permanent placements into care homes (24 nursing homes and 16 residential homes) against a ceiling of 37, which means that the level of activity was marginally above the ceiling. On a straight line projection, activity from Q1 to Q3 would suggest an outturn for 2016/17 of 145 permanent placements against a ceiling of 150.

1.11 It should be noted that the new permanent admissions figure in paragraph 1.12 above is a gross figure that does not reflect the fact that there were 50 people who were in permanent care home placements also left during the period 1st October 2016 to 31st December 2016. As a result, at the end of Q3 there were 456 older people permanently living in care homes (220 in residential care and 236 in nursing care). This figure also includes people who reached their sixty-fifth birthday in Q3 and were, therefore, counted as older people.

1.12 **Percentage of people aged 65 and over still at home 91 days after discharge from hospital to reablement** - Of the 132 people discharged from hospital to Reablement in Q2 2016/17, 94.2% (126) were still at home 91 days later, i.e. in Q3 2016/17. Of the 8 people who

were not at home at the end of the 91 day period 5 people passed away and 3 were readmitted. The reporting period for the national metric that is used for national comparison purposes is Q3 and for these residents their 91 period will be completed in Q4. This information will be reported in the 2016/17 outturn performance report to the Board at its June 2017 meeting.

C. Relationship Maturity Metrics

1.13 Eight metrics were agreed by both the Health and Wellbeing Board and HCCG's Governing Body as proxy measures for the success of the 2016/17 BCF plan in developing the working relationship between the Council and the CCG. Table 4 below provides a progress update on these metrics.

Table 4: Relationship Maturity Metrics Update

	Metric	RAG Status
1.	The preferred integration option and procurement route for intermediate care services.	**Slippage (Amber)** - The delivery of the closer integration of intermediate care services is reflected in the proposals for the 2017/19 BCF plan.
2.	The preferred integration option and procurement route for end of life services.	**Slippage (Amber) -** The delivery of the closer integration of end of life services is reflected in the proposals for the 2017/19 BCF plan.
3.	The integrated brokerage and contracting model for nursing care home placements.	**Slippage (Amber)** - Approval for revised proposals that will include nursing home placements, bed-based short-term respite, homecare as well as an expansion of Personal Health Budgets (PHBs) was approved in Q3 and will be implemented in 2017/18.
4.	The model of wrap-around services for care homes and supported living schemes.	**Slippage (Amber)** – Proposal being developed for additional input from GP primary care for agreement and proposed implementation in 2017/18. This will be in addition to new care of the care of the elderly consultant and care connection teams already agreed and currently being implemented.
5.	An integrated approach to home care market development and management.	**On track (Green) -** HCCG approval for the development of an integrated model as part of 2017/19 BCF is being sought.
6.	An integrated outcomes framework for older people.	**On track (Green)** - A draft framework is being consulted on in Q4.
7.	An agreed understanding of the impact for health of the reduction by the Council in the use of residential care.	**Slippage (Amber)** - A health impact assessment (HIA) is in development following a stakeholder workshop and will be finalised in Q4.
8.	The risk and benefits share arrangements following a shadow arrangement in 2016/17.	**On track (Green)** - This will developed as part of the process of developing the 2017 - 2019 BCF plan.

2. Scheme Delivery

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

Scheme 1 Funding	**Approved Budget**	**Forecast Outturn**	**Variance as at Month 9**	**Variance as at Month 6**	**Movement from Month 6**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
LBH - Protecting Social Care	657	657	0	2	(2)
HCCG Commissioned Services funding	390	390	0	0	0
Total Scheme 1	**1,047**	**1,047**	**0**	**0**	**0**

Scheme Financials

2.1 The forecast outturn is on track with the budget.

Scheme Delivery

2.2 *Connect to Support* - From 1st October to 31st December 2016, 3,576 individuals accessed Connect to Support and completed 4,975 sessions reviewing the information & advice pages and/or details of available services and support. This represents an increase of 2,286 people and 3,037 sessions on the same period in 2015/16.

2.3 During Q3, 21 people completed online social care assessments and 7 were by people completing it for themselves and 14 by Carers or professionals completing on behalf of another person. 10 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. There have been 9 self-assessments undertaken by Carers in Q3.

2.4 *H4All Wellbeing Service* - With a staff complement comprising of 8 Wellbeing Support Officers, 1 Triage Officer, 1 Community Development Officer and 1 Service Manager, the Wellbeing Service has supported 1,099 residents in the period 1st April to 31st January 2017 by dealing with 2,729 enquiries resulting in 11,675 contacts with or for Hillingdon residents. The service provides older residents in Hillingdon with:

- Information and advice
- Home visits
- Practical support, e.g. welfare benefits advice, falls prevention advice, counselling, home help, transport.
- Individual motivational interviewing, goal setting and ongoing support to enable them to manage their long-term conditions.
- Befriending and mentoring
- Sign-posting and referral to voluntary or statutory sector services
- Input into care plans and care planning.

2.5 The Wellbeing Service has been using the Patient Activation Measure (PAM) tool for identifying the extent to which people are motivated to manage their own health and wellbeing. Under a PAM assessment a person is asked to complete a short survey and based on their responses, they receive a PAM score (between 0 and 100). The resulting score places the person at one of four levels of activation, level 1 showing the least motivation and requiring the most intervention and level 4 the highest level and therefore potentially requiring no more than sign-posting. People who are more motivated are significantly more likely to attend screenings, check-ups and immunisations, to adopt positive behaviours (e.g., diet and exercise), and have clinical indicators in the normal range (body mass index, blood sugar levels, blood pressure and cholesterol). During the Q1 to Q3 period 576 PAM assessments were undertaken, including 153 second assessments and 9 third assessments. In nearly 69% (111) of cases there was an improvement in their scoring, which suggested that they were better equipped to manage their long-term condition. The remaining 51 people experienced either no change or a reduction in their score.

2.6 *Falls-related Admissions* - There were 190 falls-related admissions during Q3 against a ceiling of 180 for the quarter. The projected outturn of 806 admissions would exceed the ceiling for 2016/17 of 720 but would be similar to 2015/16 activity.

Scheme Risks/Issues

2.7 This scheme is RAG-rated amber for service delivery due to delays in implementing the Atrial Fibrillation (AF) pilot in 12 community pharmacies across Hillingdon. AF is a major cause of stroke and increasing early detection will assist in preventing occurrences of stroke that are avoidable. This equipment has now been purchased and distribution to community pharmacies will take place in Q4.

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

Scheme 2 Funding	**Approved Budget**	**Forecast Outturn**	**Variance as at Month 9**	**Variance as at Month 6**	**Movement from Month 6**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
LBH - Protecting Social Care	50	51	1	0	1
HCCG Commissioned Services funding	106	106	0	0	0
Total Scheme 2	**156**	**157**	**1**	**0**	**1**

Scheme Financials

2.9 There is a minor variance on the provision of services by Harlington Hospice.

Scheme Delivery

2.10 An action in the 2016/17 BCF plan was to commission an integrated specialist end of life care at home service. This had been delayed pending the outcome of the bid for external

funding to develop an integrated end of life service in Hillingdon. The results of the bid process are still awaited. Options for delivering the specialist care at home service are now reflected in proposals for 2017/19 BCF plan.

Scheme Risks/Issues

2.11 This scheme is RAG-rated as amber for scheme delivery for the reasons outlined in paragraph 2.10 above.

Scheme 3: Rapid response and integrated intermediate care.	**Scheme RAG Rating**	**Red**
	a) Finance	**Amber**
	b) Scheme Delivery	**Red**

Scheme 3 Funding	**Approved Budget**	**Forecast Outturn**	**Variance as at Month 9**	**Variance as at Month 6**	**Movement from Month 6**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding	5,347	5,347	0	0	0
LBH - Protecting Social Care funding	2,920	2,728	(191)	(63)	(128)
Total Scheme 3	**8,267**	**8,075**	**(191)**	**(63)**	**(128)**

Scheme Financials

2.12 The forecast is line with HCCG contracted spend. For LBH, there has been a reduction in the financial pressure on spot purchase of intermediate care beds and further underspends in the Reablement team due to staff vacancies.

Scheme Delivery

2.13 During Q3 the Reablement Team received 196 referrals and of these 137 were from hospitals, primarily Hillingdon Hospital and the other 59 were from the community. The community referrals represented potential hospital attendances and admissions that were consequently avoided. During this period, 295 people completed their period of reablement with no on-going social care needs, which represents 84.8% of the people new to social care referred to the service. This is against a target of 85%.

2.14 In Q3 the Rapid Response Team received 1052 referrals, 60% (632) of which came from Hillingdon Hospital, 20% (206) from GPs, 10% (105) from community services such as District Nursing and the remaining 10% (109) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 632 referrals received from Hillingdon Hospital, 468 (74%) were discharged with Rapid Response input, 150 (24%) following assessment were not medically cleared for discharge and 14 (2%) were either out of area or inappropriate referrals. All 420 people referred from the community source received input from the Rapid Response Team.

2.15 The Council's Hospital Discharge Team supported the early discharge of 275 people from Hillingdon Hospital in the period from Q1 to Q3. 'Early discharge' means that people were identified and supported into alternative care settings before the Estimated Date of Discharge (EDD). This equates to 525 bed days avoided, thereby assisting the Hospital with patient flow.

2.16 Other actions relevant to the delivery of this scheme are addressed within the Hospital Discharge Action referred to in table 5 below that also incorporates the Out of Hospital Seven Day Working Standard Action Plan.

Table 5: Hospital Discharge Action Plan Update

Task	Update	RAG Rating
1. Complete development of a joint discharge policy and procedure.	A draft setting out roles and responsibilities of partners has been completed. This will be finalised in Q4 for sign-off by partner organisations early in 2017/18.	**Amber**
2. Develop information for patients.	A £5k grant has been awarded by NHSE under the BCF Small Grants Programme to fund production of revised patient information. A multi-agency task and finish group is working on this.	**Green**
3. Establish electronic transfer of assessment, discharge notices, withdrawal and change of circumstances notices.	A funding bid has been approved that will enable this action to be implemented in Q4, subject to transfer of funds to the Council.	**Amber**
4. Develop a consistent approach to discharge planning across all THH wards.	The Hospital has recruited 9 Patient Flow Coordinators who will be allocated specific wards with the intention of ensuring consistency in the discharge process across the Hospital. The Hospital is also receiving support under the NHS Improvement's Emergency Care Improvement Programme to implement actions that will assist patients to be discharged at the earliest opportunity. Measures will not be fully implemented in 2016/17.	**Red**
5. Embed earlier referrals to Hospital transport		
6. Ensure that patient medication is available by midday on the day of discharge.		
7. Ensure the availability of sufficient capacity for timely Continuing Healthcare assessments to be undertaken.	Discharge to assess pilot includes additional CHC nurse assessor capacity to better meet demand. This will be operational in Q4.	**Amber**
8. Secure accommodation on main THH site for Adult Social Care Hospital Discharge Team.	Following intervention of the Hospital's CEO options are under consideration for delivery in Q1 2017/18.	**Amber**

Scheme Risks/Issues

2.17 This scheme is RAG rated as red because of the DTOC performance and the delay in the delivery of actions within the Hospital Discharge Action Plan and also the extent of the underspend.

2.18 The action plan is overseen by a task and finish group called the Joint Hospital Discharge Pathway Group. With the support of the A & E Delivery Board that is jointly chaired by the Chief Executive of the Brent, Harrow and Hillingdon CCGs and the Chief Executive of Hillingdon Hospital and with executive representation from other health and care partners (including Adult Social Care), the ownership for the delivery of the actions within the plan is being clarified. Partners identified as owners will be accountable to the A & E Delivery Board for task delivery with an escalation route to the Health and Wellbeing Board.

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

Scheme 4 Funding	**Approved Budget**	**Forecast Outturn**	**Variance as at Month 6**	**Variance as at Month 3**	**Movement from Month 3**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
LBH - Protecting Social Care funding	100	102	2	2	0
Total Scheme 4	**100**	**102**	**2**	**2**	**0**

Scheme Financials

2.19. There is a minor overspend forecast on seven day working which relates to Mental Health Workers.

Scheme Delivery

2.20 The actions within this scheme are now reflected in the Hospital Discharge Action Plan referred to in paragraph 2.16 above.

2.21 **Appendix 3** shows the comparison in discharge activity across the week at Hillingdon Hospital in Q3 from 2014/15 to 2016/17. From this it is possible to see that there was a 26% (137) increase in discharges on Saturdays compared to the same period in 2015/16 but a 3% (6) reduction in Sunday discharges. As in Q2, the increase in Saturday discharges was entirely attributable to an increase in discharges of people admitted for planned procedures. The number of people discharged on a Saturday who were admitted as emergencies declined by 12% (27). There was a 5% (8) reduction in discharges on Sundays.

2.22 **Appendix 3A** shows the comparison of discharges taking place before midday in Q3 from 2014/15 to 2016/17. It is possible to see from this information that activity is broadly the same as 2015/16, although there has been a 5.4% increase in the number of discharges taking place on Saturdays before midday.

2.23 The conclusion from this data is that initiatives to improve patient flow through the Hospital and produce a more even distribution of discharges across the week are starting to have an impact in respect of people admitted for planned procedures but there is as yet little impact in respect of people admitted as emergencies.

Risks/Issues

2.24 This scheme is RAG rated as amber due to slippage in the delivery of tasks reflected in the Hospital Discharge Action Plan.

Scheme 5: Integrated Community-based Care and Support	**Scheme RAG Rating**	**Green**
	a) Finance	**Green**
	b) Scheme Delivery	**Green**

Scheme 5 Funding	**Approved Budget**	**Forecast Outturn**	**Variance as at Month 9**	**Variance as at Month 6**	**Movement from Month 6**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding	6,021	5,910	(110)	(100)	(10)
LBH - Protecting Social Care funding	5.405	5,584	179	12	167
Total Scheme 5	**11,426**	**11,495**	**69**	**(88)**	**157**

Scheme Financials

2.25 Both HCCG and LBH are currently showing an underspend for the 3rd Qtr due to lower forecast expenditure of £153k than budgeted for Community Equipment, which results from the success of the joint work carried out between the partners to manage the demand on this budget. The forecast includes a pressure of £236k for Older People placements. For LBH, this scheme also includes the capital funding grant for Disabled Facilities, which is currently forecast to be fully spent.

Scheme Delivery

2.26 The tender for an integrated community equipment contract to provide aids of daily living to support people in their own homes and expedite the hospital discharge process was undertaken. Hillingdon was part of the London Community Equipment Consortium comprising of 17 London boroughs and CCGs, which was led by the London Borough of Hammersmith and Fulham. The Council is the lead for this contract locally and approval for an award of contract will be sought from the Council's Cabinet in Q4.

2.27 In Q3 2016/17 31 people aged 60 and over were assisted to stay in their own home through the provision of disabled facilities grants (DFG's), which represented 55% of the grants provided.

2.28 30% (17) of the people receiving DFG's were owner occupiers, 62% (35) were housing association tenants, and 7% (4) were private tenants.

Scheme 6: Care Home and Supported Living Market Development	Scheme RAG Rating	Amber
	a) Finance	Green
	b) Scheme Delivery	Amber

Scheme 6 Funding	Approved Budget	Forecast Outturn	Variance as at Month 9	Variance as at Month 6	Movement from Month 6
	£000's	£000's	£000's	£000's	£000's
LBH - Protecting Social Care	150	143	(7)	(7)	0
HCCG Commissioned Services funding (including non elective performance fund)	83	83	0	0	0
Total Scheme 6	**233**	**226**	**(7)**	**(7)**	**0**

Scheme Financials

2.29 There is forecast to be a minor staffing underspend on this budget for LBH.

Scheme Delivery

2.30 *Emergency admissions from care homes* - There were 401 emergency admissions from care homes from Q1 to Q3 2016/17. This represents a 22% reduction from 514 admissions in the same period in 2015/16 and would suggest an outturn for 2016/17 of 535 emergency admissions, which compares to 650 in 2015/6. This suggests that initiatives to reduce emergency admissions from care homes are having a positive impact. However, it should be noted that this data does not reflect the impact on Hillingdon Hospital of attendances and admissions of people living in care homes in the borough with non-Hillingdon GPs and also from care homes from outside of the borough.

Risks/Issues

2.31 This scheme has been RAG rated amber because of slippage in a number of pieces of work including the modelling of care home requirements to 2020 and beyond and the development of a related market position statement to give the market advanced warning of Hillingdon's requirements. A workshop is taking place in March that will enable this work to be delivered in 2017/18.

Scheme 7: Supporting Carers	Scheme RAG Rating	Green
	a) Finance	Green
	b) Scheme Delivery	Green

Scheme 7 Funding	Approved Budget	Forecast Outturn	Variance as at Month 9	Variance as at Month 6	Movement from Month 6
	£000's	£000's	£000's	£000's	£000's
LBH - Protecting Social Care	899	851	(48)	(28)	(20)
HCCG Commissioned Services funding	18	18	0	0	0
Total Scheme 7	**917**	**869**	**(48)**	**(28)**	**(20)**

Scheme Financials

2.32 For LBH, there is forecast to be a pressure on respite services to Carers due to increased placements cost being charged by providers which is offset by a reduction in the cost of carers' assessments.

Scheme Delivery

2.33 159 Carer's assessments were completed in Q3. This is made up of 27 sole assessments completed by Hillingdon Carers, 9 sole assessments completed by LBH and 123 joint assessments completed by LBH. It is projected Carers' assessment outturn for 2016/17 is 538, which reflects full assessments and not triage assessments that have been undertaken by Hillingdon Carers that have not proceeded to full assessments.

2.34 During Q3 178 Carers were provided with respite or another carer service at a cost of £376k. This compares to 118 Carers being supported at a cost of £358k in Q3 2015/16.

2.35 In Q2 the Carers in Hillingdon contract started provided by the Hillingdon Carers Partnership and led by Hillingdon Carers. This new contract creates a single point of access for Carers. Some key outputs and outcomes from the first quarter of the operation of the contract are:

- 352 new adults Carers registered with Hillingdon Carers.
- 31 new Carers of people living with dementia were identified
- 24 new young Carers also registered.
- 2,335 volunteer hours providing extra support and capacity.
- 504 respite breaks were provided to 278 adult Carers
- 728 breaks were provided through social clubs to young Carers.
- £121,486 in new grants were secured, e.g. funded second Dementia Support Worker employed by the Alzheimer's Society.

Scheme 8: Living Well with Dementia	Scheme RAG Rating	Green
	a) Finance	Green
	b) Scheme Delivery	Green

Scheme 8 Funding	Approved Budget	Forecast Outturn	Variance as at Month 9	Variance as at Month 6	Movement from Month 6
	£000's	£000's	£000's	£000's	£000's
LBH - Protecting Social Care	305	249	(56)	(38)	(18)
Total Scheme 7	**305**	**249**	**(56)**	**(38)**	**(18)**

Scheme Financials

2.36 This budget reflects the cost of providing the Wren Centre, which is currently forecasting an underspend of £56k.

Scheme Delivery

2.37 No update.

BCF Programme Management Costs

	Approved Budget	Forecast Outturn	Variance as at Month 9	Variance as at Month 6	Movement from Month 6
	£000's	£000's	£000's	£000's	£000's
BCF Programme Management	80	81	1	1	0
Total	**80**	**81**	**1**	**1**	**0**

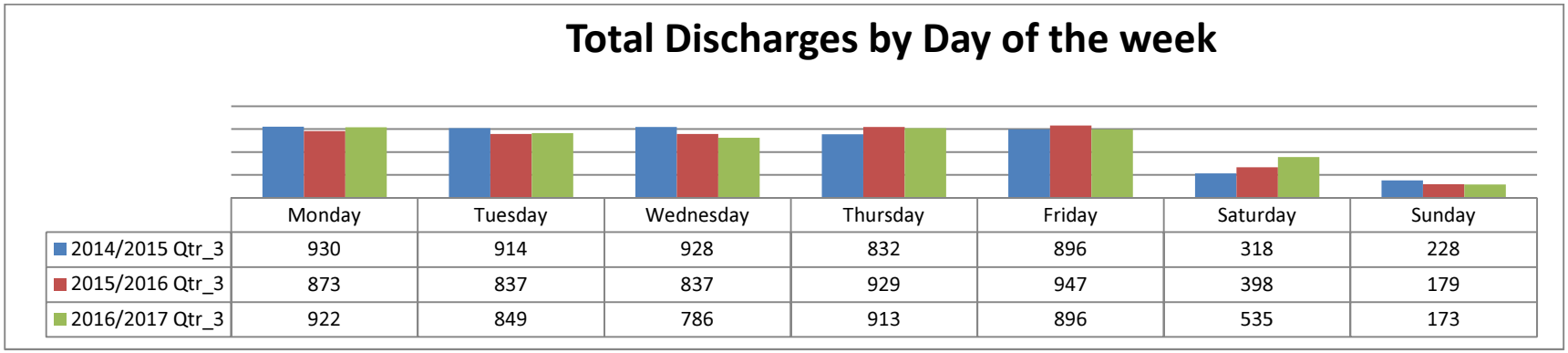
3. Key Risks or Issues

IT Interoperability

3.1 *North West London Information Sharing Agreement (NWLISA)* - The Council has yet to sign the NWLISA, which all local health providers, including GPs, and the H4All consortium have signed up to. Once some queries raised by the Council's Legal Team have been resolved the Council should be in a position to become a signatory. The target is to have this matter resolved by the end of 2016/17.

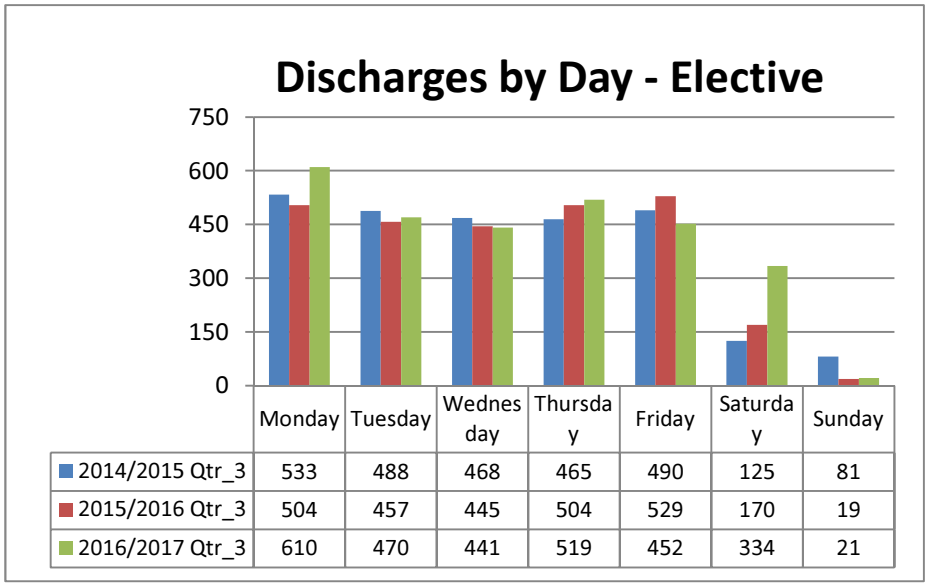
3.2 *DTOC Fines* - Under the 2014 Care Act the Hillingdon Hospital has the power to fine the Council for delayed transfers of care that are the responsibility of Adult Social Care. In most areas there is recognition that this is counter-productive and just reduces the funding available to support the social care needs of residents at a time of increasing pressure on social care budgets. In the spirit of partnership and in recognition of the support that Adult Social Care is providing and will continue to provide to the Hospital in expedite discharge, the Council and the Hospital are establishing a formal no fine agreement.

Total Discharges by Day of the Week Oct - Dec 2014/15 to 2016/17



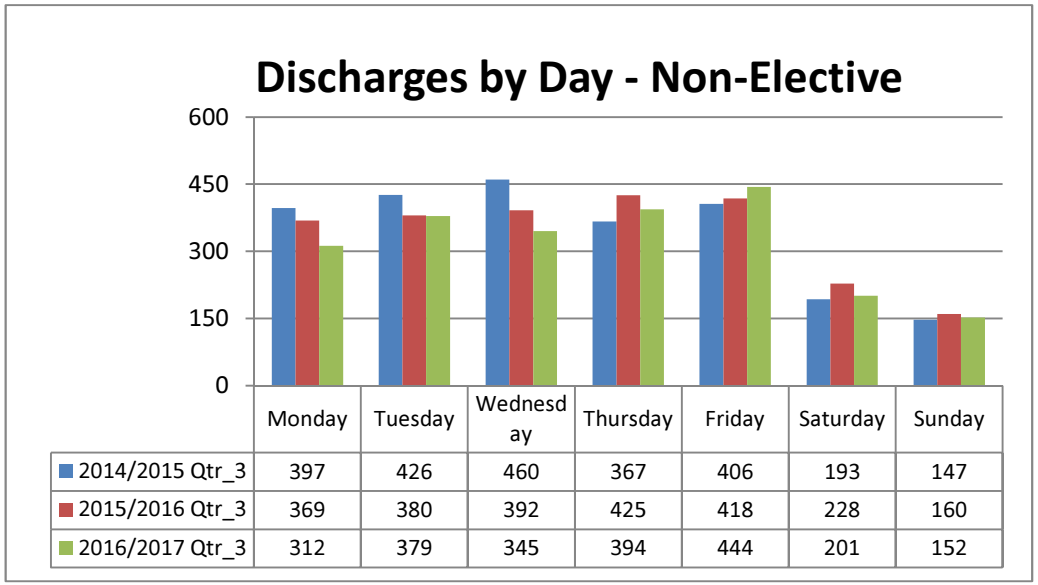
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_3	930	914	928	832	896	318	228
2015/2016 Qtr_3	873	837	837	929	947	398	179
2016/2017 Qtr_3	922	849	786	913	896	535	173

Discharges following Planned Admissions



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_3	533	488	468	465	490	125	81
2015/2016 Qtr_3	504	457	445	504	529	170	19
2016/2017 Qtr_3	610	470	441	519	452	334	21

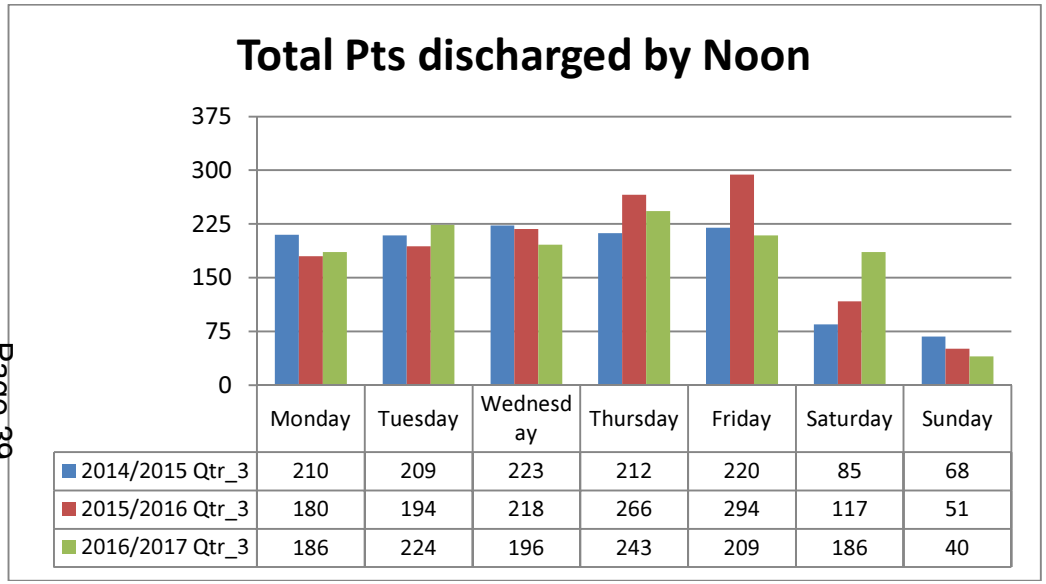
Discharges Following Unplanned Admissions



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_3	397	426	460	367	406	193	147
2015/2016 Qtr_3	369	380	392	425	418	228	160
2016/2017 Qtr_3	312	379	345	394	444	201	152

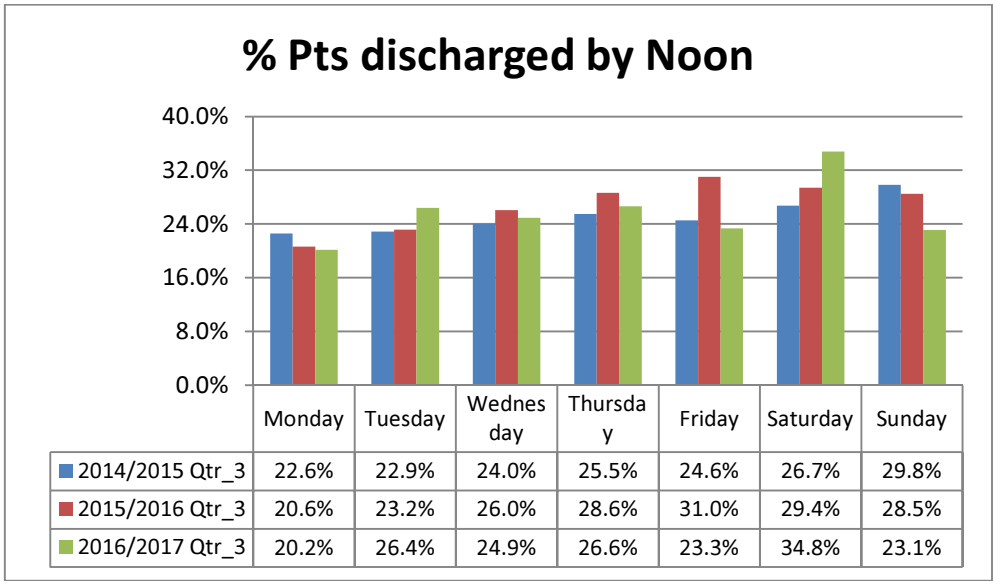
Discharges Taking Place before Midday July - September 2014/15 to 2016/17

Number of Patients Discharged Before Midday



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_3	210	209	223	212	220	85	68
2015/2016 Qtr_3	180	194	218	266	294	117	51
2016/2017 Qtr_3	186	224	196	243	209	186	40

% of Patients Discharged Before Midday



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_3	22.6%	22.9%	24.0%	25.5%	24.6%	26.7%	29.8%
2015/2016 Qtr_3	20.6%	23.2%	26.0%	28.6%	31.0%	29.4%	28.5%
2016/2017 Qtr_3	20.2%	26.4%	24.9%	26.6%	23.3%	34.8%	23.1%

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BETTER CARE FUND PLAN 2017-2019: PROPOSED PRIORITIES

Relevant Board Member(s)	Councillor Philip Corthorne Dr Ian Goodman
Organisation	London Borough of Hillingdon
Report author	Tony Zaman, Adult Social Care Kevin Byrne, Policy and Partnerships Caroline Morison, HCCG
Papers with report	Appendix 1 - Proposed 2017-18 BCF Plan Priorities Expanded.

HEADLINE INFORMATION

Summary	This report proposes the priorities for the next iteration of the Better Care Fund Plan that will cover the period 2017-19. The report identifies suggested actions intended to deliver the priorities. It also highlights some of the decisions that the Board may be asked to consider.
Contribution to plans and strategies	The Better Care Fund will contribute to the delivery of Hillingdon's Sustainability and Transformation Plan, which forms the basis of the statutory Health and Wellbeing Strategy.
Financial Cost	The pooled BCF Funds totalled £22,531k in 2016/17.
Ward(s) affected	All

RECOMMENDATIONS

That the Health and Wellbeing Board instructs officers to:

a) complete the development of priorities and associated actions described in Appendix 1; and

b) bring a completed draft plan that complies with NHSE guidance back to the June Board meeting for consideration.

INFORMATION

Context: Sustainability and Transformation Plan (STP)

1. The BCF plan is being developed within the context of the five-year STP, the Hillingdon Chapter of which the Board noted at its September meeting. The STP has been developed with the intention of transforming the local health and care landscape in order to address the projected funding gap of at least £120m (excluding children's social care) that is likely to be experienced between 2016 and 2021. This report is proposing to the Board what the contribution of the next iteration of the BCF plan to the implementation of the delivery areas within the STP plan might look like. The five STP delivery areas are:

- DA1 - Radically upgrading prevention and wellbeing.

- DA2 - Eliminating unwarranted variation and improving LTC management.
- DA3 - Achieving better outcomes and experiences for older people.
- DA4 - Improving outcomes for children and adults with mental health needs.
- DA5 - Ensuring we have safe, high quality, sustainable acute services.

Context: Two-year BCF Plan Requirement

2. The development of a further, two-year BCF plan is an NHSE requirement deriving from the 2015 Autumn Statement. At the time of drafting, the policy framework and statutory guidance for the two year plan had not been published. However, some details from the draft guidance have been released by NHSE pending final approval by ministers. The key points are summarised below.

3. *National Conditions* - The national conditions have reduced from eight to three and are:
   a) A jointly agreed plan, e.g. signed-off by the HWB, and a section 75 (s.75) agreement (National Health Service Act, 2006) that gives legal force to the financial and other arrangements contained within the plan also signed-off.
   b) Maintenance of social care funding.
   c) A ring-fenced amount for use on NHS commissioned out of hospital services.

4. *Narrative Plan Requirements* - A narrative plan will need to be submitted that includes:
a) An overall **vision for health and social care**, including the model for integration and how the plan will move services towards a more community-based, preventative approach.
b) A **coordinated and integrated plan of action** for delivering the vision, supported by evidence.
c) A clear articulation of how the plan will meet each **national condition**.
d) An agreed approach to **risk management**, including financial risk management and, where relevant, risk sharing and contingency.

5. *National Metrics* - The four metrics from 2016/17 will roll forward and these are:
a) Emergency (non-elective) admissions.
b) Permanent admissions to residential care homes.
c) Effectiveness of reablement.
d) Delayed transfers of care (DToCs).

6. *Planning Template* - As with the 2016/17 plan, a planning template will need to be submitted that includes:
a) Details of funding contributions.
b) The spending plan over the period of the plan.
c) The four national metrics.

7. *Assurance Process* - The planning assurance process will include ensuring that plans include:
   a) Evaluation and review of schemes to ensure they represent best value for patients and for the local system.
   b) A description of how the BCF plan links with the wider STP priorities.
   c) A robust DToC action plan.

8. *Timescales* - Officers understand that, subject to ministerial approval, areas will have six weeks to submit the first draft of the plan once the guidance has been published and a further six weeks to submit the final plan following NHSE feedback. It is understood that only the final plan will need the formal approval of the Board and HCCG Governing Body. It is expected that a timescale for sign-off of the s.75 agreement will be set by NHSE and Cabinet and Hillingdon Clinical Commissioning Group's (HCCG) Governing Body will be asked to approve the draft s.75 agreement in due course.

Development of Hillingdon's BCF Plans

9. An incremental approach has been taken so far in Hillingdon with the development of the BCF in order to minimise risk to both the Council and HCCG. The 2015/16 plan, which was the first BCF plan, reflected work that was largely already in progress and where business cases had been completed. The 2016/17 plan included some logical extensions of activity undertaken in 2015/16, e.g. extending the scheme on supporting Carers to all unpaid Carers; 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 was under the same governance structure; and extending the scope of the plan to include new types of activities of strategic significance to both organisations, e.g. dementia.

10. A separate report on the Board's agenda provides an update on the delivery of the 2016/17 plan and an assessment of its impact.

11. In developing proposals for the 2017/19 plan officers have been mindful of the mandate given by the Board's June 2016 meeting and also HCCG's July 2016 Governing Body meeting for the plan to reflect greater ambition. The key themes for the new plan are:

- Taking costs out of health and care system
- Supporting care market sustainability
- Jointly managing growth.

12. Table 1 below sets out the proposed priorities for the plan and identifies the linkage with the relevant STP delivery area. **Appendix 1** summarises some of the key proposed actions intended to deliver on the priorities over the period of the plan. It also identifies some of the implications, e.g. some of the decisions that the Board, Cabinet and HCCG's Governing Body may be asked to consider as a result.

Table 1: Proposed Priorities BCF Plan 2017-19

STP Delivery Area	Priority
1	*Scheme 1*: Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation. *Scheme 2*: An integrated approach to supporting Carers.
3	*Scheme 3*: Better care at end of life. *Scheme 4*: Improving hospital discharge. *Scheme 5*: Improving care market management and development. *Scheme 6*: Living well with dementia.
4	*Scheme 7*: Delivering the Like Minded Programme. *Scheme 8*: Delivering an integrated Children and Adolescent Mental Health Service (CAMHS) pathway. *Scheme 9*: Developing integrated services for children and young people.

13. The Board may wish to note the following points in respect of **Appendix 1**:

a) *Benefits for residents* - The key benefits for residents from integration arise out of circumstances where a) there is a seamless transition in service provision regardless of whether need is primarily health or social care related and b) where there is timely access to service provision to address need. The schemes focussed on end of life care (*scheme 2*), hospital discharge (*scheme 3*) and care market management and development (*scheme 4*) are intended to contribute to these objectives.

b) *Lead organisation arrangements* - Up to this point there has been no change in lead organisation and procurement and contracting arrangements. To deliver a more ambitious plan that enables the Council and HCCG to realise the benefits of integration, as well as to improve outcomes for residents, this is the logical next step. Most of the schemes in **Appendix 1** contain an element of this that it is proposed will be implemented over the life-time of the plan or where the ground work will be set up to enable it to be implemented in the period up to 2020.

c) *Financial contributions to the BCF pooled budget* - The 2016/17 BCF pooled budget included additional contributions from both the Council and HCCG. With the exception of community equipment, which demonstrates the key benefits of a pooled budget (see paragraph 11a above), this was largely symbolic. What is proposed for 2017/19 is a greater focus on what will actually make a difference and represents a greater ambition and a pragmatically incrementally approach to enable the Council and HCCG to manage the inherent risks arising from the complexity of the current health and care landscape, which is unlikely to get any less complex in the foreseeable future.

d) *Accountable Care Partnership (ACP)* - The December 2016 Board meeting considered a report about the ACP, which is the vehicle being established at the behest of HCCG to deliver more integrated care for older people. An option for consideration during the period of the next BCF plan is for the Council's social care budget for older people to be included within the ACP capitated budget. This would, theoretically, enable the ACP to achieve greater efficiencies to deliver broader health and care outcomes and contribute to meeting the £120m 2021 funding gaps referred to in paragraph 1. The extent of the ACP's development at this stage makes this too great a risk for 2017/18; however, similar outcomes can probably be achieved by much closer involvement of Adult Social Care in the ACP's development, e.g. ex officio membership at ACP Board and Executive level, as well as direct involvement in the redesign of clinical services.

e) *NWL/WLA Business Cases* - Hillingdon is unique in North West London for having a largely self-contained health and care economy, e.g. a co-terminous local authority and CCG, a single acute hospital trust and a single community health and community mental NHS trust provider. This means that Hillingdon's interests are not necessarily the same as other boroughs/CCGs within the region. NHS North West London (NWL) working in conjunction with the West London Alliance (WLA) has developed a series of business cases intended with a view to accessing money from the Sustainability and Transformation Fund (STF). Officers are mindful of the need to keep a watching brief on these developments to ensure that Hillingdon is not disadvantaged, particularly where residents of the borough may benefit from Council/CCG involvement. There are some NWL initiatives that will potentially impact on Hillingdon that therefore require local engagement, e.g. Like Minded.

Post April 2019 Position

14. It is understood that in areas where there has been good progress towards achieving integration between health and social care NHSE may not require a further plan to be developed post April 2019. Details about what constitutes good progress and any other

conditions associated with this potential graduation from the requirement for the need for a further plan are awaited, although it is likely to include evidence of the activities shown in paragraph 12a above.

Governance

15. Consistent with the approach of seeing the STP and the BCF as being intertwined, officers are proposing a single governance structure. This is addressed in more detail in a separate report on the Board's agenda regarding the STP.

Financial Implications

16. For 2016/17, the pooled BCF funding totalled £22,531k an increase of £4,541k from the 2015/16 funding of £17,990k. This was made up of an inflation uplift of £915k and additional funding added to the pooled funds by both partners of £3,626k incorporating a range of additional services including an additional £1,108k for the Disabled Facilities Grant (DFG) Capital funding.

17. The minimum sum for protecting Adult Social Care was set at £5,937k with additional Council funding of £1,172k increasing its share of the pooled fund to £10,566k (including the DFG capital funding of £3,457k). The CCG funding was set at £11,965k with £4,705k funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share).

18. The minimum amount for the BCF for 2016/17 set by Central Government for Hillingdon was published as £20,015k. The agreed total amount for the BCF for 2016/17 was £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 was £2,516k and includes additional contributions from the Council of £1,172k and from CCG of £1,344k.

19. Table 5 below sets out each BCF scheme showing funding by each partner in 2016/17.

Table 5: Financial Contribution to Schemes by Partner 2016/17

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
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**

20. BCF allocations for 2017/18 will be announced alongside the Policy Framework and BCF Planning Guidance in the near future. However based upon 2016/17 allocations and contributions to the pool, the following table gives an indication of the impact of additional

contributions to the pooled based upon the draft priorities set out in Appendix 1 and developed in this paper. The key additional Council funding proposed in 2017/18 is the inclusion of current budgets for the brokerage team (£313k) and the provision of homecare to over 65's (£7,977k). There will be additional financial impacts in 2018/19 which are still to be quantified.

Table 6: London Borough of Hillingdon indicative financial contributions to proposed Schemes in the pooled funding for BCF 2017/18

Scheme	Funding LBH £000's 2016/17	Indicative additional Funding LBH £000's 2017/18	Total Indicative Pooled Budget £000's 2017/18
Scheme 1: Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.	657		657
Scheme 2: Integrated approach to supporting Carers.	899		899
Better care for people at the end of their life.	50		50
Scheme 3: Improving Hospital Discharge.	8,410		8,410
Scheme 4: Improving care market management and development.	165	8,290	8,455
Scheme 5: Living with Dementia	305		305
Scheme 6: Delivering the like minded programme.	0		0
Scheme 7: Delivering CAMH's pathway	0		0
Scheme 8. Delivering integrated services for children and Young	0		0
Programme Management.	80		80
Total	**10,566**	**8,290**	**18,856**

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

21. The recommendation will enable a Hillingdon BCF plan to be submitted in accordance with national guidance. The BCF plan will contribute to the delivery of Hillingdon's Sustainability and Transformation plan that will support an affordable local health and care system.

Consultation Carried Out or Required

22. There will be consultation with stakeholders on the content of the proposed plan, although its contents is going to be compatible with outcomes from consultation exercises with residents and other stakeholders that has taken place over the last three years.

Policy Overview Committee comments

23. None at this stage. Subject to Board approval, officers are proposing to consult with Social Services, Housing and Public Health Policy Overview Committee and External Services Scrutiny Committee on the proposed plan priorities.

CORPORATE IMPLICATIONS

Corporate Finance Comments

24. Corporate Finance has reviewed this report, confirming that the financial implications for the London Borough of Hillingdon arising from priorities and actions outlined within this report are consistent with assumptions included in the latest iteration of the Council's Medium Term Financial Forecast approved by Cabinet and Council in February 2017. The transfer of additional Council budgets into the Better Care Fund relates to integration of Homecare commissioning for Central Hillingdon, with this additional contribution continuing to be financed from locally raised Council Tax and existing revenue streams.

Hillingdon Council Legal Comments

25. 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.

26. Further legal advice will be given as necessary at the June meeting of the Board.

BACKGROUND PAPERS

North West London Sustainability and Transformation Plan: Hillingdon Chapter
NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (as amended)

Appendix 1

Proposed 2017-18 BCF Plan Priorities Expanded

STP Delivery Area	Priority and Supporting Actions	Decision Implications
	***Scheme 1*: Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.**	
1.	**Proposed Actions 2017/18** • Review the impact of the H4All Wellbeing Service and the model of investment in preventative third sector services for older people. **Proposed Actions 2018/19** • Implement the results of the review.	• The Council to consider inclusion of LBH voluntary sector (older people) spend within 17/18 pooled budget. • H4All could be commissioned to deliver a preventative service for older people on behalf of HCCG/LBH as part of its Wellbeing Service. • This would require a decision on lead organisation arrangements from 2018/19.
	***Scheme 2*: An integrated approach to supporting Carers.**	
1.	**Proposed Actions 2017/18** • Scope extension of Personal Health Budgets (PHBs) and integrated PHBs/Direct Payments (DPs) to Carers. • Undertake market engagement to ensure supply of services for Carers to spend PHBs or integrated budgets. • Map demand for bed-based respite. • Agree integrated model for ensuring availability of bed-based respite. **Proposed Actions 2018/19** • Deliver expanded PHB provision and introduce integrated PHBs/DPs. • Undertake procurement exercise to deliver agreed bed-based respite.	• HCCG will be asked to consider a business case regarding resource implications of extending PHBs to Carers. • HCCG agreement will be sought on lead arrangements for procuring bed-based respite.

	Scheme 3: Better care at end of life.	
3.	**<u>Proposed Actions 2017/18</u>** • Establish lead provider arrangements with constituent part of the ACP. • Establish palliative care at home service with a single provider as proof of concept or include within homecare tender. *See scheme 4*. • Determine and implement agreed procurement route for palliative care at home service. • **<u>Proposed Actions 2018/19</u>** • Implement outcome of preferred procurement route for palliative care at home service.	• The Council and CCG will be asked to agree lead organisation arrangements for end of life care. • Agreement will be asked from the Council and HCCG on lead procurement and contracting arrangements for the palliative care at home service, including whether this should be a separate service or included within the homecare tender. • The Council will be asked to include its palliative care at home budget within the pooled budget from 2017/18 in accordance with 2016/17 practice. • HCCG will be asked to consider inclusion of its CHC palliative care budget in the pooled budget from 2017/18.
	***Scheme 4*: Improving hospital discharge.**	
3.	**<u>Proposed Actions 2017/18</u>** • Co-located Reablement Team with Rapid Response. • Re-locate Adult Social Care Access Team to main Hospital site. • Scope home to assess model to eliminate bed-based step down by Sept 2019/20. • Establish short-term, e.g. 2 yrs, bed-based step-down provision with wrap-around support. **<u>Proposed Actions 2018/19</u>** • Establish single Intermediate Care Service with single point of access (SPA) and single management structure. • Structurally integrate Reablement into single Intermediate Care Service. • Establish home to assess as core service model.	• Approval for co-location of Reablement Team with Rapid Response. • Agreement on who leads on procurement and contracting of bed-based step-down provision. • The Council would need to agree a delegation of functions under s75 agreement to allow the structural integration of Reablement within an integrated Intermediate Care Service from 2018/19. • HCCG will be asked whether it wishes to contribute to intermediate care in extra care provision.

	***Scheme 5*: Improving care market management and development.**	
3.	***a) Integrated Brokerage*** **Proposed Actions 2017/18** • Establish joint utilisation of e-brokerage facility in Connect to Support. • Co-locate brokerage teams. • Expand scope to include self-funders. • Expand take-up of Personal Health Budgets (PHBs) and integrated budgets, e.g. combination of Direct Payments (DPs) and PHBS **Proposed Actions 2018/19** • Deliver structural integration of brokerage teams, subject to outcome of review of Yr1.	• HCCG approval will be sought on resource implications of co-location of teams. • Resourcing arrangements for extending brokerage to include self-funders will need to be agreed between the Council and HCCG. • Resourcing the expansion of PHBs will need to be agreed between the Council and HCCG. • Structural integration of brokerage teams with a Council lead would require delegation of function by the CCG to LBH and reflected in the s75 agreement.
	b) Integrated Homecare **Proposed Actions 2017/18** Tendered for an integrated, tiered service model for central Hillingdon for LBH and whole borough for NHS. **Proposed Actions 2018/19** • Tender remaining homecare contracts under Yr1.	• The Council and HCCG would need to agree lead organisation arrangements. • The Council and HCCG would need to agree management and monitoring arrangements for homecare contracts. • HCCG will be asked to agree the inclusion of CHC homecare budget within BCF pooled budget from 2017/18. • The Council will be asked to consider inclusion of all or part of its homecare budget in the pooled budget, e.g. just older people or all service users.
	c) Care Home Market Development **Proposed Actions 2017/18** • Develop and launch market position statement to advise the market of LBH/CCG supply requirements. • Seek approval for affordable option to meet residential dementia and nursing (inc. Dementia) need. • Develop integrated nursing care home specification. • Determine agreed procurement route. • Deliver a model of primary care, e.g. GP, support for care	• The lead organisation will need to be agreed. • There will need to be agreement on the delivery route for affordable care home capacity option, e.g. LBH, LBH/HCCG, ACP or public/private partnership. • HCCG will be asked to consider inclusion of their older people's placement budget in the BCF pooled fund. • The Council will be asked to consider inclusion of its older people's placement budget in the BCF pooled fund.

3.	homes. • Explore development of career pathway for nursing care home staff through ACP. **<u>Proposed Actions 2018/19</u>** • Undertake agreed procurement route. **<u>Proposed Action 2019/20</u>** • Implement new contractual arrangements.	
3.	**d) Supporting Extra Care Sheltered Housing** **<u>Proposed Actions 2017/18</u>** • Develop a model of in-reach health and social care support for extra care schemes. • Deliver new care and wellbeing service at Cottesmore House and Triscott House. • Deliver a model of primary care, e.g. GP, support for extra care schemes. **<u>Proposed Actions 2018/19</u>** • Deliver model of in-reach health and social care support for extra care.	• The Council and HCCG will be asked to consider whether resources should sit within Care Connection Teams within Primary Care. • The Council will be asked to agree social care resource contribution to in-reach support.
	***Scheme 6*: Living well with dementia.**	
3.	**<u>Proposed Actions 2017/18</u>** • Complete the design of the Dementia Resource Centre at Grassy Meadow Court extra care scheme • Deliver the mental health in-reach support to care homes. **<u>Proposed Actions 2018/19</u>** • Deliver the Dementia Resource Centre.	• The Council and HCCG will be asked to agree budgets to be included in the BCF pooled fund.

	***Scheme 7*: Delivering the Like Minded Programme**	
4.	**<u>Proposed Actions 2017/18</u>** • Establish a bed-based Homeless Hospital Discharge Service for people with mental health needs. • Develop a short-term crisis house for people in the community with mental health needs. • Review the model of floating support for people with mental health needs, people with learning disabilities and alcohol/substance misusers. **<u>Proposed Actions 2018/19</u>** • Implement preferred procurement route for floating support.	• The Council and HCCG will be asked to agree procurement and contracting leads for these services. • The Council and HCCG will be asked to agree what budgets to be included in the BCF pooled fund for 2017/18 and 2018/19.
	***Scheme 8*: Delivering an integrated Children and Adolescent Mental Health Service (CAMHS) pathway**	
4.	**<u>Proposed Actions 2017/18</u>** • Establish two-year pathway pilot transitioning to lead provider arrangements. • Review outcomes from Yr1 and determine procurement route. • Undertake market testing exercise. • Agree community and school based health promotion/awareness activities for 2017/18 and 2018/19. **<u>Proposed Actions 2018/19</u>** • Undertake agreed pathway procurement route. **<u>Proposed Actions 2019/20</u>** • Deliver outcome from agreed procurement route.	• The Council and HCCG will be asked to agree lead organisation arrangements. • The Council and HCCG will be asked to agree which budgets to include within the pooled fund.

	***Scheme 9*: Developing integrated services for children and young people.**	
4.	**<u>Proposed Actions 2017/18</u>** • Identify the cohorts of young people groups to be considered for the development of integrated education, health and social care budgets. • Collation and analysis of relevant data. • Development and agreement of criteria based on need rather than diagnostic condition.	• The Council and HCCG will be asked to agree lead organisation from 2018/19. • The Council and HCCG will be asked to agree scope and level of contributions to pooled fund from 2018/19. • The Council and HCCG will be asked to agree the lead organisation in liaising with schools to determine their willingness to participate and contribute financially.
	<u>Proposed Actions 2018/19</u> • Identification of the optimum integrated service model. • Secure agreement on model, including scope for IT solutions. • Identify and agree procurement route, e.g. a children's ACP.	
	<u>Proposed Actions 2019/20</u> • Implement new service model for agreed population group.	

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CHILD AND ADOLESCENT MENTAL HEALTH SERVICES UPDATE REPORT

Relevant Board Member(s)	Dr Ian Goodman Councillor Philip Corthorne
Organisation	Hillingdon CCG (HCCG) London Borough of Hillingdon (LBH)
Report author	Pranay Chakravorti (LBH / HCCG)
Papers with report	Appendix 1 - CAMHS local transformation plan performance update

1. HEADLINE INFORMATION

Summary	This report provides the Board with next steps in accelerating the transformation of CAMHS in Hillingdon together with an update on delivery of Hillingdon's 2016/17 CAMHS Transformation plan.
Contribution to plans and strategies	Hillingdon's Health and Wellbeing Strategy Hillingdon's draft Sustainability and Transformation Plan Hillingdon CCG's Commissioning Intentions 2017/18 Hillingdon Joint Children and Young Persons Emotional Health & Wellbeing Transformation Plan
Financial Cost	A new transformational approach to CAMHS delivery, away from tiers, will require closer alignment of programmes and budgets to achieve a more seamless pathway through the system and to move costs from high need into early intervention and prevention. The proposal is that the CAMHS transformation work should come within the Hillingdon Better Care Fund Plan for 2017-19. In addition NHSE continues to monitor the implementation of the existing Local Transformation Plan (LTP) as part of f the CCG assurance process but, from April 2016 CAMHS funding is not provided by NHSE as new funding but is contained within CCG baselines (i.e. non-ring fenced).
Ward(s) affected	All

2. RECOMMENDATIONS

That the Health and Wellbeing Board:

a) **notes proposals to develop a new approach to commissioning CAMHS services which are to be developed and are subject to approval by HCCG and LBH.**
b) **notes the proposed management of the CAMHS implementation plan through the Better Care Fund.**
c) **notes the progress in implementing the agreed 2016/17 Local Transformation Plan (Appendix 1).**

3. INFORMATION

This paper provides a progress update, further to the paper that went to the Health and Wellbeing Board on 8th December 2016. Current CAMHS performance can be reviewed under Appendix 1 of the report.

The Board will recall the intention to commission an integrated CAMHS pathway without tiers, and that the Anna Freud Centre had facilitated a strategic seminar to look at the specification. The findings of the Anna Freud Centre work were received late last year and considered by the HCCG Patient and Public Involvement (PPI) group as well as within the partnership steering group. From this it was felt that further detailed co-production work was required, together with further discussions specifically with schools to enhance the preventative aspects of a future CAMHS pathway. This work has been added to the work programme.

December to April 2017 work programme

Service model development - Thrive Model of Delivery

A delivery model made of three complementary principles: needs led, integrated and effective & transparent.

Needs led - The THRIVE model provides a way of focusing the resources in the system on the needs of the child - it makes services focus on what the needs of the child are, and makes explicit the needs based offer to the family and young person so all are clear on what is required and, through effective shared decision-making, what they are working together to achieve.

Integrated - This focussed on a diversified system of multi-agency work that is community based and links in with the people who know the child best and whom the child knows best. This can be strengthened through underlying structures that support and encourage this approach.

Effective and Transparent – This section focuses on ensuring all parts of the system deliver evidence-informed practice and implement rigorous outcomes monitoring to measure the effectiveness of interventions and different parts of the system.

Ongoing Service Model development is reviewing current gaps against the five areas of the Thrive diagram and focussing on key gap areas as outlined below for Hillingdon:

1) *'**Thriving: prevention and health promotion** – the child or young person has no mental health issues and their need is to be kept emotionally healthy through the application of active prevention and health promotion strategies'*

Areas to be developed within the new model in Hillingdon: More capacity is required in bereavement support: 'Seasons for Growth' is only currently delivered in approximately 50% of schools but needs to be delivered in all schools. Additionally there is a requirement for Mental Health Needs Coordinators (MHeNCOs), based in all mainstream services, including early years settings, schools and colleges. These MHeNCOs will provide advice, serve as a point of liaison and offer ongoing training and support to other staff in their setting (THRIVE: Consultation and Advice).

2) *'**Advice and support** – the CYP/family has an issue but only require some advice and support to manage it'*

Areas to be developed within the new model in Hillingdon:

1) Education and training programme for the children's workforce to address high % of Tier 3 CAMHS referrals being rejected because they may not meet the criteria/threshold for treatment.

2) Developing the role of schools in supporting the emotional health and wellbeing of children and young people as well as providing support to schools to lead and plan around emotional health and wellbeing, and to continue to champion the role of taught PSHE in schools.

3) Regularly review and update the Family Information Service. Consideration should be given to how best to promote/publicise services through a wider range of mediums, including social media, sports clubs, and community notice boards. A comprehensive, easy to access on-line 'local offer' is a key requirement.

4) Development of ***Multiple Advice (or Access) Points (MAPs)*** where children, young people, parents and professionals can access immediate and high quality advice and support about their presenting difficulties.

*3) '**Getting help** – the CYP/family has a clearly identified mental health issue that is likely to be helped by a goal focused intervention working with a professional (part of this intervention may also include advice and support, and management of risk, but this will be part of an ongoing intervention)'*

Areas to be developed within the new model in Hillingdon:

1) School based counselling services and well-being plans in and out of schools;

2) Training and support for schools to manage emotional wellbeing, and challenging behaviour in schools;

3) Peer mentoring for children across primary and secondary schools;

4) Support for parents who are struggling to parent - including tailored parenting interventions, and support for parents with children aged over 5

*4) '**Getting more help** – as above but the Children and Young People needs higher level multi-agency intervention'*

Areas to be developed within the new model in Hillingdon:

1) Counselling provision for young people below the age of 13

2) Change in use of existing Tier 2 provision' - e.g. to consider primary mental health workers

3) Services to reduce sexual exploitation of vulnerable children, specifically grooming.

4) To increase use of Mental Health Coordinators (MHeNCo) in all mainstream services; early years settings, schools, colleges who should nominate and support a key individual to take a lead role in promoting children's mental health.

5) 'MindEd', e-learning package for be used for teachers, so that there is a clear focus on school and class based interventions.

6) Lack of post diagnosis counselling for parents who have received an ASD diagnosis;

5) *'**Risk Support** – this group of CYP present with high risk, but for various reasons there is not a goal focused intervention that is thought likely to help – however the CYP needs to be kept safe'*

The change in multi-agency focus and development work on an integrated service model across the whole CAMHS pathway has commenced but will take some time to implement and embed. It was felt that in this interim period it was imperative that the existing model of care with CNWL was more robust and introduced changes to service users whilst pathway work was developed. To this end a revised specialist service model has been agreed with CNWL to ensure service provision continues and improves whilst a more comprehensive model is agreed. This will commence from 1st April 2017.

This service specification covers the transition period whilst the new structures are being put in place to cover universal, targeted, specialist and highly specialist CAMHS services. Ultimately a revised 'risk support' model will include close interagency collaboration between:

- Crisis teams – social care leads, multi-agency teams that can provide both 'risk support' and 'getting help';

- Inpatient units – to provide a safe environment, whilst aligning with the local system and providing active assessment and formulation;

- A&E and paediatric acute inpatient services - for emergency and short term places of safety.

Single Point of Access implementation - Commissioners will continue to review the implementation plan to ensure the development of a single point of access for all CAMHS

referrals to CNWL. This will provide onward referral and redirection to other services where appropriate and is scheduled to begin on April 1st. This will enable standardisation of referral processes and triaging, and have a positive impact for patients and partner agencies contacting the service for the first time.

Co-production of the new CAMHS pathway
Hillingdon CCG and London Borough of Hillingdon have re-commissioned the 'Anna Freud National Centre for Families' to facilitate three co-production workshops in March with a summary report to be available to commissioners by end of early April. The organisation will work with three service areas, to support a group of young people within each area to co-produce, with professionals; a shared vision for the development of community based crisis services locally.

Key aspects of the programme;

- Review and agreement of an overall project plan – based on earlier discussions and discussions with young people.

- Half day seminar with professionals and young people – to review together the plans for the development of local community based crisis services and to begin detailed planning in delivering a service. This will include assigning key tasks to young people and professionals, working together to help deliver these – the detail of which will be agreed by the group.

- Half day training days, for young people and professionals. For young people, this could include what to expect from the project, chairing and managing meetings, managing conflict, core writing skills etc. For the professionals it might include how to engage effectively with young people within the context of a co-production project.

- Monitoring and evaluation the project.

- Testing of initial ideas developed by the young people.

- Agree broad ways of working between young people and professionals, and further review additional support/training required for these groups.

Governance
The Mental Health Transformation Board and Children and Young People Steering group will provide oversight of implementation, reporting upwards to the Health and Wellbeing Board. implementation. Both groups will review the project plan arising out of the proposed CAMHS pathway, developed from the Anna Freud organisation in March.

Early Intervention work programme - this will raise mental health awareness in schools and the wider community. LBH will work alongside the Anna Freud Centre to ensure local engagement is co-ordinated and effective. A schools engagement plan sits within a wider Action Plan to address emotional and physical health in the borough.

A key element of the LBH Healthy Schools programme is for schools to improve the emotional health and wellbeing of pupils through the delivery of universal and targeted projects. Ten schools have been trained in the last quarter with a further five booked on for training before the end of March.

The Get Active to Stay Well programme is a physical activity is a referral based 'physical activity for mental health' programme for vulnerable young people, which secured from London Sport. This has been publicised with internal and external partners such as the Youth Offending, Looked After Children, Targeted and Universal Youth services, CAMHS and Hillingdon Carers and P3. Thirty Five referrals have been received to date and delivery of sessions will begin in the first week of March.

Making Every Contact Count (MECC) training has been made available for young people. Recruitment of a group young people (16 to 18 years old) will begin in March to equip them with skills to have conversations about different healthy lifestyle factors, including emotional wellbeing, with other young people. The trained young people will then have to complete 25 hours of volunteering over a six month period (through the Hillingdon Young Volunteers Targeted Youth Programme) by attending existing sessions at the borough's Young People's Centres to engage with and provide peer support to other young people.

4. FINANCIAL IMPLICATIONS

The performance data in Appendix 1 outlines the ongoing work HCCG and CNWL are undertaking in reducing the waiting time backlog, utilising the in-year investment of £128k.

The proposed new Model of Care for CAMHS will promote an integrated service, without tiers, with a Single Point of Access. The Board is requested to note the proposal that organisational resources are pooled through the Better Care Fund. This will allow an additional level of governance and transparency allied to the usual contract monitoring mechanisms which exist within HCCG and the LBH.

The proposed actions will occur in 2017/18 and beyond, monitored through the Better Care Fund:

BCF Proposed 2017/18 actions:

- Establishment of a two-year pathway pilot transitioning to lead provider arrangements.
- Review outcomes from Year 1 and determine procurement route.
- Undertake market testing exercise.
- Agree community and school based health promotion / awareness activities for 2017/18.

BCF Proposed 2018/19 actions:

- Undertake agreed pathway procurement route

BCF Proposed 2019/20 actions:

- Deliver outcome from agreed procurement route.

The level of funding to be allocated by organisations within the BCF will be determined and aligned to the integrated CAMHS pathway being developed by the Anna Freud organisation. Final proposals will come to HCCG governing body and LBH Cabinet for approval.

5. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

The transformation of children and young people's emotional wellbeing and mental health services will enable more young people to access evidence based mental health services, which meets their needs. For the wider population of Hillingdon children and young people will develop skills which will improve their emotional health and wellbeing and develop skills to improve their emotional resilience.

Consultation Carried Out or Required

The 'Future in Mind team' has undertaken consultation across NW London, including Hillingdon, in 2015, prior to the submission of the CAMHS LTP. There has also been consultation undertaken with children and young people, in Hillingdon at the Youth Council, forums and through schools. A children and young people's mental health event took place in July 2016 (Fundamentals Health Event) to allow children and young people have their say on Hillingdon services.

In 2015 Healthwatch Hillingdon undertook consultation with children, young people and families which focussed upon self-harm and was instrumental in the development of the new self-harm service.

Feedback from Hillingdon children and young people, to date, has also included a CAMHS Focus groups.

Hillingdon CCG have commissioned the 'Anna Freud National Centre for Families' to facilitate three co-production workshops in February with a summary report to be available to commissioners by end of March.

Policy Overview Committee comments

None at this stage.

6. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

None.

Hillingdon Council Legal comments

There are no legal issues arising out of the recommendations proposed at the outset of this report.

7. BACKGROUND PAPERS

None.

Appendix 1- LOCAL TRANSFORMATION PLAN : CURRENT PERFORMANCE

a) CAMHS

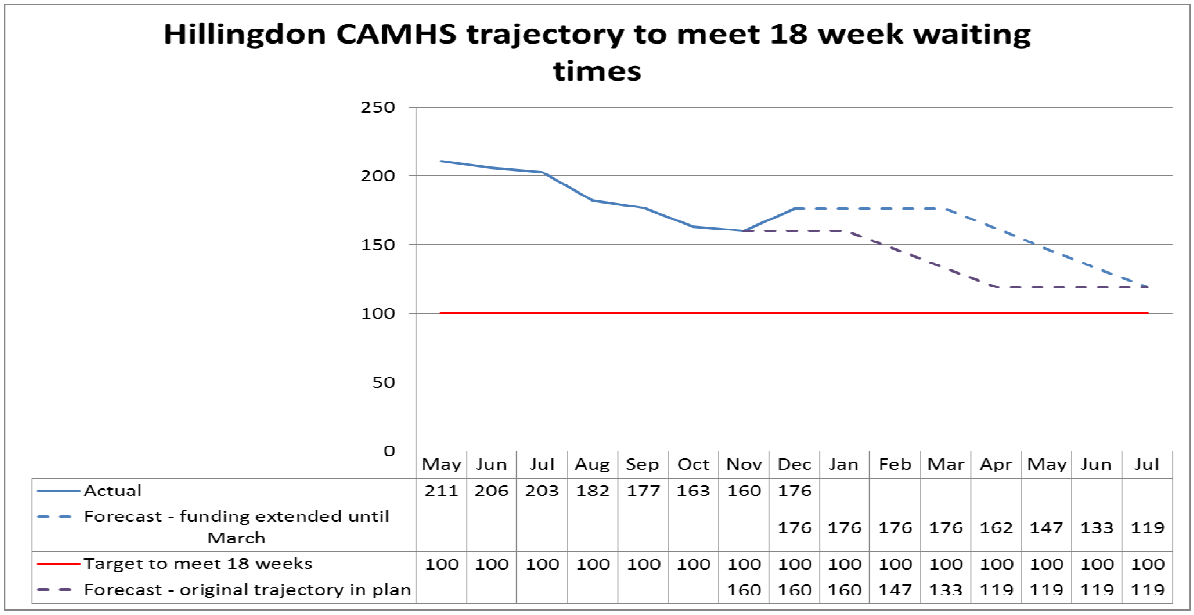
CAMHS performance via HCCG contract with CNWL - 18 Week waiting times

NHS England has released funding nationally to all CCG's to reduce waiting times for CAMHS services. CNWL have submitted trajectories for reducing waiting lists with this funding and have received the following allocations. NHS England has provided HCCG with £64,000 in the first tranche of funding to be released and a further £64,000 is the second tranche as outlined below:

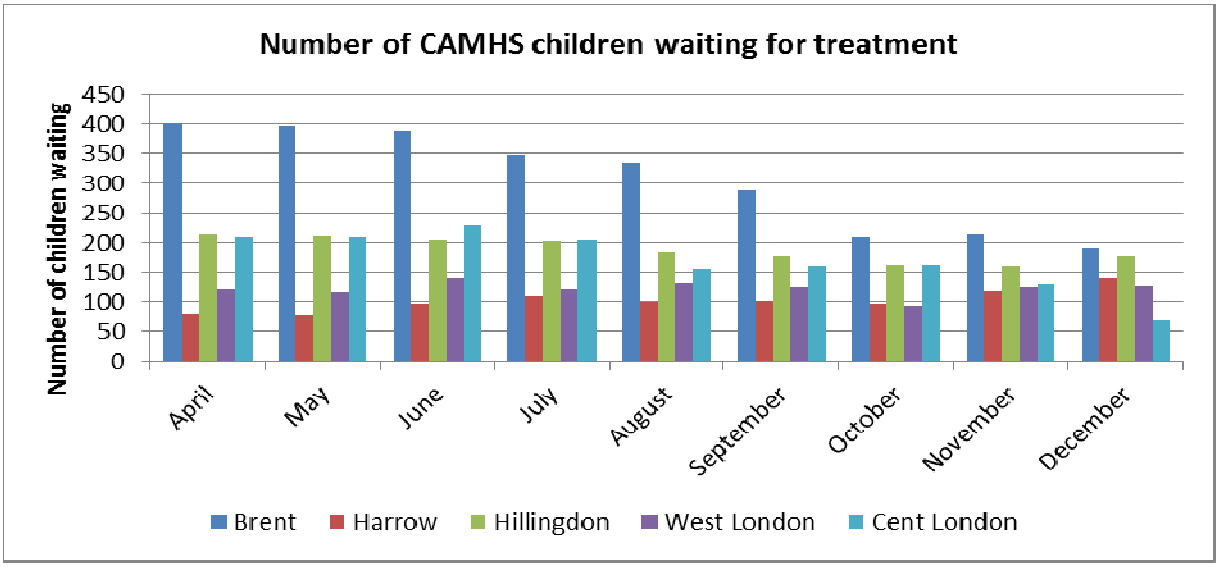
CCG	First tranche	Second tranche
Harrow	£53,500	£53,500
Brent	£150,00	
Hillingdon	£64,000	£64,000
Central London	£42,000	£42,000
West London	£51,000	£51,000

Since April 2016 the Hillingdon CAMHS service has been using three agency staff members, who were internally funded, to reduce the backlog of children waiting to be seen. This has successfully reduced the backlog from 211 in May to 160 in November. However due to uncertainty with future funding all three agency staff members left in December and therefore the backlog has increased slightly to 176 by the end of December. Assurances of continued funding have been now provided by NHS England who released funding to HCCG in January 2017, with pass through of funds to CNWL in February. This has enabled CNWL to continue recruiting to these posts. However, it is anticipated that recruitment will take three months, until the end of March, and therefore a reduction in backlog will not be possible until additional capacity has been recruited.

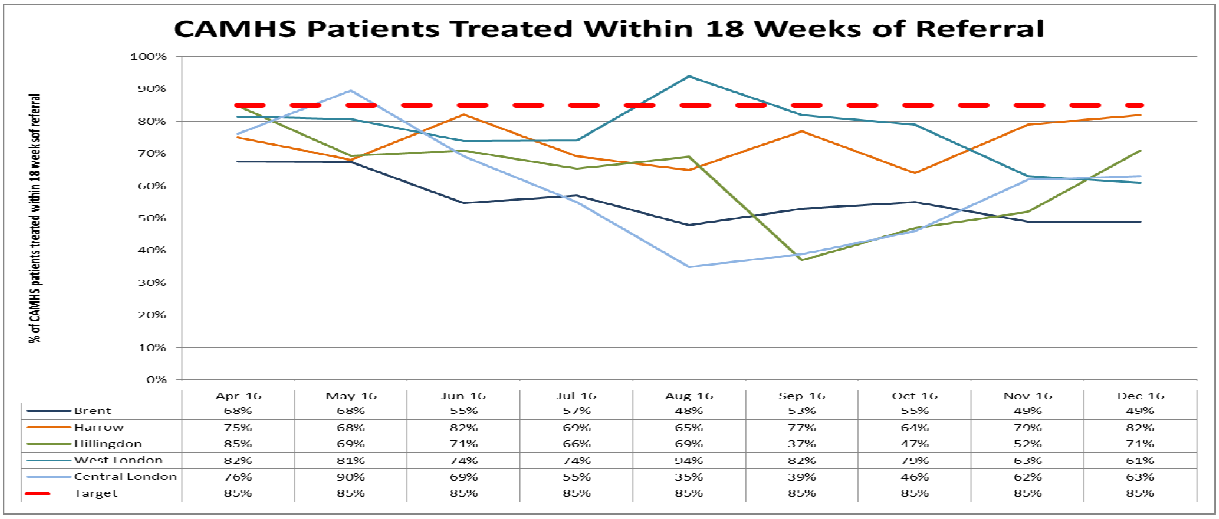
The table below details the original trajectory and the changed trajectory allowing for three months recruitment and the growth in December. This assumes no further growth in referrals above the 10% already seen.



	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Actual	211	206	203	182	177	163	160	176							
Forecast - funding extended until March								176	176	176	176	162	147	133	119
Target to meet 18 weeks	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Forecast - original trajectory in plan							160	160	160	147	133	119	119	119	119



The revised plan will consider the use of measures such as on-line therapies, with licenses purchased for a 12 month period to ensure that improvements in waiting times continue post the end of the financial year for which funding has been committed.



	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Brent	68%	68%	55%	57%	48%	58%	55%	49%	49%
Harrow	75%	68%	82%	69%	65%	77%	64%	79%	82%
Hillingdon	85%	69%	71%	66%	69%	87%	47%	52%	71%
West London	82%	81%	74%	74%	94%	82%	75%	63%	61%
Central London	76%	90%	69%	55%	35%	39%	46%	62%	63%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%

CNWL provide CAMHS services to five London boroughs and Milton Keynes. In the five London boroughs, North West London (NWL) CCG's have set CNWL a target to treat 85% of children within 18 weeks of referral. Currently this target is not being met in any of the five boroughs. Historical demand into the service has exceeded capacity, particularly in the three outer boroughs creating a backlog of children waiting to be seen. Referral levels have continued to increase in 2016/17 with a 7% growth across all boroughs.

Risk Management of Patients awaiting treatment

Each of the CAMHS teams has systems in place for managing and triaging referrals into the service. All teams will prioritise referral and allocations based on urgency and risk presentation.

Where teams have waiting lists there is weekly review of the list by clinical staff to check who has been waiting and for which interventions. Service users are then taken from the list for assessment or treatment. All Children and Young People and their families are given details of how to contact the service and who to speak to, should the situation within the family not change and it becomes more risky. This is part of good clinical risk management but also helping families feel they have skills to support the young person. The teams all operate 'speedy slots' where an urgent assessment can take place should someone need to be prioritised. Some families can be contained through telephone advice. All will be given information on support groups or websites to turn to that may help whilst they wait for treatment.

The service does experience families making contact with teams to ask for advice on dealing with issues or to be moved further up the list to be seen. Groups have also been offered to some young people whilst they wait for particular interventions but outcomes have been mixed in terms of dropout rates.

Web based approaches are being actively explored. The families will be advised to go to Accident & Emergency if the situation is uncontainable.

b) Paediatric Eating Disorders - Performance Summary Feb-17

Target Description	Target	Apr -16	May -16	Jun -16	Jul-16	Aug-	Sep -16	Oct -16	Nov -16	Dec -16	Jan -17	Feb -17	Mar -17
Waiting times - routine	30%	50	100	50	82	75	67	100					
Waiting times - urgent	100%	n/a	80	78	25	100	67	100					

c) Self-Harm

There are currently two patients in Tier 4 inpatient settings receiving treatment for self-harm. This represents an improvement from the position in February where there were four patients. HCCG are working closely with NHS England to facilitate safe discharge of these patients when their conditions are stabilised.

HILLINGDON CCG UPDATE

Relevant Board Member(s)	Dr Ian Goodman
Organisation	Hillingdon Clinical Commissioning Group
Report author	Caroline Morison, Joan Veysey; Jonathan Tymms; Sarah Walker
Papers with report	None.

1. HEADLINE INFORMATION

Summary	This paper provides an update to the Health and Wellbeing Board on key areas of CCG work. The paper encompasses: • Delegation of primary care commissioning • Primary care transformation • Accountable care partnership due diligence process • Financial position M9 • Update on QIPP 16/17 • 17/18 operational plan • Changes to the governing body
Contribution to plans and strategies	The items above relate to the HCCGs: • 5 year strategic plan • Out of hospital (local services) strategy • Financial strategy • Shaping a Healthier Future
Financial Cost	Not applicable to this paper.
Relevant Policy Overview & Scrutiny Committee	External Services Overview and Scrutiny Committee
Ward(s) affected	All

2. RECOMMENDATION

That the Health and Wellbeing Board notes this update.

3. INFORMATION

The following section summarises key areas of work the CCG wishes to bring to the attention of the Health and Wellbeing Board.

3.1 Delegation of primary care commissioning

Responsibility for commissioning primary care (general practice) currently sits with NHS England. As part of the changes set out in the NHS Five Year Forward View NHS England are encouraging CCGs to take on a greater role in the commissioning of primary care.

Hillingdon CCG currently commissions jointly with NHS England (known as 'level 2' delegated commissioning). However NWL CCGs have considered the option to apply for and take on 'level 3' delegated commissioning from April 2017, subject to a ballot of the relevant CCG membership (e.g. all general practices in the borough of Hillingdon). This would mean that commissioning decisions related to primary care would be solely determined at a CCG level.

The CCG has been working with practices to understand and, where possible, address queries and concerns relating to delegation. Main areas for clarification have included:

- The capacity of the CCG to effectively deliver the function
- Priority areas for investment
- Enhanced levels of dialogue and accountability between members and the Governing Body

The CCG has addressed these through:

- Approving investment in the primary care team as well as working with NHSE and the other NWL CCGs to define roles and responsibilities
- Defining areas of investment for 17-18 to include improved access, visiting services (with a focus on care homes), additional clinical pharmacist capacity and new models of care for long term conditions
- A commitment to re-shape and increase the opportunities for discussion and engagement between members and the Governing Body

In addition the CCG commissioned a due diligence report from a third party (RSM). RSM worked both with the current NHSE team and GP practices (through an online survey) to understand the current risks and issues with regards to primary care commissioning. The report was shared with practices in advance of the membership vote on 22nd February.

The outcome of the membership vote was that Hillingdon voted in favour of taking on level 3 delegated commissioning. This will mean that from 1 April 2017, Hillingdon CCG will take full responsibility for the management of their GP and primary care services. This will allow the CCG to tailor services more effectively to meet local patients' needs. This new way of working will also give patients more opportunity to input and influence how primary care services are developed. Following the result of the vote a new governing body committee will be established in order to carry out this new role.

3.2 Primary care transformation

The development of a single primary care federation for Hillingdon continues with the roll out of an extended hours service across the borough. The service went live during the Christmas period in the south of the borough and following an evaluation of utilisation and the enabling systems and processes, will be extended to an additional two locations over the coming months.

The service (currently based at the HESA centre) offers appointments to 8pm in the evenings on weekdays and between 8am and 8pm on Saturdays and Sundays.

NHS England and Hillingdon CCG have agreed to run the procurement process for the APMS primary care contract for the HESA centre outside of the NHS England Tranche 5 process. The decision was taken at the December primary care co-commissioning committee. The main factors for taking a local approach are:

- The level of local determination in the decision-making process
- The timeline required for the NHSE process which was not aligned with local transformation programmes

NHS Shared Business Services will support the process with further oversight and governance provided by the primary care co-commissioning committee.

3.3 Accountable Care Partnership – due diligence

The due diligence process for Hillingdon Health and Care Partners (HHCP) is now underway. The process is designed to assess the current stage of development of HHCP across seven domains: strategy and vision, leadership and governance, processes, technology, financial and risk management, people and culture and integration. Each domain has a number of criteria which the ACP will need to evidence its performance and capabilities against. Minimum thresholds have been set for year one, and higher thresholds for year two. Performance is assessed against four tiers: emerging, developing, established and leading.

The process includes self-assessment together with a challenge panel and board to board session. The entire process will take place over two years but a key gateway will be in April 17 that enables the ACP to progress to the 'testing year' of 17/18.

Challenge panels will include a wide range of stakeholders including lay representation, clinicians external to Hillingdon, local authority representation (including public health and social care) and CCG leads. The outcome of the first panel on 23rd February will form the basis of a board to board session on 9th March leading to an agreed development plan for 17-18.

3.4 Financial position M9

Overall, at month 9, the CCG is achieving its YTD planned surplus of £2.7m. The CCG is reporting to achieve its £3.6m planned surplus by Year End, although this is in part due to a number of non-recurrent benefits (see below).

Whilst the CCG continues to report achievement of its planned YTD and FOT financial targets, there remain a number of risks within the CCG's financial position which mainly relate to over-performance on the CCG's main Acute Contracts and also significant financial pressures in its Continuing Care budgets.

The over-performance on the contract with THH relates to higher than planned increases in Accident & Emergency activity and also OP referrals in a number of specialties. Emergency admissions have reduced from last year but costs have increased due to an increase in the length of stay and acuity of patients at THH.

There is also significant over performance at London North West Hospitals (mainly stroke related activity), Imperial (Non-Elective and Maternity) and the Royal Brompton.

Continuing Care costs are currently projected to increase by £3.2m (20%) compared to last year. Part of this increase in overall cost (c£900k) relates to the national increase in Funded Nursing Care reimbursement. In addition there have been significant increases in activity and placements relating to Palliative Care, Older people and also Section 117s.

Additional external resource has been identified within Continuing Care to review costs of high cost packages.

To achieve its forecast outturn plan, the CCG has now deployed most of its available reserves, in both programme and running costs, and has also factored in non-recurrent balance sheet gains from 15/16 (£2.5m) into the FOT.

Overall Position- Executive Summary Month 9 YTD and FOT

Table 1

EXECUTIVE SUMMARY		Year to Date Month 9			Forecast Outturn Position		
	Final Budgets (£000)	YTD Budget (£000)	YTD Actual (£000)	Variance Sur/(deficit) (£000)	FOT Actual (£000)	FOT Variance Sur/(deficit) (£000)	FOT QIPP Variance (£000)
Commissioning of Healthcare							
Acute Contracts	206,468	154,946	158,843	(3,896)	211,696	(5,228)	(1,359)
Acute Reserves	2,556	1,619	0	1,619	829	1,726	0
Other Acute Commissioning	13,209	9,160	8,838	322	12,840	369	276
Mental Health Commissioning	25,213	18,589	18,408	180	25,077	136	183
Continuing Care	16,045	11,905	14,523	(2,618)	19,294	(3,249)	(109)
Community	30,847	23,074	22,959	115	30,814	33	69
Prescribing	35,784	27,115	26,570	545	35,196	588	230
Primary Care	7,010	4,371	3,798	574	6,669	341	0
Sub-total	**337,132**	**250,779**	**253,938**	**(3,159)**	**342,416**	**(5,285)**	**(710)**
Corporate & Estates	4,573	3,400	3,429	(29)	4,565	8	0
TOTAL	**341,705**	**254,179**	**257,367**	**(3,187)**	**346,981**	**(5,276)**	**(710)**
Reserves & Contingency							
Contingency	2,134	1,600	0	1,600	0	2,134	0
Uncommitted Reserves	4,149	0	0	0	4,149	0	0
2015/16 Balance Sheet Gains	0	0	(1,542)	1,542	(2,552)	2,552	0
RESERVES Total:	**6,283**	**1,600**	**(1,542)**	**3,142**	**1,597**	**4,686**	**0**
Total 2016-17 Programme Budgets	**347,987**	**255,780**	**255,825**	**(45)**	**348,578**	**(591)**	**(710)**
Planned Surplus/(Deficit)	3,616	2,712	0	2,712	**0**	**3,616**	**0**
Total Programme	**351,603**	**258,492**	**255,825**	**2,667**	**348,578**	**3,025**	**(710)**
RUNNING COSTS							
Running Costs	**6,279**	**4,095**	**4,049**	**45**	**5,688**	**591**	**0**
CCG Total	**357,882**	**262,586**	**259,874**	**2,712**	**354,266**	**3,616**	**(710)**

Year To Date Position- Acute Contracts and Continuing Care

Table 2

ACUTE CONTRACTS		Year to Date Month 9		
	SLA Value (£000)	YTD Budget (£000)	YTD Actual (£000)	Variance Sur/(deficit) (£000)
Chelsea And Westminster Hospital NHS Foundation Trust	2,353	1,767	1,825	(58)
Imperial College Healthcare NHS Trust	12,066	9,058	9,355	(297)
London North West Hospitals	16,580	12,409	12,983	(574)
Royal Brompton And Harefield NHS Foundation Trust	6,442	4,831	6,079	(1,248)
The Hillingdon Hospitals NHS Foundation Trust	131,802	98,972	102,872	(3,900)
The Hillingdon Hospitals NHS Foundation Trust - Transitional Support	3,300	2,475	0	2,475
Sub-total - In Sector SLAs	**172,543**	**129,512**	**133,113**	**(3,602)**
Sub-total - Out of Sector SLAs	**31,984**	**23,978**	**24,294**	**(316)**
Sub-total - Non NHS SLAs	**1,942**	**1,456**	**1,435**	**21**
Total - Acute SLAs	**206,468**	**154,946**	**158,843**	**(3,896)**

CONTINUING CARE		Year to Date Month 9		
	Final Budgets (£000)	YTD Budget (£000)	YTD Actual (£000)	Variance Sur/(deficit) (£000)
Mental Health AMI (Under 65)	59	44	3	41
Mental Health EMI (Over 65) - Residential	2,865	2,149	2,384	(234)
Mental Health EMI (Over 65) - Domiciliary	277	208	201	7
Physical Disabilities (Under 65) - Residential	2,015	1,511	1,848	(337)
Physical Disabilities (Under 65) - Domiciliary	2,201	1,651	1,396	254
Elderly Frail (Over 65) - Residential	951	713	1,077	(363)
Elderly Frail (Over 65) - Domiciliary	92	69	153	(84)
Palliative Care - Residential	381	286	552	(266)
Palliative Care - Domiciliary	424	318	617	(299)
Sub-total - CHC Adult Fully Funded	**9,265**	**6,949**	**8,230**	**(1,281)**
Sub-total - Funded Nursing Care	**2,095**	**1,571**	**2,069**	**(498)**
Sub-total - CHC Children	**1,263**	**947**	**1,220**	**(273)**
Sub-total - CHC Other	**628**	**342**	**695**	**(353)**
Sub-total - CHC Adult Joint Funded	**2,794**	**2,095**	**2,309**	**(213)**
Total - Continuing Care	**16,045**	**11,905**	**14,523**	**(2,618)**

FOT Position- Acute Contracts and Continuing Care

Table 3

ACUTE CONTRACTS	Year to Date Month 9		Forecast Outturn Position	
	YTD Actual (£000)	Variance Sur/(deficit) (£000)	FOT Actual (£000)	FOT Variance Sur/(deficit) (£000)
Chelsea And Westminster Hospital NHS Foundation Trust	1,825	(58)	2,435	(82)
Imperial College Healthcare NHS Trust	9,355	(297)	12,562	(496)
London North West Hospitals	12,983	(574)	17,260	(679)
Royal Brompton And Harefield NHS Foundation Trust	6,079	(1,248)	8,105	(1,663)
The Hillingdon Hospitals NHS Foundation Trust	102,872	(3,900)	137,055	(5,253)
The Hillingdon Hospitals NHS Foundation Trust - Transitional Support	0	2,475	0	3,300
Sub-total - In Sector SLAs	**133,113**	**(3,602)**	**177,417**	**(4,874)**
Sub-total - Out of Sector SLAs	**24,294**	**(316)**	**32,386**	**(402)**
Sub-total - Non NHS SLAs	**1,435**	**21**	**1,893**	**48**
Total - Acute SLAs	**158,843**	**(3,896)**	**211,696**	**(5,228)**

CONTINUING CARE	Year to Date Month 9		Forecast Outturn Position	
	YTD Actual (£000)	Variance Sur/(deficit) (£000)	FOT Actual (£000)	FOT Variance Sur/(deficit) (£000)
Mental Health AMI (Under 65)	3	41	3	56
Mental Health EMI (Over 65) - Residential	2,384	(234)	3,142	(277)
Mental Health EMI (Over 65) - Domiciliary	201	7	248	29
Physical Disabilities (Under 65) - Residential	1,848	(337)	2,356	(341)
Physical Disabilities (Under 65) - Domiciliary	1,396	254	1,878	323
Elderly Frail (Over 65) - Residential	1,077	(363)	1,543	(592)
Elderly Frail (Over 65) - Domiciliary	153	(84)	211	(119)
Palliative Care - Residential	552	(266)	741	(360)
Palliative Care - Domiciliary	617	(299)	854	(430)
Sub-total - CHC Adult Fully Funded	**8,230**	**(1,281)**	**10,975**	**(1,710)**
Sub-total - Funded Nursing Care	**2,069**	**(498)**	**2,749**	**(654)**
Sub-total - CHC Children	**1,220**	**(273)**	**1,534**	**(271)**
Sub-total - CHC Other	**695**	**(353)**	**1,148**	**(521)**
Sub-total - CHC Adult Joint Funded	**2,309**	**(213)**	**2,888**	**(94)**
Total - Continuing Care	**14,523**	**(2,618)**	**19,294**	**(3,249)**

3.5 16/17 QIPP

The 16/17 Net QIPP Target is £8,645k. Current FOT as at M10 is (£683k), giving an FOT of £7,990 (or 92%) an improvement of £27k since M9.

16/17 QIPP Performance

Workstream	16/17 Net Target Savings £'000	FOT Variation from target M10 £'000	FOT Variation from target M9 £'000	Difference M9 v M10 £'000
Unplanned Care	1,805	401	309	92
Planned Care	2,734	(818)	(733)	(85)
Long Term Conditions	547	(222)	(235)	13
Older Peoples	1,107	(277)	(225)	(52)
Mental Health	746	89	89	-
Prescribing	1,573	253	194	59
Continuing Health Care	162	(109)	(109)	-
Total	8,645	(683)	(710)	27

Planned care

Planned care continues to deliver a shortfall with the main areas of slippage being:

Ophthalmology: Project impacted by late start date. An activity review is underway to review delivery against contracted activity and associated credits to CCG which will improve the end of year position.

MSK: Pain Management – An activity review is underway to review delivery against contracted activity and associated credits to CCG which will improve the end of year position.

Dermatology: An activity review is underway to review delivery against contracted activity and associated credits to CCG which will improve the end of year position. The contract ends December 2017, with contract options being assessed.

Long Term Conditions

The Long Term conditions position has improved marginally in M10. Overall there is a £222k FOT shortfall in M10 driven largely by the Expert Patient Programme (£54k), Pulmonary Rehab Tariff (£59k), and Stroke Early Supported Discharge (£38k).

Older People

Overall there is a £277 FOT shortfall in M10 due to delays in appointing to the Care of The Elderly consultant posts in A&E. One post continues to be vacant following unsuccessful recruitment processes. The CCG is likely to recover c£120k from the vacant post for 16/17.

There is also continuing decline in Rapid Access Clinics (£106k FOT shortfall). This project has had delayed service and process implementation. Full year benefits should occur in 17/18.

Continuing Health Care

There remains a £109k FOT shortfall in CHC. This needs to be seen in the context of the overall over performance in CHC activity for which a business plan is being developed for 17/18.

17/18 QIPP

The CCG has identified £12.6m gross QIPP (£9.6 net) to support delivery of a balanced financial position in 17/18.

The current focus of the planning work is on risk assuring delivery of the savings and finalising the relevant project and programme plans to ensure robust implementation.

3.6 Operating plan 17/18

Hillingdon CCG successfully agreed all key contracts for 17/18 and 18/19, by 23rd December, three months earlier than usual and covering two financial years.

Acute contracts across NWL have been agreed using a common approach and the contract agreements are based on activity growth assumptions aligned with the STP and QIPP assumptions that match the 'Shaping a Healthier Future: Strategic Outline Case' that has been submitted to NHSE.

The financial environment for 17/18 is challenging and the agreed contract values represent a significant financial challenge to both commissioner and provider to deliver their respective control totals. Further collaborative work will identify opportunities to reduce activity and cost. To manage risk in the NWL system, a marginal rate on over-performance above the baselines has been set at 70% and performance below the baseline will be payable at 30%. There is also a 50% risk-share on high cost drugs (HCD) above or below an agreed threshold.

The community contract with CNWL for 17/18 and 18/19 are years two and three of the three year contract agreed last year so change is minimal from previous planning assumptions. For the CNWL mental health contract, the CCG has increased its investment in mental health services in line with 'parity of esteem' assumptions but also built in the delivery of significant transformation in mental health services.

3.7 Changes to Governing Body

The CCG welcomes Dr Angela Joseph to the Governing Body as the new elected member for Hayes and Harlington. Dr Joseph is a partner at Kingsway Practice. We are pleased to confirm Dr Kuldhir Johal as the new CCG vice-chair following a nominations process that took place during January. We also welcome Diane Jones as our new Director of Quality. Diane joins us from Greenwich CCG where she has been in the role of Director of Integrated Governance.

4. FINANCIAL IMPLICATIONS

None in relation to this update paper.

5. LEGAL IMPLICATIONS

None in relation to this update paper.

6. BACKGROUND PAPERS

- North West London 5 Year Strategic Plan
- Hillingdon CCG Out of Hospital Strategy
- Hillingdon CCG Operating Plan 2015/16
- London Primary Care Strategic Commissioning Framework

HEALTHWATCH HILLINGDON UPDATE

Relevant Board Member(s)	Stephen Otter
Organisation	Healthwatch Hillingdon
Report author	Graham Hawkes, Chief Executive Officer, Healthwatch Hillingdon
Papers with report	Appendix A - Safely 'Home' to the Right Care

HEADLINE INFORMATION

Summary	To receive a report from Healthwatch Hillingdon on the delivery of its statutory functions for this period.
Contribution to plans and strategies	Joint Health & Wellbeing Strategy
Financial Cost	None
Relevant Policy Overview & Scrutiny Committee	N/A
Ward(s) affected	N/A

RECOMMENDATION

That the Health and Wellbeing Board notes the report received.

1. INFORMATION

Healthwatch Hillingdon is contracted by the London Borough of Hillingdon, under the terms of the grant in aid funding agreement, to deliver the functions of a local Healthwatch, as defined in the Health and Social Care Act 2012.

Healthwatch Hillingdon is required under the terms of the grant aid funding agreement to report to the London Borough of Hillingdon on its activities, achievements and finances on a quarterly basis throughout the duration of the agreement.

2. SUMMARY

2.1. The body of this report to The London Borough of Hillingdon's Health and Wellbeing Board summarises the outcomes, impacts and progress made by Healthwatch Hillingdon in the delivery of its functions and activities for this period. It should be noted that a comprehensive report is presented by the Chief Executive Officer to the Directors/Trustees at the Healthwatch Hillingdon Board Meetings and is available to view on our website: (http://healthwatchhillingdon.org.uk/index.php/publications)

3. OUTCOMES

Healthwatch Hillingdon would wish to draw the Health and Wellbeing Board's attention to some of the outcomes highlighted by its work during the first quarter.

Discharge from Hillingdon Hospital Project

On Thursday 23rd February 2017 we published a new report – Safely 'Home' to the Right Care – outlining the personal experiences of older people who have recently been discharged from Hillingdon Hospital.

We formally submit the report to the Health and Wellbeing Board as Appendix A.

The report is the culmination of a 6 month engagement programme which saw us engage with 172 inpatients at Hillingdon Hospital, 52 patients post discharge and the professionals and staff from over 20 organisations.

The intelligence we have collected during our research has provided us with a valuable insight into older people's experiences of being discharged from Hillingdon Hospital, and the care and support provided to them in the community. Evidence suggests that by providing uniform processes, better information for people and improving communication between patients, care staff and the component organisations, will be key to the discharge pathway being improved.

We have seen a positive response to the report from commissioners and providers. There has been an acknowledgment that improvement is needed and a number of recommendations outlined in the report have already been implemented.

Our evidence has also informed the Better Care Fund and additional actions have been added to the delivery plan, which is monitored by the Health and Wellbeing Board.

We will also look to monitor progress against our recommendations with all partners through the Older People's Services Delivery Group.

Healthwatch Hillingdon have produced a short film of patient's lived experiences to accompany this report. This can be viewed at:
https://m.youtube.com/watch?v=5mgLI37uPzE

Lymphoedema Service

Our last Report highlighted the lack of appropriate primary (non-cancer related) Lymphoedema service in London Borough of Hillingdon. We are pleased to confirm that the NHS Hillingdon CCG have now launched a new Lymphoedema service that will provide access to all Hillingdon patients with a need for Lymphoedema care and support. This is very welcomed news, and we applaud the NHS Hillingdon CCG for investing in this new service for the benefit of our local residents. The new service means that secondary Lymphoedema patients (cancer-related) will be under the care of the Mount Vernon Cancer Centre; whereas patients with secondary Lymphoedema will be able to access care from Harlington Hospice.

Information, Advice and Support

During this quarter we recorded a total of 173 enquires relevant to our function.

108 of these were from residents in receipt of our signposting service.

74% of residents accessed our service through the shop, which remains the main point of contact for our information, advice and support service.

N.B. We would advise the Health and Wellbeing Board that with the imminent opening of the new retail store in the Pavilions, it is very likely that we will be given notice on the shop lease. We have been actively looking at alternative premises. This is unlikely to be of a comparable size, or in a high street location.

Table A gives a breakdown of the number and type of enquiry we have received.

Type of enquiry	Number	% of enquiries
Refer to a health or care service	30	28
Refer to a voluntary sector service	6	6
Requesting information / advice	20	19
Requesting help / assistance	12	11
General Enquiry	40	37

Table A

Table B shows the source of these enquiries.

Source of enquires	Number	% of source
shopper	80	74
event	1	1
referral	7	6
promo	2	2
advert	0	0
website	0	0
known	8	7
other	2	2
unknown	8	7

Table B

Armed Forces ex-serviceman

Mr D (mid 30s) was medically discharged due to injuries sustained whilst serving in the Armed Forces. Mr D is struggling to come to terms with his injuries, both emotionally and physically, as well as the constant pain. Mr D feels that he has been shunted from one part of the NHS to another since his discharge from the army and feels that he has not been supported by anyone, including the Royal British Legion. Healthwatch Hillingdon contacted the Royal British Legion and requested additional support for Mr D. Healthwatch Hillingdon also contacted London Borough of Hillingdon social services to request an assessment of Mr D's needs.

Clinical Waste Disposal

We heard from a resident of one supported accommodation complex that due to large number of residents with increasing care needs, that the communal household-waste-only

bin has an extremely pungent odour due to the disposal of human waste/soiled pads etc. “The smell and flies are just too much”. It is claimed that most of the human waste is disposed of by domiciliary agency care staff. The individual has made a complaint to the London Borough of Hillingdon Environmental Health Department but were informed that they are unable to take any action to address the waste/odour issues. The disposal of human waste material is a complex legal area and falls outside the remit of Healthwatch Hillingdon. However, it would be considered good practice for all domiciliary care agency staff to be reminded (as part of their regularly training) that human waste should be either taken away by the agency for appropriate disposal or sealed in appropriate bags prior to disposal in domestic waste bins. The environmental disposal rules covering supported accommodation is the same as a domestic setting (covering clinical as well as human waste) whereas the rules governing nursing homes are stricter. This is an area that may require further consideration as more elderly residents are accommodated in supported housing schemes. Each supported accommodation site make require a different waste assessment to ensure residents are housed in dignified settings.

Concerns and complaints

Healthwatch Hillingdon recorded 65 experiences, concerns and complaints in this quarter. The areas by organisational function are broken down in Table C.

Concern/complaint Category	Number	% of recorded
CCG	1	2
Primary care: GP	15	23
Primary care: Pharmacy	3	5
Primary care: Optician	1	2
Primary care: Dental	3	5
Hospitals	24	37
Mental Health Services	3	5
Community Health	3	5
Social Care	8	12
Care Agency	0	0
Care Home	1	2
Patient Transport	0	0
Community Wheel Chair Service	2	3
3rd sector service	0	0

Table C

Referring to Advocacy

1 referral was made to VoiceAbility (independent NHS Complaints Advocacy) during this period.

Overview

The following is to note from the analysis of the recorded concerns and complaints data this quarter.

Prescription difficulties

Mother of young daughter with special needs moved to Hillingdon recently. Since 2012 daughter has been prescribed certain medication for her seizures by Great Ormond Street Hospital (GOSH) & The Hillingdon Hospital (THH). Prior to their move to the London Borough of Hillingdon, their previous GP was able to provide regular prescriptions for the specialist medication. However, their GP informed the mother that they were not comfortable or confident to prescribe this medication or provide repeat prescriptions (this can occur where certain specialist prescribed medications have to be closely monitored etc.). Both GOSH and THH consultants have written to the GP stating that this is the most suitable medication for her daughter, but still the GP is unable to write the prescription. On one occasion mother was unable to get the medication from GOSH/THH in time and this resulted in her daughter suffering a seizure. Mother is finding getting access to the medication really difficult and hugely stressful. This case has been referred to VoiceAbility as the family wish to make a formal complaint. However, as this particular case raises a number of important issues for people requiring special/specific prescriptions from specialist Hospitals, we are in the process of liaising with the NHS Hillingdon CCG with the aim of developing and establishing agreed protocols/pathways to cover these types of situations.

Strategic Working

Accountable Care Partnership (ACP)

We are pleased to advise that Hillingdon Health and Care Partners have invited Healthwatch Hillingdon to join the Provider Board in a non-voting lay capacity to take an active part in the governance and development of the ACP.

Children's and Adolescent Mental Health Services (CAMHS)

Healthwatch Hillingdon continues to monitor the delivery of the transformation plan through our seat on the Children & Young Peoples Emotional Health & Wellbeing Steering Group.

We have expressed some concerns at the speed of progress currently being made on the development of the new pathway. With newly commissioned services embedding we do not want the impetus to slow down. Especially when we are starting to see the positive outcomes of this work stream. It was specifically pleasing to see a recent story published by CNWL, about how the new Community eating disorder service had changed the life of Leah and her family. It is very encouraging to know that all our efforts are making a tangible difference. http://bit.ly/2kQyDfg

Engagement Overview

Direct Engagement

This quarter we recorded direct engagement with 634 members of the public. 413 were engaged through our discharge and maternity projects. A further 221 residents through 13 community engagement events. Some of the events attended this quarter include the Older People's Assembly, the Disability Assembly and Brunel universities Volunteers' Fair. As always, these large-scale events provided an excellent opportunity to promote the work of Healthwatch.

During this quarter, we also spoke at coffee mornings held by organisations such as the Salvation Army, Hillingdon Carers, Parkinson's UK and the Alzheimer's Society. As we

anticipated, the number of attendees at these events were relatively small (on average 15-20 people) however this allowed for group discussions and more comprehensive feedback.

The key concerns highlighted by residents who attended the coffee morning events included access to GP appointments, not seeing the same GP at appointments (lack of continuity), repeat prescriptions and dental charges. The individual comments collected varied from individual to individual.

At the Oak Farm library coffee morning, an elderly lady informed me of her late husband's frustration of having his haematology appointment cancelled 11 consecutive times at the Hillingdon Hospital. She also expressed her own frustration at having had her hospital appointment cancelled on several occasions.

The coffee mornings have overall proved to be a very effective way of gathering targeted feedback and we will continue to incorporate them as part of our future engagement activities.

During 2017 we also plan to resume our presence at The Hillingdon Hospital by holding a stand at the main entrance. We will also reach out to Hillingdon's faith groups including mosques, churches and temples and youth organisations to capture the views and experiences of those who are seldom heard.

Volunteering

In November 2016 a production company volunteered to help us make a film to accompany our discharge project report. With the help of volunteer actors, the film was shot over a Friday afternoon. We are extremely grateful for everybody's time and efforts over a total of 60 hours.

We have recruited a new volunteer who will be assisting us with the redesign of our website. She joined the Healthwatch team in January and we hope she will bring with her some new and fresh ideas on how we can make our site more user friendly.

Retention amongst existing volunteers remains high. We currently have 7 active volunteers assisting us with our social media, data entry, newsletter and engagement activities, however, due to the introduction of the CRM database to Healthwatch Hillingdon which is unsuitable for volunteers to use, we may need to reconsider the roles of office based volunteers. These volunteers have undertaken 126 hours of volunteering for this quarter.

Volunteer Development

By partnering with the training provider 'The Skills Network', we offered our volunteers the opportunity to gain a level 2 qualification in a range of subjects. Currently 8 Healthwatch volunteers are undertaking level 2 courses. Subjects studied include: Autism, Business Administration, Customer Service, Information Advice & Guidance, and Dementia Awareness. On completion of their course and a combined study of over 250 hours, volunteers will receive a level 2 NCFE certificate.

Social Media

We continue to maintain a healthy online presence on Facebook and Twitter by regularly posting news stories, information & events on health and social care and encouraging our online communities to converse with us and share their views. The number of Twitter followers has exceeded 1000 this quarter.

Our most popular tweets and posts this quarter includes '#Movember', our attendance at the International Volunteering Conference in December and our extended Christmas opening hours.

On Instagram, we are approaching 60 followers and are gaining on average 7-8 new followers each month – slow but steady progress. We use it to regularly post images of our outreach and engagement activities and followers engage with us by commenting on or liking our posts. There are currently over 400 million active users on Instagram worldwide it therefore has the potential to become a very powerful visual marketing tool.

Our website has received visits from nearly 20,000 individual IP addresses between October and December 2016. They visited 47,000 times and looked at 150,000 pages.

3. PROJECT UPDATES

Maternity Care

The engagement programme for the project has now been completed. We have spoken to over 250 women. The data collected has been analysed and an initial evidence document produced for stakeholders on the experience of women of the maternity service in Hillingdon.

Following response from The Hillingdon Hospital NHS FT, Hillingdon CCG and Hillingdon Council's Children Centres we will be formulating the final report which will be published in March 2017 and formally presented to the next Health and Wellbeing Board.

4. ENTER AND VIEW ACTIVITY

PLACE Assessments

8 assessors carried out 2 PLACE assessments in October and November 2017 at Mount Vernon and Hillingdon Hospital respectively.

One of our most experienced assessors is now attending the hospital PLACE steering group for Healthwatch. This group monitors the delivery of the improvement plan.

5. KEY PERFORMANCE INDICATORS (KPIs)

To enable Healthwatch Hillingdon to measure organisational performance, 8 quantifiable Key Performance Indicators (KPIs), aligned to Healthwatch Hillingdon's strategic priorities and objectives have been set for 2015-2017.

The following table provides a summary of our performance against these targets.

Key Performance Indicators 2016/17

*Targets are not set for these KPIs as measure is determined by reactive factors.

KPI no.	Description	Relevant Strategic Priority	Monthly Target 2016-17	Q1			Q2			Q3			Accumulative Totals	
				2014-2015	2015-2016	2016-2017	2014-2015	2015-2016	2016-2017	2014-2015	2015-2016	2016-2017	Target	Actual
1	Hours contributed by volunteers	SP4	525	692	550	**637**	732	625	**522**	583	462	**491**	1575	**1650**
2	People directly engaged	SP1 SP4	300		354	**434**		333	**270**		250	**634**	900	**1338**
3	New enquiries from the public	SP1 SP5	125	124	232	**177**	126	402	**296**	96	241	**173**	375	**646**
4	Referrals to complaints or advocacy services	SP5	N/A*	19	9	**12**	15	14	**8**	18	7	**1**	N/A*	**21**
5	Commissioner / Provider meetings	SP3 SP4 SP5 SP7	50	68	49	**93**	68	60	**69**	87	54	**69**	150	**231**
6	Consumer group meetings / events	SP1 SP7	10	62	22	**16**	48	25	**15**	42	10	**15**	30	**31**
7	Statutory reviews of service providers	SP5 SP4	N/A*	0	0	**0**	0	0	**0**	0	1	**0**	N/A*	**0**
8	Non-statutory reviews of service providers	SP5 SP4	N/A*	5	7	**3**	2	4	**3**	4	3	**2**	N/A*	**8**

healthwatch Hillingdon

Safely "home" to the right care

The experiences of Older People being discharged from Hillingdon Hospital and the onward care they received in the community

February 2017

CONTENTS

We have produced a short film of patients lived experiences to accompany this report.

Watch it at: https://m.youtube.com/watch?v=5mgLI37uPzE

A special thank you to Save the Dog productions for volunteering their services to make this film

Save the Dog productions

+44 (0) 20 8355 2672
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HEALTHWATCH HILLINGDON

Introduction

Healthwatch Hillingdon is a health and social care watchdog. We are here to help our residents get the best out of their health and care services, and give them a voice to influence and challenge how health and care services are provided throughout Hillingdon.

Healthwatch Hillingdon has very strong operational relationships with the local NHS, Council and Voluntary Sector organisations. We are an independent partner and a valued "critical friend" within health and social care.

Membership of the Hillingdon Health and Wellbeing Board and Hillingdon Clinical Commissioning Group Governing Body enables us to have considerable strategic input into the shaping of local commissioning and the delivery of services.

As a local partner, we are kept well-informed, can challenge and seek assurances on behalf of our residents, ensure that the lived experience of patients and the public are clearly heard, and are influencing decisions and improving health and social care in Hillingdon.

Reports and Recommendations

Healthwatch Hillingdon produces evidence based reports for commissioners and providers, to inform them of the views and experiences of people who use health and social care services in the London Borough of Hillingdon.

Commissioners and providers must have regard for our views, reports and any recommendations made and respond in writing to explain what actions they will take, or why they have decided not to act. [i]

Healthwatch have a duty to publish reports they share with commissioners and providers, and their responses, in public.

Our reports and recommendations are also shared with:

- Hillingdon Health and Wellbeing Board
- Hillingdon External Services Scrutiny Committee
- Healthwatch England
- The Care Quality Commission

EXECUTIVE SUMMARY

Overview

Nationally there is a recognition that health and social care services face enormous challenges because of financial pressures and a rising in demand, driven by a growing ageing population.

As statutory organisations look to address this challenge several initiatives and strategies are being implemented at differing rates across the country.

In Hillingdon, these include a number of programmes that initially concentrate on the adult population over the age of 65.

- The Better Care Fund
- Whole System Integration (Accountable Care Partnership)
- GP Networks (Federation)

With these local initiatives in their infancy and recognising that the pressures upon Hillingdon Hospital were dramatically increasing - with unprecedented numbers attending A&E and rising numbers of delayed discharges being recorded – Healthwatch Hillingdon decided to look at how this was affecting patient experience.

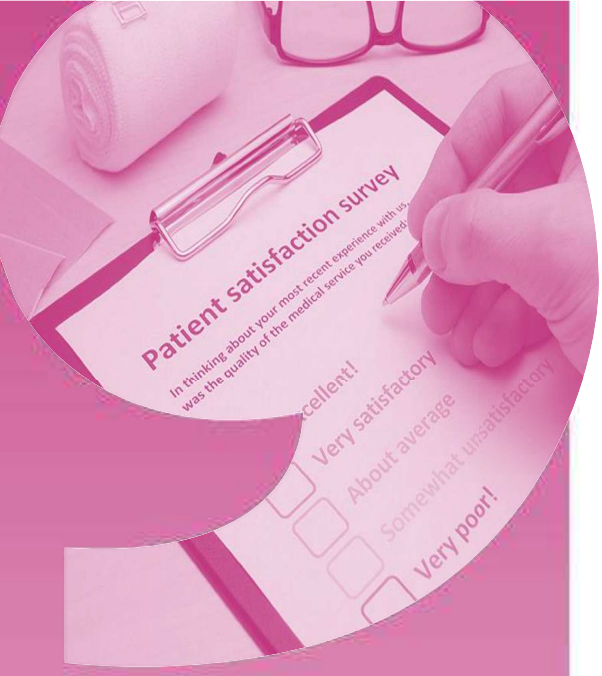
Objectives

Our discharge project set out to engage with Hillingdon residents over the age of 65, who have recently been involved in the discharge process at Hillingdon Hospital.

Through their personal experience, we looked to gain a greater understanding of the effectiveness of discharge processes and the support and care provided to them post discharge, in their home, or another care facility.

We looked to ascertain what works well and outline recommendations where service delivery may require improvement.

The project was also an opportunity to benchmark current service provision. As a tool to evaluate the effectiveness of the new programmes as they are embedded over the coming years.



Methodology

An extensive engagement programme carried out between June and October 2016 saw us interview and survey, 172 inpatients at Hillingdon Hospital, 52 of those patients post discharge and the professionals and staff from over 20 organisations.

Findings

The over 65's express an overwhelming feeling of pride in the NHS and hospital services. They are quick to praise Hillingdon Hospital for their caring and attentive staff, and give individual examples of exemplary conduct.

They are largely from a generation where they just 'get on with it' and 'don't want to cause trouble', and as such some were reluctant to say anything against their care. We found that they were far more comfortable speaking to us after discharge, than they were on the ward.

The satisfaction rate for discharge and the follow up care is varied. Patients expectations differ considerably resulting in polarised views on the same subject.

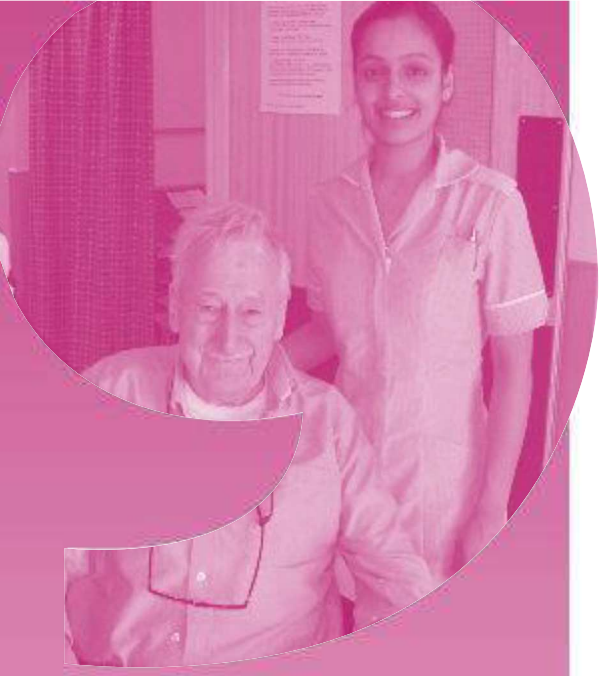
Service delivery is not always consistent and there are a number of areas which we found impacted upon the patient/carer experience.

The professionals and staff we spoke to during our engagement demonstrated that they are committed to providing the best care they can in their role.

They were candid in their responses.

It was sad to note that we found general dissatisfaction amongst professionals and staff. Many expressing frustration, as they highlighted a number of operational barriers and areas along the discharge pathway that required improving.

The evidence provided by both the staff and patients, and the impact upon their experience of the discharge pathway, broadly falls into 3 categories:



Communication and Information

Patient/carers said that they want to be fully informed across the whole pathway. They stated that the communication between them and professionals and the information provided to them is often poor. Many reported that they were not involved in the planning of their discharge and follow-up care and support. They have illustrated where they have been unable to speak to a doctor, have forgotten or become confused about what they have been told, do not know what medicines to take, who is coming to see them at home, or how to arrange a private care home placement, or care package. This leads to them being uncertain and anxious which becomes a barrier between them and staff. This promotes a situation which is not positive for either party. When uninformed, patients/carers persistently seek answers and this increases the number of interactions with staff, which in turn impacts negatively upon already stretched staff, by taking them away from other activities.

Evidence would suggest that by providing clear written information to inform patient/carers and support them to make decisions would empower them to become partners in the discharge process. This will improve outcomes for both patients, partner organisations and their staff.

Recommendations

1. The Trust has a booklet titled 'Working Together'. This was a trust wide initiative which commenced in September 2014 with the aim of issuing this booklet to all admitted patients. This booklet would then be filled in during the inpatient stay, and would be completed on discharge complying with many of the details listed in the NICE requirements[ii].

   We would recommend that this booklet is reviewed and updated to produce a 'Patient Journey' booklet that keeps patient/carer fully informed during the inpatient stay and outlines the details of the follow-up care and support arranged.

This will then act as a clear method of communication between patient/carers and professionals in hospital and in the community.

2. We would recommend that patient/carers are provided with written information about social care and continuing health care assessments in line with the Care Act[iii]. This should clearly outline, entitlement, assessment process, financial implications and support and information to make decisions on the selection of private care.

3. We would recommend that where an individual has substantial difficulty in being involved in the assessment process and their onward care provision, that an independent advocacy should be provided.

Processes and Procedures

Throughout the course of our engagement patient/carers informed us that during their inpatient stay the staff were working hard to provide them with good care.

There was a general observation that they often felt staff were stretched and did not have the time they would like to attend to the patient's needs. They also perceived a variation in care between the day and night shifts, and permanent and agency staff.

The use of agency staff and workforce pressures were also raised by staff in both the hospital and the community.

Several patients reported that they felt under pressure to leave hospital. With some highlighting that they had been told by staff that their bed was needed for somebody else.

Our researchers saw a marked difference in the discharge procedures on each ward and several patient/carers who had experienced multiple inpatient stays also identified this to us. This is exampled by the discrepancy in how patients awaiting medication and transport are processed. Depending upon which ward, patients of a similar condition, could either, wait in their bed, be

asked to sit in the ward's day room, or will be sent to the discharge lounge.

Professionals and staff also echoed concerns around procedures not being uniform across the wards.

From the conversations we had in the discharge lounge, we found that patients often waited for many hours, without hot food or other facilities. This was particularly apparent for those awaiting patient transport.

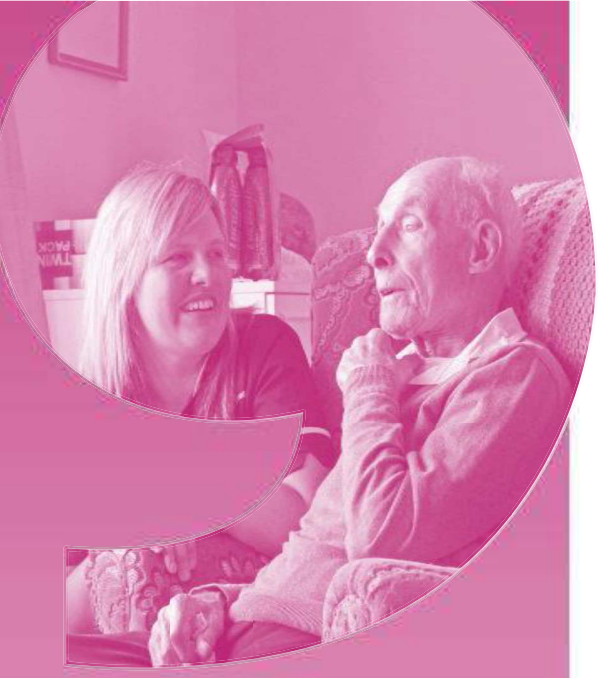
Although waiting for medication at discharge remains a frustration for both patients and staff, on the whole all patients went home with the medication they required. Some patient/carers did highlight to us that they were confused about their medication; especially those who were dispensed multiple drugs at discharge.

Recommendations

4. We would recommend that the hospital looks to standardise the discharge process across all wards. A compulsory uniform process could provide many benefits to improve the patient and staff experience.

   When identical and consistent, a process becomes natural and this can only positively affect the pressures on staff. Applying the same process may also assist the hospital in its compliance with the 'Safer Staffing' initiative. Staff and agency staff can seamlessly transfer between wards. Resulting in bank staff able to work on any ward with confidence, agency staff training and induction becomes easier, returning agency staff become familiar, and escalation wards can be opened quickly. This in turn may help with staff recruitment and retention and positively affect the quality of care provided to patients. As staff have more time and opportunity to care for patients in the way they want to. Possibly improving staff moral and encouraging agency staff to become substantive.

5. We would recommend a review of the discharge lounge be carried out, to assess how effective it is in meeting the needs of patient/carers who are waiting there. Without any pre-emption of this assessment,



we would suggest the scope includes looking at facilities/amenities available to patients, food and drink, and timely information on their medication or transport.

6. We would recommend that in addition to written instructions for those patients being prescribed multiply medications, that the hospital also looks to provide Dosette boxes, or blister packs. This will mitigate against possible unintentional overdose, improve patient safety and could avoid some readmissions.

7. We would recommend that when discharging an older person that it becomes standard practice to proactively refer to Hillingdon Carers for further support, especially when:

   - the patient is the carer for their partner.
   - the partner is the sole carer for the patient.

Closer integration and joined up working

We have already spoken about communication and how written clear information is needed to aid patient/carers in the discharge process. Patient/carers also pointed out to us that organisations do not necessarily communicate with each other well, or work as closely together as they could. They have told us about their GP not receiving a discharge summary, not being accepted on transfer to intermediate care and being sent back to the hospital. Assessments being carried out separately by social services and hospital staff, not all relevant partners being invited to multi-disciplinary team meetings and domiciliary carers not knowing how to contact district nursing.

Timely communication between organisations is something the 'system' has been striving to achieve for some time. Patients tell us it is something they want too. The 'Patient Journey' booklet we propose could go part way to connecting organisations who are currently providing care for an individual, but more work needs to

be done to connect the whole 'system' and for the 'system' to have a joint way of keeping patients/carers involved and informed.

Ensuring the organisations that will be providing care, are all involved in the discharge process is a key element for patients and their ongoing care. Patients and their families do not always see this and that needs to be embedded in the discharge process. Patients/carers tell us they want this to include domiciliary care agencies and care homes directly.

Although not picked up in our conversations with patients it should also be noted that our researchers were told of confusion amongst ward staff of the function of the Joint Discharge Team, and it was questioned whether it was being fully effective.

Organisations need to know about each other's services and know how to signpost patients/carers effectively to each other.

The Accountable Care Partnership is an opportunity to deliver this closer understanding of the different organisations and improve our joint working but again close working relationships need to be built with organisations providing 'social' care.

Recommendations

8. We would recommend that serious consideration is given to the proposed ***single point of access for discharge***.
    - As a possible solution to providing wrap around and integrated care for the patient/carer.
    - And; as an information hub for professionals to greatly improve communication between organisations and the understanding of each other's services.
9. We recommend that there is an evaluation of the Integrated Discharge Team. To review membership and effectiveness.

Rising demand for services, combined with restricted or reduced funding, is putting pressure on the capacity of local health and social care systems. The number of people aged 65 and over in England is increasing rapidly. The relative growth in numbers of older people is important. The number of older people with an emergency admission to hospital increased by 18% between 2010-11 and 2014-15. In 2014-15, the percentage of older people admitted to hospital after attending accident and emergency (A&E) was 50% compared with 16% for those aged under 65.

Although overall length of stay for older patients following an emergency admission has decreased from 12.9 to 11.9 days between 2010-11 and 2014-15 - suggesting improved efficiency - the overall number of bed days resulting from an emergency admission has still increased by 9% from 17.8 million to 19.4 million days.

Put simply, without major change, these recent trends indicate that the more older people there are, the more pressure there will be on hospitals.

While NHS spending has grown by 5% in real terms between 2010-11 and 2014-15, local authority spending on adult social care has reduced by 10% in real terms since 2009-10

Extract from "Discharging older patients from hospital" published by the National Audit Office May 2016[iv]

England

With a growing population, people living longer and a rise in the number of people living with one or more long term conditions, the need for the health service and social care support is increasing.

30% of the population have one or more long-term condition and these conditions account for £7 out of every £10 spent on health and care in England.[v]

Currently, people aged over 65 represent 18% of the total population, up from 12% in 1966. It is projected that by

With the continued rise in demand, against a backdrop of financial pressures, it is nationally recognised that health and social care services face enormous challenges.

2039[vi] nearly a quarter of the population will be over 65, with 1 in 12 people being over 80.

It is reported that over 5 years there has been an 18% increase in emergency admissions for older people.[vii]

Nearly two-thirds of people admitted to hospital are over 65 years old. Accounting for almost 70% of emergency bed days.[viii]

On average, the over 65's tend to stay longer in hospital and they are more likely to have their discharge delayed, after they are clinically fit to leave.

In the last 2 years there has been an increase of 55% in the average number of delayed transfers of care that are attributable to social care.[ix]

For older people, longer stays in hospital can have adverse effects. They can quickly lose mobility and the ability to live independently. This can increase their long-term care needs and worsen their health outcomes.

In real terms 81% of local authorities have cut their spending on social care for older people over the past five years.[x] With a 30% drop in older adults receiving publicly-funded community based services, 18% fewer receiving home care and 50% less, day care.[xi]

With the continued rise in demand, against a backdrop of financial pressures, it is nationally recognised that health and social care services face enormous challenges.

Hillingdon

The challenges in Hillingdon are no different.

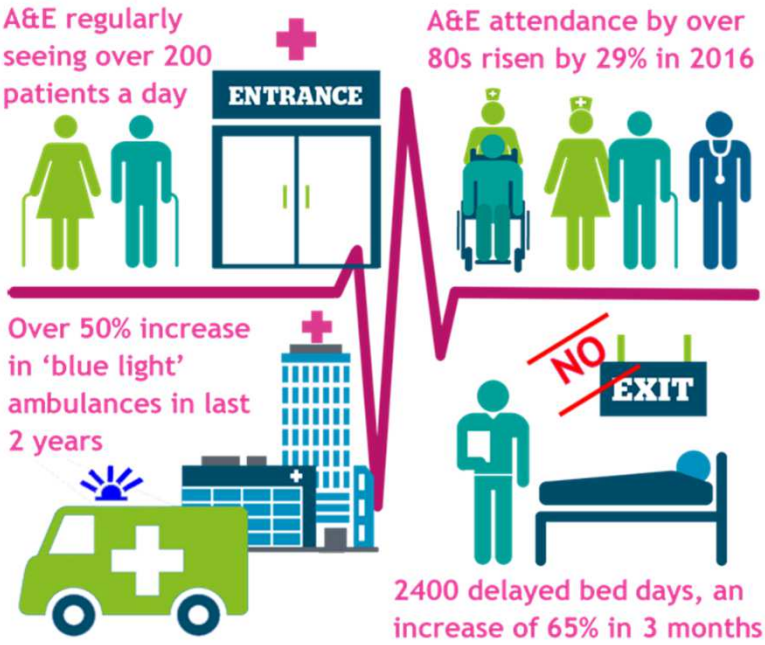
The Hillingdon Hospital's A&E department has a calculated daily capacity for 160 patients and is regularly seeing over 200.

In the last 2 years there has been an increase of over 50% in the arrival of 'blue light' category 1 emergency ambulances – who carry the sickest patients.

Attendance at A&E by older people is rising. Most noticeably in the over 80s which has risen by 29% in the last year.

With the development of Ambulatory Care Clinics[xii] the number of over 65s admitted into Hillingdon Hospital has actually reduced by 6% in 2016. However, delayed discharges of medically fit people have risen sharply. During the period of our engagement they rose 65%. With over 2400 delayed bed days recorded in that quarter (July to Sept 2016).

Although 15% of these delays are due to patient choice, the majority - 70% - are attributed to finding placements in residential or nursing homes.



For Social Services and NHS Continuing Health Care, securing sufficient capacity, in care homes and domiciliary care, to meet current need is a definite challenge in the borough.

And; for all care providers in Hillingdon the recruitment and retaining of staff continues to be difficult and is compounding their pressures.

Strategic Plans

There is a view shared by many that to address these new challenges, the NHS needs to adapt and change.

In the NHS England, Five Year Forward View[xiii] the NHS' national leadership outline a clear strategic vision for the NHS to meet these challenges.

A plan to improve the nation's health, transform the quality of care delivery, and make the NHS financially sustainable[xiv]

The vision concentrates on prevention, supporting people to take control of their own health, GPs working together at scale and for new models of care.

A future, where organisational barriers are broken down and NHS organisations work closely, in collaboration, with the council, voluntary sector and local people to improve health and care for their population.

Local Plans

It had long been recognised that to improve the local health and social care system in Hillingdon, care would need to delivered differently.

Led by Hillingdon Clinical Commissioning Group and the Local Authority there have been a number of strategic initiatives that have been started in Hillingdon. The majority of these have concentrated on the care provided to Hillingdon's older residents:

- Integrated Care Programme
- Better Care Fund
- Whole System Integration - Accountable Care Partnership
- GP Networks

These work streams have all focused on collaboration and organisations working closely together, to change the way in which care is delivered.

This has led to mature relationships being built between organisation and Hillingdon being in a good place to build on the current initiatives as part of the Sustainability and Transformation Plan.[xv]

INTRODUCTION

Discharge processes cut across the responsibilities of multiple agencies and have long been recognised, as an indicator to assess the effectiveness of care in a local health and social care system.

In a 'perfect system', multi-agency working and collaboration is seamless. People are appropriately supported at home. Hospital activity is planned and when admitted to hospital for emergency unplanned activity, the patient is timely discharged back to being supported in the community.

The Healthwatch England report 'Safely home: What happens when people leave hospital and care settings?'[xvi], published in July 2015, provides evidence that health and social care systems across England are far from 'perfect'.

Healthwatch Hillingdon had already recorded many patient's stories relating to discharge and the provision of care and support in the community, for residents over 65. Through our strategic involvement, we were using this information to inform the change programmes.

With pressures upon Hillingdon Hospital dramatically increasing - with unprecedented numbers attending A&E and rising numbers of delayed discharges being recorded. Healthwatch Hillingdon decided to look at how this was affecting patient experience.

Our discharge project set out to engage with Hillingdon residents over the age of 65, who have recently been involved in the discharge process at Hillingdon Hospital.

Through their personal experience, we looked to gain a greater understanding of the effectiveness of discharge processes and the support and care provided to them post discharge, in their home, or another care facility.

We looked to ascertain what works well and outline recommendations where service delivery may require improvement.

The project was also an opportunity to benchmark current service provision. As a tool to evaluate the

effectiveness of the new programmes as they are embedded over the coming years.

We worked closely with The Hillingdon Hospital NHS FT and we would like to thank them for facilitating access to the patients and staff we have spoken to during our engagement program.

We would also say thank you to all the organisations who we engaged with and the staff we spoke to. Their insight gave us a greater understanding of the patient journey, from hospital to 'home' and a further dimension to understand what works well and what could be improved.

We also express a special thank you to all the patients and their carers or families that have taken the time to tell us about their experiences.

The Patient and Carer experience outlined in this report has been shared with local Partners who either commission or provide care to give them an opportunity to:

- assess the quality and effectiveness of discharge and the follow-up care we provide in the community
- consider how this evidence can inform current work streams
- consider how we can use this evidence to develop better services for Hillingdon's residents.

During our research, we have identified possible solutions and outline these as recommendations for Partner organisations to consider.

If implemented, these recommendations may help towards improving:

- the patient/carer experience
- staff experience and job satisfaction
- quality and safety of care
- length of stay
- readmissions

METHODOLOGY

Stage 1

172 patients were interviewed and completed a survey on 17 different wards (including the Discharge Lounge), over a period of 2 months. Patients gave written permission for Healthwatch to follow up the survey with another survey once they had been discharged from hospital. The second survey would ask about their experience of the discharge and how they were coping post discharge.

The survey was sometimes completed by a patient's advocate, and permission was given for us to follow up with this contact.

The survey data was then recorded into a database for analysis.

Stage 2

Patients interviewed on the wards, or their advocates, were then phoned at home 30 days after their original interview. This contact asked how the discharge process had gone, and if adequate care was in place for their needs.

This was a more challenging aspect of the project as some patients were still in hospital, some had died, and some were no longer at the contact number.

52 discharged patients/advocates completed the second survey. These were recorded into the database for analysis.

Stage 3

We met with over 20 local organisations who commission, or provide care services for the over 65's in Hillingdon, within hospital and the community. This engagement, with senior managers and frontline staff, looked to

identify and understand the processes and procedures involved in discharge; and the factors, barriers and enablers that contribute to providing patients with a safe transfer from hospital to being cared for in the community.

Views were canvassed from the following:

- The Hillingdon CCG
- Continuing Health Care
- Hospital staff and managers
- London Borough of Hillingdon Social Care
- Age UK Hillingdon
- Hillingdon Carers
- Care homes
- CNWL Community Services
- GPs
- H4ALL
- Domiciliary care agencies

DIGNITY, CARE AND COMPASSION

Older patients arriving at THH are from a generation who express pride in what they regard as 'their' NHS.

They are largely from a generation where they just 'get on with it' and 'don't want to cause trouble or be a nuisance'. They endure, and don't like to complain. They feel vulnerable as many have lost confidence with age.

81% of patients said that they were either satisfied or very satisfied with the way they were treated overall. They said staff were caring and trying their best, but wards were very busy, which led to lengthy waits in being attended to, long waits for medication and poor communication. It was no surprise therefore when asked what could be improved, 31% of these said they felt the hospital was understaffed and needed more doctors and nurses.

Of the 19% of patients who said they were dissatisfied or very dissatisfied with their care. The reasons given for their dissatisfaction were:

- requests made to staff were not completed
- no continuity of care
- night staff are less caring than day staff
- agency staff are not as good as permanent staff
- never see the same face
- having to frequently move wards
- personal care not carried out, like cleaning dentures
- anxiety over toileting and not being assisted to go
- not understanding what is happening to them

The professionals and staff that we spoke to also recognised that there is an inconsistency of care. Hospital staff pointed out that this is not helped by the high turnover of staff and the need to use agency staff, who lack a clear understanding of hospital procedures. They also recognised the lack of consistent discharge processes for staff to follow across the wards. Set processes and procedures are often not followed. Instead, organic procedures have developed on each ward.

10% of patients and their families expressed deep dissatisfaction in what they consider to be a major failure in the discharge pathway, again siting staff under pressure as being the reason for poor communication and procedures. Many felt under pressure to leave the hospital as they were very aware of the urgent need for beds. Professionals that we spoke to concurred with the view saying that they felt under pressure to discharge patients, as the hospital is under huge pressure from the demand coming through the doors.

Pain relief was a concern of patients, with many saying they had to wait lengthy periods to obtain authorisation from unavailable doctors for medication to be administered. This is an issue also recognised within the hospital, again attributed to pressure of demand and lack of available doctors and nurses.

COMMUNICATION

30% of patients and/or their carers referred to poor communication and lack of understanding about their condition. Professionals and staff also recognised the need for better communication and explanation for patients and families/carers, but see the need for better processes and management to be able to free up 'fire-fighting' time in order to invest in the necessary commitment to clearer communication.

Patients and families/carers wanted an understanding of their situation from a member of staff. They were often told they needed to speak to a doctor for this, but that could mean waiting a considerable time. Professionals and staff also felt there is a need for a communication process consistently applied. Some wards seem to allow an appointments system with doctors, others do not. It seems to be very hard to get any time with a doctor.

Patients sometimes forget, don't hear or get confused about what they have been told. This can lead to the family /carers being uninformed, which leads to family seeking information from staff which is often time consuming and frustrating. Patients and their families/carers would therefore like information from doctors explaining the current situation and what would happen next, written down.

Staff told us that this would also help them, as much of their time is taken up with enquiries from families, and not all staff roles are aware of the full situation on a patient to be able to effectively give an update.

Patients also felt confused by conflicting information from staff on their discharge. Physios may have told them one thing, the Occupational Therapist another, ward staff something else. Discharge dates kept changing, expectations were raised then dashed. Through all this patents felt they weren't communicated to adequately or listened to. Families/Carers felt anxious and didn't understand what diagnosis, prognosis or treatment had taken place or how to avoid the condition in the future. There was no one they could talk to who could tell them the whole co-ordinated picture.

65% of patients, carers or family members felt they were not given the chance to raise any concerns they had about their discharge or going home. They would have liked the opportunity to talk about their concerns and have information on how to manage their condition after going home. Many felt advice on nutrition would have helped but this wasn't necessarily available.

Families/Carers say there is poor communication of what 'Continuing Health Care' means, and what help they can get for their loved ones when they come out of hospital. Professionals and staff echoed this confusion and saw part of the solution as being a clear user friendly published discharge policy, which everyone can follow and refer to. Staff said that they are aware that families think they are not told about continuing health care options as the NHS wants to 'save money'. Transparency is key, and staff would welcome a clear process to guide patients/families through all the options for leaving hospital care.

PATIENT NEEDS ASSESSMENT

Relatives of patients expressed a desire to be included in discussions about their loved ones when the patient is incapable of contributing to an assessment of their needs. They felt that an assessment may not be accurate when relying on confused information from an unwell patient. Professionals also raised concern that both

families/carers, and the right skillsets were not always present at meetings to fully inform a decision on care needs. Quite often, daily home carers who know the patient intimately are not asked for any input into understanding the patient's on-going needs. Professionals also pointed out that the lack of joined up IT systems meant that not all the information is always available to make a fully informed decision.

Professionals also felt that sometimes needs could be met for patients at home by community services, but what may be available for a patient is not always understood. A better awareness of community services at the assessment stage could expedite an earlier discharge.

There was confusion amongst professionals about whose responsibility it was to find out the financial situation of a patient in need of continuing care. It was felt that staff required a greater understanding and training on the roles and responsibilities at assessment.

We found that assessments can be carried out on the same patient, by the hospital, social services and a care home. Which leads to confusion for patients and their families and disagreement between organisations.

Patients and their families/carers wanted to understand how the assessment was conducted and the conclusions arrived at. Families also wanted clarity around who makes the decisions on care going forward for the patient.

Families have told us about meetings that they have attended where recommendations for care packages have been made by medical staff but overridden afterwards by social workers. This we have found is also frustrating for professional staff who told us that their expertise and advice is overridden.

Patients and families/carers want accurate information on assessments and their entitlements. They feel the whole funding entitlement rules are very confusing. Many were worried that they must attempt to sell their parent's house while they're still in hospital, in order to pay for care when they come out.

Clear understandable written information explaining options would go a long way to alleviating the stress on families at such a difficult time. Professionals concurred with this view, and agreed that funding rules are complex and difficult to explain.

Finding a care home is particularly difficult regardless of funding, especially if the patient has dementia and behavioural problems. Relatives expressed anxiety over lack of help procuring a home, and the time it takes to get their loved ones placed.

Professional staff expressed frustration over families refusing care home placements which led to beds being unavailable for acute medical need.

They felt that having a joint placement board for patients needing a care home would be more efficient than the Local Authority and Clinical Commissioning Group working separately. A joint board would stop duplication of effort and competition for a scarce resource.

When asked to determine whether they can meet the needs of an individual, care homes are sent a FACE assessment form[xvii], outlining the care and support the patient requires. Care homes felt that the process could be made more efficient and it would benefit patients, if the assessment form did not contain acronyms, and was always dated to confirm it was current.

CARE PLANS AND DISCHARGE INFORMATION

Although the NICE[xviii] regulations state that a patient leaving hospital in need of on-going care should have a fully documented plan, this rarely happens. Only 14% of our sample said that they had been given anything that explained what care they would be getting on discharge.

Staff told us that they would welcome a consistent template for providing discharging patients with a plan, as currently there is a mixture of different methods: some provide written advice for the patients, while most just issue the discharge summary.

Patients who left with a 'Discharge Summary' said it probably meant something to their doctor but it meant very little to them as it is written in medical language.

Care professionals told us that in the absence of anything else the Discharge Summary was a useful document, but found it to be inaccurate in some cases, and often written too early and therefore not documenting recent issues.

A Discharge Summary document is given to the patient and a copy sent to the GP. However, there are other services caring for the patient in the community that would benefit from having this information. On occasions patients are attended at home for the first time without any prior knowledge of a person's condition.

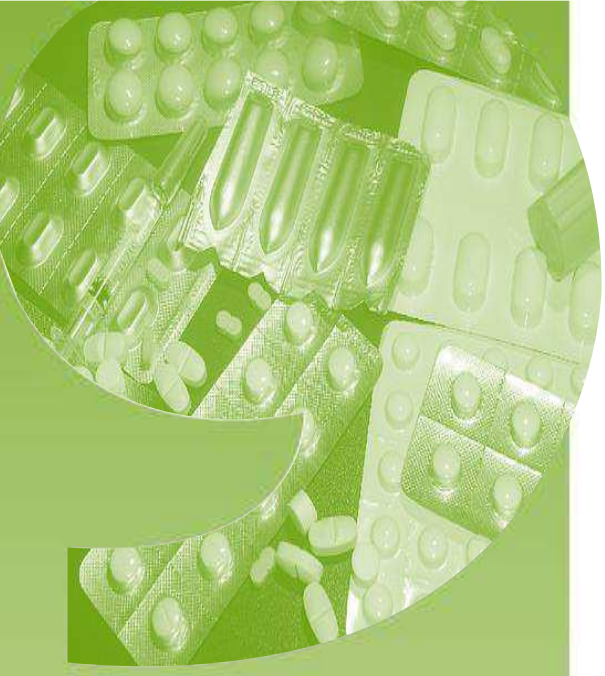
Care homes told us that they would welcome a clear plan, arriving with the patient, written in plain English, without acronyms. They saw inconsistency in the information they received with a discharged patient, with some wards giving care homes no information, making it difficult to provide initial effective care.

Some families said they were shocked at the care package received, not being what was agreed at discharge meetings, and would have challenged this had there been a published care plan in place.

We found that little regard, or help, is given to the family carers of the patients returning home. No support or signposting is offered. Quite often carers are not aware of the help they can get and are often the frail elderly partners of the patient. Or, the patient is the carer themselves, returning home whilst still in need of recovery to look after a partner with a chronic condition.

Professionals told us that a referral for a carers assessment at the point of discharge would ensure that the family carer was contacted and offered support. Lack of joined up communication and processes were often given as examples of where the 'system' is failing the discharging patient and their family carer.

Whilst some treatment areas of the hospital are good at providing information on discharge and on how to manage a condition, this is not consistent throughout the



hospital. Many patients/family/carers say they left not knowing how to manage a condition, or what to do. Professionals concurred that information was patchy.

Patients/families/carers would like written information at discharge which clearly shows:

- the details of the patient's condition
- what has been done to them in hospital
- who they can contact if they have a problem
- medicines needed and frequency
- what support they can expect when they get home
- who will be providing this support
- how they can contact the support
- what they can do to manage their condition
- details of useful community and voluntary services who can support them

Professionals felt a care plan on the discharge of a complex case was invaluable, but advised that there needs to be just one unified plan. Currently the patient can be provided one by both the NHS and Social Services. We were given an example, where assessments are carried out in hospital for patients who are already known to Social Services and on a plan. This is confusing for patients and felt to be a duplication of resource.

MEDICATION

Medication is a big issue for patients. Whilst 95% of patients said they were discharged with the necessary medicines, many were unclear about dosage or frequency.

Many commented on being given a big bag of tablets which they had no idea how to cope with. Many elderly patients do not have the memory to manage tablets as prescribed.

Medication is also confusing for care agency staff, who often rely on family members (who are also confused) to administer the correct medication.

> I think provision of an updated dosset box by the hospital will be the single most improvement in quality of care for this elderly group of patients.

Relatives who have a good relationship with their local pharmacist told us that they were too concerned about giving the wrong dosage to their loved ones and so took the bags of tablets to their local pharmacist, who have in many cases sorted out Dosette boxes to help.

Two patients had been previously admitted for inadvertently overdosing on their loose tablets.

It was the general consensus of all parties, that blister packs, or Dosette boxes, should be provided at discharge to ensure that patients take the right medicines and the correct dosage.

Under the current process, blister packs and dosette boxes are prescribed by GPs and not stocked at the hospital. Hospital staff told us of a number of occasions where discharges were delayed by days, whilst a blister pack was obtained.

One GP said **"I think provision of an updated dosset box by the hospital [at discharge] will be the single most improvement in quality of care for this elderly group of patients."**

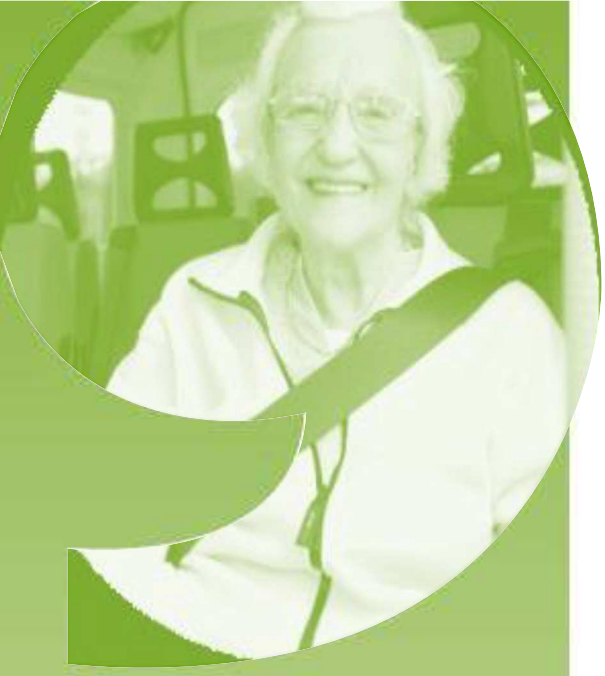
Patients, families and carers also want to fully understand what the medicines are for.

Many were confused about old medicines used before their hospital admission, whether they should continue to take them alongside the new medication prescribed. This is again also confusing for both family carers and carers from agencies.

Another big issue is medication not being ready when a patient is ready to leave the hospital. This can mean a patient is waiting for hours in the discharge lounge, day room, or their bed.

Patients want a discharge process where the pharmacy is fully aligned with time of discharge. This of course is impacted by finding a doctor to sign off medications needed for discharge.

Both patients and professionals highlighted incidents where inefficiencies in providing medication led to patients, who were medically fit, staying in hospital longer.



Professionals in the hospital recognise timely medication at discharge as being an issue. A frustrated staff member cited “like many issues, due to the demands, there isn’t the time to stand back and address the processes”.

There is also a clear consensus that the pharmacy should have opening hours to match the hours of demand, especially at the weekend.

Finding an available doctor to sign off medication is also an issue for patients needing medication during their stay. Pain relief is often delayed awaiting doctor sign off.

TRANSPORT

Half of our patients surveyed after discharge went home by hospital transport. Many of them commented on the long wait times for transport.

Those waiting in the discharge lounge commented that there are no facilities for long wait patients. There is no entertainment (TV or magazines), no hot meal provision, Professionals and staff in the hospital raised with us this issue and were equally concerned that it had no provision for patients who cannot sit in a chair and need to lie down, and support for confused patients who wander.

If patients want a co-ordinated discharge process which means they do not have to wait for up to 8 hours for a vehicle to take them home. They want a seamless discharge process where medication and transport comes together in time for a patient to go home. Especially when family, or agency carers, have been informed and are there waiting to receive them.

Families and care homes described transport to transfer patients being arranged for late in the evening. Care homes spoke about patients arriving as late as 11pm which isn’t good for the resident, or the care home. A few expressed concerns that patients can arrive unannounced when they are not prepared for a new admission.

Again, professionals in and out of the hospital recognise that the transport process is ‘poor’. It is expected to be ‘unreliable’. They give examples of poor joined up working and communication, which often results in

delayed discharges, as patients miss their ‘slot’ and must wait another day(s) for re-scheduled passage home.

The more experienced transport crews do communicate with the care agencies directly, to ensure they rendezvous with carers when taking a patient home. But this is not standard process and vulnerable patients can be left at home without carers present.

Poor communication has been cited for transport turning up to collect patients for follow-up outpatient appointments, when the appointment was the following or previous week, or the patient was now deceased.

Hospital transport is currently being retendered and is under review. This opportunity needs to be taken to ensure that, the service for patients at discharge is safe, efficient, and that methods are devised for timely communication between the transport, and family or carers when the patient is being taken home.

DISCHARGE

42% of patients thought it was the right time to leave hospital when they did and were extremely grateful for ‘fantastic medical treatment’.

36% of patients felt they left hospital too early, some felt this was due to the hospital’s urgent need for beds. Patients want to be discharged when, and only when they are medically fit. They want to be discharged when everything is in place for a safe return home. They wanted to feel that their own health situation is the primary concern, not the need for their bed.

Professionals felt that individually each hospital department was working robustly to ensure a timely and safe discharge. It is acknowledged that most staff are working flat out, under great pressure to care for patients and ensure they go ‘home’ with a positive outcome. However, staff acknowledged that this has led to a ‘blame culture’ where patients and families are being told ‘we’ve done our bit, we are now waiting on them” and they are not seen as a united team. This is giving patients a negative impression and a perception that their care is disjointed.

Both patients and families/carers felt that there needs to be more joined up working between the hospital and social services as there are delays and confusion over what care is being provided and who will be providing it.

Patients want to know when they are going to be discharged and for the date/time to be met, not postponed. They want a seamless service, to leave on time without waiting, and they want to leave with a care plan and clear written advice on what is going to happen next. Professionals also want a more effective discharge service. They want discharges spread evenly over a 7 day week, and a discharge plan for all professionals to see and work towards.

POST DISCHARGE

68% of patients felt the right care was in place on leaving hospital. However, 32% felt care was only partly in place or not in place at all.

Patients wanted to be discharged to a safe place with the supporting equipment implemented before they got there. This wasn't always the case.

They wanted to know exactly what the expected care package was, and what community services they would be receiving, when these were going to arrive and how to contact them if they didn't.

Professionals in the community also said that although the GP is provided with a copy of the discharge summary it would help them to receive a copy to have more understanding of the patient's condition and circumstances.

Relatives and patients were unsure of what happened when re-enablement care finishes. They were anxious about who would care for them and whose responsibility it was to arrange.

They wanted to understand what outpatient appointments they would need to attend, and when, and how they would get there.

They also wanted to know who they could contact if they found themselves in difficulty after leaving the hospital.

Going forward patients and relatives/carers wanted to know how to manage their condition so that they could avoid hospital admissions in the future.

Professionals who gave their view on post discharge services, agreed that agency carers require better training to help them identify signs of deterioration in the person they cared for, administer medication more effectively, and be able to seek relevant help from the right agencies to prevent a hospital admission.

It was acknowledged that some care agencies provide a robust training programme for their carers, but sadly this is not always the case. Regulations to ensure carers are sufficiently trained and given the tools to do the job effectively, would be welcomed by some.

Professionals inside and outside the hospital also felt that there needs to be greater education for relatives of dementia patients, to understand the end stage of the disease and how it can be eased with palliative care at home rather than in a hospital setting.

It was felt that this also applies to Care Home staff who need training to better understand end of life stage of dementia and support to have confidence that the home can provide the palliative care and hospital intervention is not required.

Professionals felt the post discharge planning process could be improved by better co-ordination of GP and community services to ensure a patient has a considered plan of care available to them.

RECOMMENDATIONS

Communication and Information

1. The Trust has a booklet titled 'Working Together'. This was a trust wide initiative which commenced in September 2014 with the aim of issuing this booklet to all admitted patients. This booklet would then be filled in during the inpatient stay, and would be completed on discharge complying with many of the details listed in the NICE requirements.

   We would recommend that this booklet is reviewed and updated to produce a 'Patient Journey' booklet that keeps patient/carer fully informed.

   This will then act as a method of communication between patient/carers and professionals in hospital and in the community.

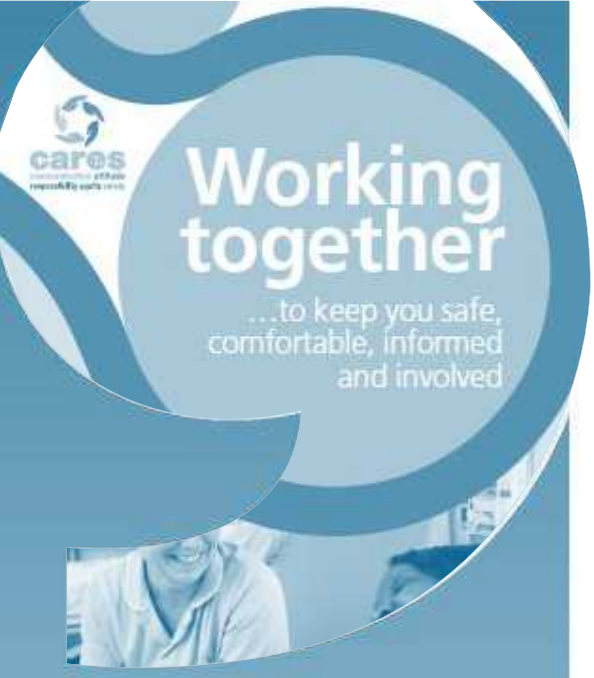
2. We would recommend that patient/carers are provided with written information about social care and continuing health care assessments in line with the Care Act. This should clearly outline, entitlement, assessment process, financial implications and support and information to make decisions on the selection of private care.

3. We recommend that an independent advocacy service should be provided for individuals who have substantial difficulty in being involved in the assessment and discharge planning process.

Processes and Procedures

4. We would recommend that the hospital looks to standardise the discharge process across all wards. A compulsory uniform process could provide many benefits to improve the patient and staff experience.

   When identical and consistent, a process becomes natural and this can only positively affect the pressures on staff. Applying the same process may also assist the hospital in its compliance with the 'Safer Staffing' initiative[xix]. Staff and agency staff can seamlessly transfer between wards. Resulting in bank staff able to work on any ward with confidence, agency staff training and induction becomes easier, returning agency staff become familiar, and escalation wards can be opened quickly. This in turn may help with staff recruitment

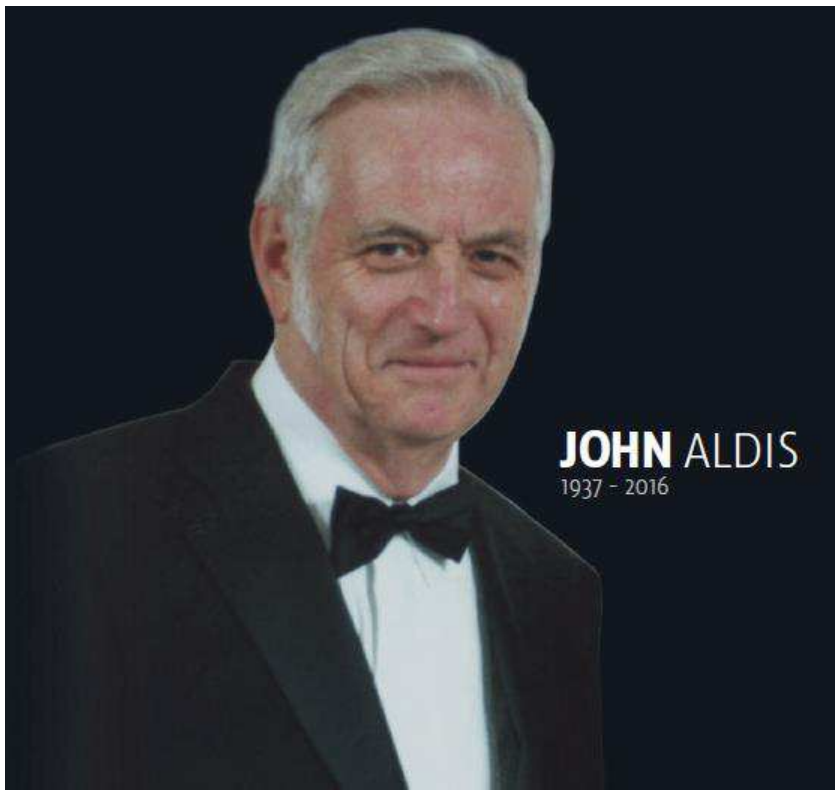


and retention and positively affect the quality of care provided to patients, as staff have more time and opportunity to care for patients in the way they want to. Possibly improving staff moral and encouraging agency staff to become substantive.

5. We would recommend a review of the discharge lounge be carried out, to assess how effective it is in meeting the needs of patient/carers who are waiting there. Without any pre-emption of this assessment, we would suggest the scope includes looking at facilities/amenities available to patients, food and drink, and timely information on their medication or transport.
6. We would recommend that in addition to written instructions for those patients being prescribed multiply medications, that the hospital also looks to provide Dosette boxes. This will mitigate against possible unintentional overdose and improve patient safety.
7. We would recommend that when discharging an older person that it becomes standard practice to proactively refer to Hillingdon Carers for further support, especially when:
   - the patient is the carer for their partner.
   - the partner is the sole carer for the patient.

Closer integration and joined up working

8. We would recommend that serious consideration is given to the proposed ***single point of access for discharge***.
   - As a possible solution to providing wrap around and integrated care for the patient/carer.
   - And; as an information hub for professionals to greatly improve communication between organisations and the understanding of each other's services.
9. We recommend that there is an evaluation of the Integrated Discharge Team. To review membership and effectiveness.



My Big Brother John

Background

First of all, let me offer some background information and my opinion as to what led to his premature death.

Around six years ago, my brother suffered a stroke from which he never fully recovered. This led to mobility issues which became more evident approximately six months ago. He was often having falls inside his home which inevitably led to hospital admissions ...and they were becoming more frequent. There were also very early signs of dementia setting in.

Just after his 79th birthday in January, I suggested to him that he took out a Lasting Power of Attorney for his Health (LPH) naming his only next of kin (me) as his executor. I also asked him did he wish to stay in his own home for the remainder of his days. He replied "Yes". I also explained to him that the LPH would not kick in until he was mentally unable to make his own decisions. He said he would think about the LPH.

By April, he was back in Hillingdon with a urine infection. He was incontinent (mainly because of his mobility

*Stories are of the lived experience of patients and their family members. They are their own accounts and written in their own words. Some names have been changed to protect anonymity.

issues) and prone to this kind of infection. By this time Social Services had decided he need full time care which was duly implemented. 4 visits by two carers every day. By this time, I had also asked Age UK to take care of his house cleaning (one hour a day, Monday to Friday). They had taken care of his shopping once a week for the last two years. John also asked me to apply for the LPH which I did.

For the next two months he was often getting into difficulties getting up and down stairs and suffering falls as a result because his mobility was getting worse. So, I had some of the downstairs area cleared and a hospital bed and hoist were installed by the district nurse's department of Social Services. His doctor paid him a visit and diagnosed that he had rheumatoid arthritis in his hands and arranged for him a visit to the hospital for some time in July. The rheumatoid arthritis condition made it difficult for him to hold things plus he was pretty much a "dead weight" with his limbs. He never got to that appointment because the doctor's practice (Medical Centre in Ruislip) forgot to mention that he couldn't walk by himself to the hospital transport that had come to pick him up! I contacted the practice to discuss my brother's health and to get the transport changed so he could meet his appointment at a later date. I did say that I would soon be getting the LPH - their answer was they would not discuss my brother's health and would only discuss it once I had it in my possession and they had proof that I in fact had the LPH - not very helpful to say the least.

We are now into late July and I noticed that my brother had an irritable cough, but thought no more of it. Approximately three weeks later I went to visit him again and he still had the cough - but he said he was OK. A few days after that I get a call to say that John was admitted to hospital (Friday 12th August I think) because he had slipped off his chair (which sets off an alarm) and the attending carers noticed that his urine was a really dark colour.

The following is mostly from conversations I had with Ward Staff at Hillingdon Hospital and other parties:

So, he was in Hillingdon Hospital for the urine infection.

His stepson had a call about this time from the hospital to ask whether he was a heavy drinker because of the colour of his urine. John had not touched any alcohol by choice soon after his Wife died some four and a half years earlier. It is more like dehydration!

The Discharge Fiasco

The urine infection got cleared up in about four days. On the Wednesday, a doctor who noticed his cough, checked him out and diagnosed that he had the early signs of pneumonia. His throat had swollen up as a result and his diet had to be changed to soft foods.

The medical staff at the hospital suggested that he recover in his own home and would be discharged the next day (Thursday) taking with him medication from the hospital pharmacy. Hillingdon Hospital notified Social Services who in turn notified John's carers that they would be "back on" as he was coming home on the Thursday.

Well, he never got there. Why? Because pharmacy didn't have the medication that was prescribed. Meanwhile the carers were at the house, but no John.

The next day (Friday), pharmacy supplied the medication required. The carers showed up again. However, Hospital Transport couldn't spare anyone until nearly 11pm at night. I was told he should get home around midnight. I said to the ward nurse she must be joking because who was going to get him into the house as there wouldn't be anyone there to greet him. She said OK, it'll have to be Monday now.

(I would suggest: that unknown to me, he was getting no antibiotics for the pneumonia condition, because the ward staff saw him just as a patient waiting to go home. It is conjecture, but I 'm putting two and two together and making four. Of course, there is another scenario - he was getting the medication, but despite him getting worse, they still discharged him because all they were interested in was the availability of his bed - if that was the case then I don't know how the management can sleep at night)

Monday changed everything. Finally, he got driven home by Hospital Transport, with his medication. Problem was, John was gasping for breath because he could hardly breath. It was also the hottest day of August. The driver noticed the difficulties my brother was having and pointed it out to the two awaiting carers at his home. They took one look at him and called for an ambulance. The ambulance got there within 30 minutes. The Paramedics took a look at him and were heard to say 'which idiots let this one out'. They tried to take him back to Hillingdon but were informed there were no beds available. So they took him to Northwick Park Hospital where he was transferred into the intensive care ward.

He was on near enough, pure oxygen for four days. But a patient cannot stay on pure Oxygen forever. So he was transferred out of there to another ward where he was put on half-oxygen.

(Sunday, 28th August) That was the last time I saw John alive. To be honest he seemed quite cheerful but struggling to speak. I thought 'he's over the worst; he'll get better and through it OK'.

I kept in touch with Northwick Park just about everyday from that point onwards. Towards the end of that week the staff at Northwick Park were saying that his heart was becoming a problem because of the pneumonia and that if he got into difficulties they would not try to revive him. By the Sunday (4th September) the hospital said he was in pain from breathing difficulties and that they were going to administer Morphine. When hospital staff tell you they are going to administer Morphine, you know it's the beginning of the end but you live in hope.

Thursday 8th September

John died at 7am on the morning of Thursday 8th September of Bronchial Pneumonia. Northwick Park had obviously tried to contact me early in the morning, but I hadn't picked up. So they phoned John's stepson in Wigan. He sent me a text to say that I should call "Vill" at the hospital. I did so about 8.30am to enquire what the problem was with John. He told me "John has expired". I didn't quite catch the last word and asked him to repeat it. He repeated it: "John has expired".

No-one at Hillingdon seems to talk to each other. It's not that they don't care, I'm sure they do, it just seems that no-one is working off the same page. If they had been, my brother would probably still be alive today!

That made me so angry, I replied "He's not a Packet of Cornflakes or a robot -he's a human being! Try died, deceased or passed away, not frigging expired!" Shocking to speak to the bereaved like that!

I said I wanted to see him to say good-bye to the body. He said "How quickly could you get here". I said "It takes approximately one and a half hours but I probably won't get there until 12 noon and please do not leave him in the ward - because they were going to until I got there. I said it's unfair to the other patients".

Oh incidentally, one more thing- The LPH came through on the 8th September, the day he died.

No-one at Hillingdon seems to talk to each other. It's not that they don't care, I'm sure they do, it just seems that no-one is working off the same page. If they had been, my brother would probably still be alive today!

Mary's Story

My Mum was in Hillingdon hospital for 7 and a half weeks. She was moved during this time from one ward in the hospital as they needed the bed, to Hawthorne. On the day she was moved to Hawthorne, they said there was a referral for my Mum to go there but that they hadn't accepted her, and so didn't know why she had turned up. There doesn't seem to be any joined-up communication.

Whilst in Hawthorn mum had to be sent to A&E at Northwick Park. Mum stayed in a ward there for a few days and then was discharged back to Hillingdon's Stroke Unit. Yet again a ward she was being moved to who were not expecting her, another breakdown in communication, this time between hospitals.

Before Mum came home for a home visit I asked to speak with the doctor. I was told that there was no need to speak with a doctor as she wasn't being discharged, it was just a home visit to assess how she would cope at home.

Mum came home for a visit with the OT who was assessing her, and she stayed home that day. There was no discharge, the ward didn't realise she was going to stay home. So, I had to go back to collect her medication and a commode. I asked to see a doctor as I had questions but there wasn't one available.

The ward eventually gave me a discharge summary note which a doctor had written under the heading 'Under relevant legal information'- "I have not seen or assessed this patient, I have only been involved in preparing this discharge summary from medical notes".

There were no adaptations or equipment in place, no medication ready and the care hadn't been confirmed. I am caring for my mother but I won't be able to do it by myself forever. I tried to speak with a doctor as I have not had an update on Mum's condition or how she has been treated or why she was discharged so abruptly. I was told to ring at 9am the following morning, but there was no doctor to talk to.

I was told that Mum needs physio but that there was a 6-week waiting list of physio which Mum needs.

As it turns out Mum's unplanned early discharge meant that she came home with an infection level that was increasing again (something that had been monitored since 10th Aug). Her own GP got the rapid response team to do further tests, which showed the infection level had increased further and mum was put on antibiotics. Surely, she shouldn’t have been discharged with a growing chest infection???

An outpatient’s appointment was sent to us for her to attend the Elderly Day Hospital clinic with arranged hospital transport. I rang the hospital transport the day before to check what time they were coming.

When I phoned up I was told that she wasn't on the list to be picked up for any appointment. The upshot of this was that Mum couldn't have a new appointment for another two weeks. The ironic thing was the hospital transport turned up at our home the next day to take her to the appointment. There is just no joined up thinking.

> Mum was in Hillingdon Hospital in September this year, where she received fantastic care and attention from the staff there.

Kate's Story

My Mum was in Hillingdon Hospital in September this year, where she received fantastic care and attention from the staff there. She had been in Hillingdon before this incident and had to stay in for an extra 10 days while the care package was sorted out. This was a long time for her to be in there just waiting.

Mum went in again in September this year with fluid on her lungs. While this seems to have been addressed, I kept asking to speak to a doctor to find out what had been done, and how we can avoid it again. It seems the actual Doctors have no intention of speaking to family members and certainly make it impossible to speak to them, I never got to speak to a doctor, I kept asking but one never updated me with any information.

Mum was given the Friday as a discharge date. I arranged with the hospital that she would be brought home in the hospital transport ambulance at 4pm as I had arranged for 2 carers to receive her at her house. This was necessary as Mum cannot walk, is very deaf, diabetic and needs support. For some reason the hospital transport ignored this instruction and took her home at 2pm. They took the key out of her key safe and let themselves in, dumping my Mum on the bed. They left her alone without a drink or any support.

She rang my Aunt who lives far away. My Aunt tried to get hold of the carers to go around straight away but they couldn't, so she was left disorientated and alone for 2 hours. I'm really not happy about this as my Mum is 80 years old and it is disorientating enough coming out of hospital, but to be dumped on a bed and just left is not how an elderly person with multiple health conditions should be treated.

Harry's Story

My mother-in-law was in Hillingdon Hospital for 3 months this year following a stroke. The outcome of her current condition is that she cannot eat food unless it is pureed

as there is a risk of choking. In considering her discharge, we went to a discharge planning meeting where I thought we would be discussing her needs and deciding what would be best for her on her return to home.

The meeting had multidisciplinary staff there, and on the advice of an OT, it was decided that my mother-in-law would need carers 3 times a day. This would ensure she is fed and cared for appropriately. This is the understanding that I had on leaving the meeting.

However, on the day that my mother-in-law was discharged it became clear that a carer would only be visiting twice a day. I was very concerned about this and thought they had made a mistake, as it wasn't what was agreed at the planning meeting. I rang the hospital and was told that Social Services who did not turn up at the planning meeting, had overridden the planning meeting decision, and had changed the care package to a carer twice a day.

It seems that Social Services had done their own assessment without any of my mother-in-law's family being present. As her main carer, and the one who knows her best, I feel that my concerns about my mother-in-law were not taken into account. After contacting Social Services on the day of discharge and explaining that care at mealtimes was essential, the care package was amended to 3 times a day, but we shouldn't have had to go through that stress to ensure my mother-in-law was discharged safely. The carers visiting my mother-in-law were the re-enablement carers who attend for 6 weeks after discharge. Social Services Manager arranged for a Care Agency to take over after 6 weeks as it was clear that my mother in law was not going to cope on her own. We were given no advice where to go for private carers if this agency was not suitable. I was not given any advice on support for carers which I desperately needed as I was overwhelmed with all the different arrangements that needed to be sorted out. I think that the hospital should do an automatic referral to Hillingdon Carers as this would trigger a contact to enable some support.

My mother-in-law left hospital with no care plan explaining her condition and what care she would get or who to contact if we had a problem. If she had left with

Things have gradually become more “normal” over the last few months but it has been a very long and tortuous journey which could have been made so much simpler if the correct support had been there from the very beginning.

a care plan we would have known immediately that the package of care was inadequate.

Another thing that concerned me was the medication. My mother-in-law has to take a variety of tablets at different times of the day. It's confusing for anyone to administer, I don't know why Hillingdon Hospital couldn't put them in a blister pack. I had to dispense her medications into a Dosette box myself crushing them up before giving them to her. Eventually, I managed to get her GP to arrange for the blister packs with a new pharmacy.

Things have gradually become more “normal” over the last few months but it has been a very long and tortuous journey which could have been made so much simpler if the correct support had been there from the very beginning.

Geoff’s Story

Over a period of three years I have been in Hillingdon Hospital twice for operations to remove cancers in my bladder, both operations went extremely well and I cannot fault the professionalism of the surgeons and the immediate after care staff.

After the first operation I was taken to a ward to recover where I was told to keep drinking several litres of water to flush out blood and clots until my urine ran clear, a doctor who was supervising me at the time advised me to call for him if my urine turned bloody and painful which it did during the night so I asked the duty nurse to call for the doctor, after waiting for at least 1 hour nobody came so I asked the nurse again as I was becoming anxious, after another hour a pharmacist turned up and gave me a bag of medications which puzzled me as I had not asked for this, he insisted it was for me, however I noticed the medications were addressed to a polish sounding name and suspected this medication was for the foreign sounding patient in the next ward who had been screaming 'Pain' all night, the pharmacist did apologise for the mix up.

In my opinion we cannot fault the work of our Doctors and Nurses but it is obvious to us all that they are overwhelmed with work and shortage of beds and staff

After the second operation three years later due to the same cancer returning I was again taken to a ward to recover and drink lots of water, when my urine ran clear I was surprised to be discharged early to return home, I suspected the hospital was desperately short of beds.

After being at home for several hours and drinking lots of water I began to experience pain and the urge to urinate but discovered that even using all my strength I could only squeeze out a few drops of blood.

I then started to worry that all the bloodied urine would be forced back up to my Kidneys or my bladder would burst causing further complications so in desperation I rang 111 who called me an ambulance to take me to A&E.

I was readmitted where the clots were removed and after an overnight stay I was discharged home wearing a catheter and urine bag for one week supervised by community nurses.

I have since completely recovered.

In my opinion we cannot fault the work of our Doctors and Nurses but it is obvious to us all that they are overwhelmed with work and shortage of beds and staff, even some staff who cannot speak English.

Vera's Story - "Isn't it ironic……."

Isn't it ironic…that towards the end of my research as Healthwatch lead on the Hospital Discharge project my 83 year old mother-in-law, Vera, fell breaking her hip. This meant that I got to see at close hand, the end- to-end process of the elderly patient journey and share the experience with those I had interviewed.

I'd just like to say that I have a long and proud association with Hillingdon hospital having lived in Hillingdon all my life. I was born at Hillingdon Hospital, I had my children there, and my parents died peacefully there. I have nothing but respect and admiration for the men and women who work there and strive every day to restore health to the sick and the broken: they saved the life of my 3 year old daughter when she had a burst appendix, and they saved my friend whose organs failed due to infection. I have much to thank them for.

In carrying out research for the project I was able to see the immense pressure the hospital is under. They work relentlessly to deal with the hundreds of thousands of people coming through the door. There is no let up, no period of calm before the storm, it storms all the time.

It cannot be unexpected that the service has become almost completely reactive. There is little time to stand back and see the wood for the trees. Processes do not necessarily flow as originally planned, and this is what I saw when my mother-in-law started on her journey.

Monday 5th December 2016

We were away when we received a call explaining that Vera had fallen in her kitchen making a cup of tea. She doesn't remember falling. She was admitted and operated on in the same day which we thought was excellent.

When we saw her the next day she was sitting up and although high on pain killers was relieved to have been fixed, she was very comfortable and happy with the care she was getting from 'terrific' nurses. She has previously had a stroke in 2013 but had recovered well and just needed a carer once a day to help her shower safely.

After a few days, physios had her up attempting to walk again which was great. On the third day of being there she had her hairdresser come in and set her hair. She was positive and looking forward to going home. We were pleased with her care, there were things like her teeth not being cleaned, or hearing aids not being put in but we were there every day and were able to do this for her. What was reassuring was the thoroughness of the staff to establish what caused the fall, her heart was tested and she was scanned.

As the days went on it became clear that surgically she was fixed and therefore could go onto the rehabilitation ward before going home. It wasn't clear how long she would be there, but the days turned into weeks. She was very distressed when she realised that she was going to be in hospital for Christmas but in the event the staff there were fantastic. They bent over backwards to make it a happy event for all patients.

We visited her twice a day whilst she was there, 3 times on Christmas day but never had the opportunity to speak with a doctor or clarify what was happening. We were told by a nurse that she had broken her hip and had had a hip replacement. We were told by the Occupational Therapist (OT) that she had broken her femur at the top and not her hip, and that it had been pinned. We were told by the physiotherapist that she had a partial hip replacement.

She seemed to be doing well, and the physio had her up and walking daily but apparently, the delay for discharge was due to a urinary tract infection - UTI, and the fact that the Civic hadn't allocated her a social worker. It was also delayed for the need to ensure the home environment was safe for her.

They were following the instructions for hip replacement care and therefore all seating at home had to be 2 inches higher than her knee to floor measurement. We had to measure all the furniture at home and provide annotated drawings of heights.

The OT said her sofa was too low and had to be raised by a company that comes in and does it. She also said a perching stool would be necessary for Vera to rest on her

way to the bedroom. And a commode would be necessary for the first few weeks. We asked if we could take her home in the car, but was told the seat would be too low and could cause damage to her hip, so hospital transport would be arranged.

We were told that at the ward meeting the UTI was discussed and identified 4 days before any medication was administered as it had taken time to get a doctor to write the prescription. During this period of no treatment Vera had frequently asked to go to the toilet. One night a nurse on duty refused to take her to the toilet causing her much distress. We raised this with the ward manager the next day and he was appalled that this could have happened.

On Wednesday 28th December the OT told us that they were still trying to get hold of the Civic to sort out a social worker and ask about re-ablement care. We were asked for her current care agency as they would ring them and sort out care for her.

We heard nothing more until Friday 30th at 11:30 when we received a call when we were out of the Borough from the OT asking for the keysafe number for her paperwork. During this conversation it became clear that Mum might be coming out on this day.

First Discharge

We received another call at 2pm from a nurse telling us Mum would be coming out at 5pm. We asked how this was possible when no alterations had been made at home, she didn't have any outdoor clothes to come home in, and no care was in place. We were told that she had a dressing gown that she could come home in, that care from Harlington Hospice had been arranged, and there was no mention of alterations at home.

We took clothes up to the hospital and sat with her until 5pm. There was no sign of any transport. We went to her flat at 6:30 to wait to receive her. At 7:45 the hospital transport eventually brought her home. She had missed an evening meal as she was supposed to leave at 5pm. My husband went to the hospital transport to greet her only to find her on the floor of the vehicle. The driver said she had fallen and was about to ring for an

ambulance. My husband helped her up and got her into the flat. She was fine but very shaken. It would have been safer to bring her home earlier in the car! This was reported the Ward Manager on Tuesday 3rd January but there was no record of this incident.

Care After First Discharge

The care that had been arranged from Harlington Hospice had called twice earlier to an empty flat as it had not been communicated to them that there was a delay.

As there had been no alterations or OT home assessment, Mum's sofa was too low and her bed too high. This resulted in her falling during the night on 31st December whilst she was trying to transfer from her commode to her bed. Careline called us out.

Carers from Harlington Hospice were great, although due to scheduling pressures she was not helped out of bed until 10am which she found distressing. Before breaking her hip/femur she would have got out of bed herself, had a cup of tea and waited for her carer to help her shower, but after spending 26 days in hospital it was noticeable how weak she had got, and how her confidence has depleted, especially after falling in the hospital transport.

She had physio for 5 days after leaving hospital, which was extremely beneficial but not long enough to help her replace the decline in strength over her hospital stay. She did not qualify for re-ablement care although no logical explanation was given and we were never told who the assigned social worker was. No alterations were ever made to her flat to help her with the height of furniture. No phone call was made by the hospital to her care agency as we were led to believe, we sorted that out.

As a family we replaced the mattress to the right height, and we also bought her a new chair which was the right height. We did this as we were financially able to. Had there been conversations at the hospital, and we were there twice a day, we could have agreed between us what would be done before she came home, and who

was going to do it in preparation for her to be safe on arrival.

As it was she came home to an unsafe environment. It took us a few days to procure a new mattress and riser chair for her. During this time she had her first fall on New Years Eve at 11pm transferring from her bed to the commode. She sank to the floor and no longer has the strength to get herself up. This now happens 3-4 times a week which is really distressing for her and us. She no longer has the confidence to go into the kitchen or do the things in the flat that she used to do before going into hospital.

There was also confusion over her medication. She left with a paper bag full of several different boxes of tablets, but a call from the ward after discharge informed us that she shouldn't take one particular tablet at all.

She is surgically fixed but the 26 days in hospital has put back her capability to live a fulfilled independent life. We are now faced with an elderly lady who keeps sinking to the floor. We have requested an OT assessment through the GP, but don't know if we are doing the right thing, or how long it will take to get help and advice. Unfortunately, my mother-in-law was readmitted to hospital within 30 days of her discharge.

Readmission - Saturday 28th January 2017

A week after her 84th birthday, she had the possible symptoms of a stroke, and a painful foot. We weren't too sure what was going on and so rang 111 for advice.

They talked us through diagnostic tests and said a paramedic would be on the way. 2 hours later there still wasn't a paramedic and we were getting further concerned as she was becoming more distressed. The operators on 111 upgraded the call to a 999 call and the ambulance arrived shortly after.

The lovely Hillingdon ambulance crew took us to Northwick Park as they said the stroke unit there was second to none. We arrived at 10pm and she was immediately assessed, had a cannula inserted, and assigned to a High Dependency Unit (HDU). From there

she was taken for a CT scan, a foot xray and other tests. The speed of initial action was impressive. We waited for her to return from the scan/xray. She returned distressed as she has asked to urinate whilst away and her request had been ignored causing her to wet herself.

We waited then until 4:30am when a doctor came to update us on what was happening. The CT scan was clear, it didn't look like a stroke but he explained in detail how something else maybe going on in the body presenting stroke symptoms. We asked how her foot was as she said she couldn't put weight on it. He said he hadn't seen the xray so didn't know.

She was admitted onto the stroke ward at 5am on the Sunday morning, 7 hours after we arrived. On the Monday the consultant pulled up a chair and gave us a very positive account of what would happen. Mum would be dressed in her day clothes and frequently encouraged to walk about and gain mobility, she would have speech therapy and they would work hard on her rehabilitation to get her out as soon as she could walk to the toilet and back. We were very impressed with the level of care and energy that was being invested in her.

Wednesday, four days into her treatment there was a bit of a set back. Someone had at last looked at Mum's xray and the worsening bruising on her foot, and realised that she had in fact broken and possibly dislocated her big toe. There was another incident of a night member of staff chiding her for wanting to urinate again, which distressed her greatly, but on the whole her care was good. She wasn't in fact strong enough to walk to the bathroom and back but they had done all they could medically. It was explained that it is important to get an elderly person home so they don't loose further muscle function/get an infection/become institutionalised.

Second Discharge

Vera was due to be discharged on Monday 6th February, 8 days after her admission. We were hopeful that she had the right care in place. The hospital seemed very aware of the effect of an elderly stay in hospital and were extremely proactive in keeping her mobile on the ward,

and ensuring that she would receive a course of rehab at home.

So everything was arranged, Vera was coming home at 1pm. We had got all her food in for the week, flowers etc and we were feeling positive. We received a call from the hospital discharge coordinator asking what time the carers were arranged for? I explained that I didn't know, as I was told twice by the hospital I did not have to worry about carers, as they would be arranging for us like the last time she was discharged. At Hillingdon Vera had received a supported discharge and we were under the impression this would be reinstated. The coordinator advised me Hillingdon Hospital have just told her Vera is a self-funder, so I needed to arrange something quickly today! I tried the carers who had been looking after Vera but they were not available until the following Saturday. I explained this to the coordinator, but was told if Vera doesn't come home today, they will be transferring her to Hillingdon Hospital.

Why no communication with Hillingdon Hospital before the day of discharge? I do not know. I am still not sure what assessment was done to see what Vera can afford. What I do know is that we do not want her going back to Hillingdon, when she is fit to go home, and I will be my mother-in-law's carer 4 times a day until permanent carers are arranged.

Shirley Clipp
Healthwatch Project Lead - Hospital Discharges

The Hillingdon Hospitals NHS
NHS Foundation Trust

Thank you so much for sharing the findings and recommendations from the Healthwatch Hospital Discharge Project 2016. This detailed project has provided our older patients and their carers an objective, supportive conduit to provide feedback regarding their experiences of discharge from the Trust. The information contained in the report is invaluable and will be used to help us improve discharge processes, and the support available for patients and carers, during this key part of the patient journey.

It was very pleasing to read in the Summary Findings that "the over 65's express an overwhelming feeling of pride in the NHS and hospital services" and that they are "quick to praise Hillingdon Hospital for their caring and attentive staff". Thank you for sharing this positive feedback.

However, it was disappointing to read that a significant number of patients experience poor communication regarding their discharge, and that many did not feel they were involved in the plans for their discharge. It was also concerning to read that some patients perceived a variation in care between day and night shifts and between permanent and agency staff. All our staff are expected to adhere to our "Cares" values and behavioural framework: the quality of care should not vary across different periods of time. The senior nurses for each division are giving this matter their close attention. We also noted the report highlighted marked variation from ward to ward in how discharge processes are implemented, and that inter-agency working is not always joined-up. These areas need addressing to ensure patients are empowered partners in care and that they experience a seamless transition from the hospital to their discharge destination.

We are keen to work in partnership with Healthwatch, Care Partners and other key stakeholders to progress the very helpful recommendations you have made in this report. Specific work already underway includes:

- Redrafting of our Working Together leaflet to encompass suggestions in the report.
- Developing written information for patients and carers in relation to NHS Continuing Healthcare Assessments.
- Continuation of work in progress to review and revise discharge processes and procedures including prescribing and issuing of TTA medication and the format of Multi-Disciplinary Meetings to aid discharge planning.
- Developing an in-house survey to capture patient and carer feedback and satisfaction scores following discharge.

Other initiatives will be scoped and taken forward over coming months.

In conclusion, The Hillingdon Hospitals NHS Foundation Trust welcomes the findings of this report and looks forward to working with colleagues and service users in implementing the recommendations it contains to improve patient and carer experience.

Theresa Murphy
Director of Patient Experience and Nursing

Hillingdon Health and Care Partners

Thank you for sharing the Healthwatch Discharge Project - evidence report for local partners, at the last Older Peoples' Strategy meeting.

I have agreed to provide you a response on behalf of the Hillingdon Health and Care Partnership (HHCP) Accountable Care Partnership (ACP).

This is made up of:

- The Hillingdon Hospitals NHS Foundation Trust (THH)
- Central and North West London NHS Foundation Trust (CNWL),
- H4All CIC, a federation of voluntary sector partners – Hillingdon Age UK, Harlington Hospice, DASH, MIND Hillingdon and Hillingdon Carers
- Hillingdon four GP networks, due to become Hillingdon GP federation from April 2017

Whilst providers may do their own individual responses (assume THH will be responding with regards to their specific in patient issues) the following input has been given from the HHCP partners with particular consideration of their work as part of an ACP.

The report sets out the key areas for consideration:

- Assessment of the quality and effectiveness of discharge and the follow-up care we provide in the community
- How the evidence can inform current work streams
- How we can use the evidence to develop better services for Hillingdon's residents

The recommendations fall into three categories:

1. **Communication and information**

- Working Together booklet – produce 'Patient Journey' (THH)

- Written information about Social services and continuing health care assessments (THH)

2. **Process and procedures**

- Standardising the discharge process across all wards (THH)
- Review of the discharge lounge (THH)
- Additional written instructions – for multiple medications (THH)
- Provision of Dosette boxes (THH)

3. **Clear integration and joined up working**

- Clearer communication between providers – 'Patient Journey' booklet (ALL)
- Joined up approach across all providers in coordinating discharge (ALL)
- Confusion of staff on who and when to refer to services – no signposting (ALL)

We are obviously very concerned to read of some such disappointing experiences people have had in the Hillingdon discharge system but we welcome the recommendations in the report as this provides material on which we can base our service design for older people. Through Hillingdon Health and Care Partners (HHCP), an Accountable Care Partnership (ACP), we have the opportunity to particularly improve the integration of services and provide patient centred care for older people in Hillingdon.

The aim of HHCP is to establish a truly integrated health and social care system. The areas we have identified we need to achieve:

- Addresses individual needs in a holistic way
- Offers more care in the community and in people's homes rather than in acute hospitals
- Invests in prediction, prevention, early intervention and out of hospital services

- Joins up services across organisations and across care settings
- Adopts evidence based pathways
- Concentrates acute services to enable delivery of care in the most appropriate setting
- Offers better overall value for money

The discharge report clearly identifies some significant areas where the experience of people being discharged from hospital requires improvement and the recommendations will be used to influence the work streams that are currently being developed. We are really keen to see the ACP partnership tackle many of the issues you have highlighted that relate to the interface between hospital and the community and we are already working in some areas that we think will be helpful.

Since 2012 there have been developments within the intermediate care pathways and improvements in the admission avoidance (Rapid Response Team -RRT, intermediate care beds) and early supported discharge (RRT, Homesafe, Falls, Take Home & Settle, Early Stroke Discharge and respiratory outreach). However further work can be implemented to continue to build on improving community care with co-ordinated care planning and advance care planning.

Some of the key work areas within our clinical design work include:

- **Information sharing** to prevent the repetition of basic information to several teams (with initial work around due to lack of joined up IT). Some improvement in information sharing from community has recently been noted through access to GP records for hospital staff via Hillingdon Care records.
- **Development of the ICP and development of fifteen care connection teams**

  A centralised care plan is key to coordinating care. The model for the Care Connection Teams (CCT) is based on this principle. Where a patient attends or is admitted to hospital for information is automatically

transferred from the hospital to GP via Docman. These patients are then discussed with the CCT and GP with a view to need for telephone contact / visit to ensure they are stable. This might include proactive calls to the hospital team from the Guided Care Nurse where the patient /family were well known and this information would support safe planning of discharge. In complex cases when a discharge summary was accessed suggesting changes in physical status, care needs, medication and need for follow up (blood tests / clinics / GP review), the patient was contacted.

The new Guided Care Matron (GCM) role enables a holistic review (in the patient home if needed) to ensure understanding of the changes and follow through on actions. This review includes medication reconciliation and compliance (an area being focussed on with hospital pharmacy and community pharmacy support), follow up with other services to support if problems became more apparent post discharge (care connection team / voluntary sector especially) and advice and update of care plan with GP and when needed geriatrician / other specialist. With reduced lengths of stay the requirement for improved timely community support is essential and this service provides a contact and link which was much appreciated by patients as per the pilot feedback.

We will look to promote co-ordinated and advanced care planning.

- We are also supporting THH with **'Patient Journey' booklet** and how this can be successfully implemented and used across all providers

- **Medications issues;** One of the key aspects of concern highlighted in the report is around understanding of new health problems, medications and ongoing follow up post discharge plus physical support / social care input. Whilst there are clearly processes and communication within the hospital trust to improve on, some of this work will be captured through the role out of care connection teams across the borough especially for those complex patients with longer stays.

- **Escalated care plan and workstreams** are based upon the initial Whole systems integration work in the North of the borough and patient voice input about less repetition of story, increased collaboration between differing service and simplification of processes. As a result, those receiving care will have an improved experience and seamless transition between services according to need. Those delivering it will also better understand how to provide optimal care and refer to other services and support appropriately, ensuring less silo working and greater confidence in services available.

- **Review of the current Rapid Response service and step down beds** to be able to support patients with more complex needs, creating access to timely diagnostics and exploring intravenous treatments – the introduction of the geriatrician posts is a start but exploring further options especially around diagnostics and OOH support. We are already seeing a closer working between rapid response team and the hospital for both admission prevention and supported discharge.

- **Streamlining pathways and establishing single point of access (SPA) for community support services including rapid response.** This will include increased ability to provide escalated care in the community (intravenous antibiotics, blood tests) and safely avoid unnecessary admission, assist early discharge. We hope a single contact will make it easier to give patients details of where to call, should they have any problems with access to community services after discharge. We aim to simplify the number of different commissioned Rapid Response pathways to enable the service to take patients according to their needs rather than fitting pathway criteria.

- **Increased community support for patients with more complex needs through enhanced RRT service, ambulatory care pathways and rapid access clinics.**

- **Increased frontline geriatrician support at interface (ED and AMU, telephone support for GP and RRT).**

- **Better integration of intermediate care services** within the borough to enable patients to flow more seamlessly through the pathway. The introduction of a Single Point of Access proposed as part of the escalated care work stream will help in providing a solution to wrap around and integrated care for the patient/carer and act as an information hub for professionals.

Through implementing the above key areas of improvement we aim to have an overall positive impact on the delivery and quality of care for Hillingdon's residents. The key words we need to keep focused on to ensure this succeeds are – Communication, Integration, Ownership and Responsiveness.

We believe that HHCP will be able to offer a really positive contribution to those issues raised in your report relating to the interface between acute and community care and look forward to getting more feedback following redesign.

Jo Manley: ACP Programme Director on behalf of Hillingdon Health and Care Partners

HILLINGDON
LONDON

Thank you for sharing your report at November's meeting of the Older People's Strategy Group and I think that this will be helpful in supporting the drive for change within the local health and care system.

The purpose of this letter is to respond to some of the key issues raised that are pertinent to Adult Social Care.

PRE-DISCHARGE

Patient Information

The report reiterates importance of having available clear information for patients about the discharge process so that they know what to expect and what choices are available to them.

You will be aware from the November meeting of the Joint Hospital Discharge Pathway Group that a task and finish group is being established that will look at the information available and how this can be improved, including the development of a 'Patient Journey' booklet. The level of detail about access to social care to be included in this, including an explanation of the National Eligibility criteria and also about the fact that social care support is subject to a financial assessment, is something for this group to consider. What is clear is that we collectively need to ensure that clear information is available and distributed in a consistent way to patients.

Processes and Procedures

The need to standardise discharge processes across all wards has been acknowledged by health and care partners and there is work in progress through the Hospital Discharge Pathway Group to develop a formal procedure intended to support patient choices that will provide clarity about roles and responsibilities across all partner organisations. The aim is to have this sign-off by partner organisations by the end of 2016/17.

Joint Discharge Team

It is interesting that some staff expressed confusion about the role of the Integrated Discharge Team and again identifies communication issues. The intention for 2017/18 is for the Hospital, the Council and the CCG to work together to secure a decision about funding in Q4 2016/17. This will then provide an opportunity to ensure that staff are fully briefed to avoid continuing confusion going into 2017/18.

POST-DISCHARGE CARE

There were a number of points highlighted in your report about post-discharge care that I think can be summarised under the headings of information and communication, roles and responsibilities and the local homecare market. I will address each of these in turn.

Information and Communication

The issues identified in your report about people being supported by the Reablement Team not knowing what would happen to them after their period of reablement and also people not understanding what package of care to expect relates very much to the general theme about the availability of suitable information and also about communication. This is something that will be looked at as part of the patient information task and finish group referred to above.

Roles and Responsibilities

The Council has noted that for some service users the number of care workers providing their care and the frequency of attendance did not match their expectations. We believe that this relates to the blurring of lines of responsibility between medical and social work staff. The new policy and procedure referred to earlier will help to clarify the decisions that properly sit with the respective professionals and this should assist in relieving scope for service users being left confused.

Local Homecare Market

Your report identified an issue about care workers not attending at times that fitted in with service users' routines. This is not an unreasonable request from

service users and the Council has done a lot of work with homecare providers to improve capacity and stabilise the local market to help deliver this. Unfortunately, where a lot of people require calls at particular times of the day, e.g. early morning, this is not always possible, especially as priority has to be given to those whose circumstances necessitate calls at specific times of the days, e.g. because of medication needs.

The Council will continue to work with providers to improve the capacity and quality of homecare provision and Healthwatch will continue to have a vital role in providing feedback on the service user experience of care. However, you will be aware that the nature of the homecare market in a high employment area such as Hillingdon means that this is not an easy issue to address.

The final point in respect of homecare was about care workers not staying for the allocated time. This is an issue when the care worker charges for care that has not been delivered; if they manage to complete what is required within a shorter period of time and only charge for the time present then this is not an issue. Where a care worker claims for time delivering care that has not been provided then this is likely to constitute fraud and there have been criminal prosecutions in Hillingdon in recent years where this has occurred. Where the Council becomes aware of these instances we will liaise with the Police to ensure that there is a thorough investigation and prosecution where there is sufficient evidence.

Going forward all of the Council's homecare providers will be required to use electronic call monitoring systems and this means that they will then only be paid for the time recorded. This should reduce the scope for this to occur in the future.

I hope that you have found this information useful and please do not hesitate to come back to me if you have any further queries or if you think there are any points that have not been addressed.

Gary Collier
Health and Social Care Integration Manager

CONCLUSION

The evidence we have collected during our research has provided us with a valuable insight into older people's experiences of being discharged from Hillingdon Hospital, and the care and support provided to them in the community.

We acknowledge that health and social care services are under extreme pressure. However, we believe that to maintain high quality services in these challenging times, it is even more important to focus on patient experience.

By engaging with our residents we have provided a rich source of information for commissioners and providers to gain a better understanding of the care delivered to Hillingdon's older residents, and how local people feel the quality of their care can be improved.

Our insight suggests that it is overwhelmingly clear that better information and communication between patients, care staff and organisations, are key if services are to be developed and improved. It could be argued that achieving this maybe the most important factor to transforming care services in Hillingdon.

Organisations have responded positively to our report and have acknowledged that improvement is needed.

A number of the recommendations outlined in the report have already been implemented.

Our evidence has also informed the Better Care Fund and additional actions have been added to the delivery plan, which is monitored at the Hillingdon Health and Wellbeing Board.

We look forward to continually working with, the public, commissioners and providers to improve care for our older residents.

BIBLIOGRAPHY

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[ii] https://www.nice.org.uk/guidance/ng27 https://www.nice.org.uk/guidance/qs136 Quality standard [QS136] Published date: December 2016 Transition between inpatient hospital settings and community or care home settings for adults with social care needs overview

[iii] Care Act 2014 Chapter 23 Received Royal Assent: 14 May 2014

[iv] https://www.nao.org.uk/report/discharging-older-patients-from-hospital/

[v] https://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf

[vi] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration

[vii] https://www.nao.org.uk/report/discharging-older-patients-from-hospital/

[viii] https://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf

[ix] http://content.digital.nhs.uk/catalogue/PUB21900/meas-from-asc-of-eng-1516-Report.pdf

[x] https://www.kingsfund.org.uk/publications/social-care-older-people

[xi] http://www.qualitywatch.org.uk/blog/another-year-cuts-social-care

[xii] Ambulatory Care is a patient focused service where some conditions may be treated without the need for an overnight stay in hospital. You will receive the same medical treatment you would previously have received as an inpatient.

[xiii] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

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[xvi] http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/170715_healthwatch_special_inquiry_2015_1.pdf

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[xviii] https://www.nice.org.uk/guidance/qs136

https://www.nice.org.uk/guidance/ng27

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UPDATE: STRATEGIC ESTATE DEVELOPMENT

Relevant Board Member(s)	Dr Ian Goodman, Chair, Hillingdon CCG Councillor Phillip Corthorne
Organisation	Hillingdon Clinical Commissioning Group
Report author	Sue Hardy, Head of Strategic Estate Development, Hillingdon CCG Nicola Wyatt, S106 Monitoring & Implementation Officer, Residents Services Directorate, London Borough of Hillingdon
Papers with report	Appendix 1: Section 106 Healthcare Facilities Contributions (Dec 2016) Appendix 2: Access to GP Surgeries

1. HEADLINE INFORMATION

Summary	This paper updates the Board on the CCG strategic estate initiatives and the proposed spend of S106 health facilities contributions in the Borough.
Contribution to plans and strategies	Joint Health & Wellbeing Strategy, Out of Hospital Strategy, Strategic Service Delivery Plan
Financial Cost	To be identified as part of the business case for each individual project
Relevant Policy Overview & Scrutiny Committee	N/A
Ward(s) affected	All

2. RECOMMENDATION

That the Health and Wellbeing Board notes the progress being made towards the delivery of the CCGs strategic estates plans.

3. BACKGROUND

In 2014 Hillingdon CCG published its Strategic Service Delivery Plan (SSDP) which outlines the local context in Hillingdon CCG, the scale of change required to deliver the Out of Hospital Strategy and the model of care that is being developed at a national, regional and local level.

The document also considers the delivery implications of this new model of care. The aim is to achieve a patient-centred and integrated system of accessible, proactive and coordinated care;

but in order to implement this major change to the existing health and care infrastructure is required.

The SSDP presents detailed activity and estates modelling, focusing on the use of the existing health estate, the future space requirements and the identification of potential sites for locality based health and wellbeing hubs.

The pipeline for hubs has been identified as the following:

Hayes and Harlington: Hesa Health Centre (already operational)
Uxbridge and West Drayton: St. Andrew Park development as the preferred location
North Hillingdon: Mount Vernon Hospital site as the preferred location

To realise the benefits outlined in the Five Year Forward View, The Department of Health issued a guidance document in June 2015 titled 'Local Estate Strategies – a framework for commissioners'. CCGs were asked to:

- produce a Local Estate Strategy in partnership with local stakeholders
- establish a Strategic Estate Group

The Hillingdon Strategic Estates Group was formed in September 2015 and has met quarterly since then. Representatives from the Council, Central and North West London Trust, Hillingdon Hospital Trust, NHS Property Services, the Local Medical Council and CCG have been in attendance.

It is essential that service and estates planning are integrated to ensure that quality estate is available to deliver high quality services and make well informed investment decisions. This approach will facilitate the best use of existing property, ensure that new estate developments meet service need and enable the disposal of surplus estate.

Good quality strategic estates' planning is vital to:

- maximising use of facilities
- delivering value for money
- enhancing patients/public experiences

Local circumstances should dictate what is appropriate for local health economies. The strategy should reflect the local footprint and should include secondary and tertiary care in addition to community and primary care and include wider public sector partners in its development.

The main priority of the Strategic Estates Group to date has been to produce the draft estate strategy; this document is based on the SSDP and in addition provides an overview of all estate in the Borough used for the delivery of healthcare services and capture future investment plans of each stakeholder.

The membership of the Group and the Terms of Reference (ToR) has recently been reviewed to reflect the work required to support the delivery of the Sustainability and Transformations Transformation Plan. The revised membership and ToR will help foster greater collaboration between local government and the NHS. The aim is to develop a joint estates strategy taking

account of all regeneration and service rationalisation plans, to deliver the agreed network of local hubs and GP practices, supported by the One Public Estate programme.

4. HILLINGDON ESTATE STRATEGY

The CCG is in the process of implementing the key priorities set out in its current estate strategy. An overview of the strategy was presented to the Health and Wellbeing Board in December 2016.

Below is an outline of the Hillingdon vision of how the key priorities outlined within the Five Year Forward view and the STP guidance will be addressed:

Health & Wellbeing

- Working collaboratively across health, social care and public health we will improve outcomes and reduce inequalities for our population with a focus on those with both traditional Long Term Conditions (including both physical and mental health LTCs) and emergent categories of LTCs such as pain, frailty and social isolation.
- Our coordinated programme of work will bring together our existing plans for the BCF and our Health & Wellbeing Strategy (HWBB) and engage our whole community to create a resilient population and assist people to remain independent with better quality of life for longer.

Care & Quality

- We will provide care that is safe, effective and delivered by experienced practitioners through collaborative working across health and social care services.
- We will be able to share information that improves the quality of health and social care services and that enables our population to make informed choices.
- We will deliver the best and highest quality care possible within the constraints of our local economy and the growth in demand that we are predicting.

Finance & Efficiency

- It is simply not viable to continue trying to respond to increasing demand for services, particularly at the expense of preventative action. We are committed to finding financial savings and ways to achieve better outcomes for individuals and their families through the better integration of services and by reducing demand through an increased focus on prevention and patient activation.

The SSDP had previously been developed to identify the estate solution required to support the delivery of the transformation of care and established a plan for a hub service of between 2,700 and 3,600 m^2 split over three key locations across the Borough.

The estate strategy has been further developed to include the Local Authority and primary care estate used for the delivery of health/social care and overall estate metrics on condition, market rent impacts and cost per clinic room/workstation.

Key Drivers and Challenges

- To meet an estimated increase in demand and complexity of care delivered in the community for out of hospital care across the area of 30%-35%
- Enable a major shift in care from within a hospital setting to an out-of-hospital setting so more people are treated closer to their homes
- A need to improve utilisation of the existing estate and effectively target strategic investment in new estate in locations appropriate for a Hub health care delivery model

Forecast population and demographic growth in Hillingdon suggests an increasingly diverse population.

Key points emerging from the strategic review

- The need to progress the aims of the SSDP and implement the hub strategy. Focussing investment in locations which support the out-of-hospital health care challenge at Uxbridge/West Drayton, North Hillingdon and Hayes & Harlington
- The need to secure long term premises solution for the Shakespeare Medical Centre
- The need to address poor primary care infrastructure by making sure GP practices are in the right location and in fit for purpose accommodation

Current status of strategic estate priorities

The table below summarises the projects and the current status.

Project	Status
Create an out of hospital Hub in North Hillingdon	Negotiations ongoing with the Hillingdon Hospital Trust to locate the North Hub on the Mount Vernon Hospital site. Potential opportunity to co-locate the Hub with the Trust proposed skin clinic. A Project Initiation Document for the Hub has been produced and will be presented to the CCG Governing Body for approval within the next month.
Create an out of hospital Hub in Uxbridge and West Drayton	The opportunity to locate the proposed Uxbridge and West Drayton Hub on the St Andrews Park site now appears unlikely. The CCG is working in partnership with Central and North West London NHS Foundation Trust(CNWL) to identify alternative site options.
Building capacity for Hayes and Harlington	The CCG is working closely with Council colleagues to establish the impact of the Hayes Housing Zone on local health services. It has been identified that in addition to the Hub at Hesa Health Centre accommodation of between 1000m2 and 1500 m2 is required to deliver additional capacity for primary care. This requirement will be built into local infrastructure plans.
New premises for Shakespeare Medical Centre	Negotiations between the practice, CCG and Council are progressing well for the proposed relocation of the practice to new premises on the former Woodside Day Centre site. Draft design work and Heads of Terms have been produced for a Council-led development.

Yiewsley Health Centre	The CCG has been successful in securing funding to refurbish some recently vacated space at the site into additional clinical accommodation. This will create additional capacity for primary care provision at the site. A long term solution for the site is still being explored with the support of CNWL.
Future of Northwood and Pinner Community Hospital	NHS Property Services is exploring redevelopment options on the Northwood and Pinner site including the possibility of re-providing the existing health centre into a modern replacement facility on-site. Our purpose is to manage and develop the NHS estate to best meet healthcare needs, whilst creating additional value for the NHS. Any redevelopment options will be comprehensively reviewed with the planning authority, need to be financially robust and adequately consider the project risks involved. Furthermore, proposals are subject to consultation with the existing tenants of the building and the CCG. If the project feasibility is proved as a result of the review then a proposal will be brought forward for consideration.
Improving Access to Primary Care	The CCG continues to review the quality and capacity of primary care premises across the borough. Investment plans are being developed. The attached slides (appendix 2) are an excerpt from HCCG's analysis of primary care, and provide the Board with an overview of the distance people are from a GP, the capacity of existing GP surgeries and where s106 funding has been identified.

Other property considerations

- Further data and property analysis on the condition of the public sector estate undertaken and being incorporated into strategic planning documents.
- A full review of the GP estate by NHS England and the CCG has been undertaken and will inform the production of a primary care strategy in early 2017
- Conclude work with Hillingdon Hospital Trust over the next 3 months to determine the preferred site for the Hub at Mount Vernon Hospital.
- Work with the planning and property teams at the Council to close down the future health estate requirements within the Hayes Town Housing Zone.

Financial considerations

Across North West London the NHS is undertaking a review of the Implementation Business Case (ImBC) developed for the Shaping a Healthier Future Programme, including both the capital and revenue implications of the Hubs. The NWL CCG Governing Bodies in December 2016 approved the Implementation Business Case for the first tranche of capital required to deliver the Shaping a Healthier Future estates projects including the two Hillingdon Hubs and investment at Hillingdon Hospital. The document is now with NHS England for assurance and approval which is currently programmed for April 2017.

Hillingdon Council, in consultation with the NHS in Hillingdon, has been collecting S106 contributions for health from residential developers where the size and scale of the housing scheme has been identified as having an impact on the delivery of local health services. Funding has been secured by the Council for investment in health premises and services in the Borough in order to help meet increased demand for health services as a result of new development. This additional non-recurrent funding has been used to build capacity within the primary care estate and subject to the Council's formal s106 allocation process, it is proposed that any further contributions received are used to the remainder will help to offset the cost of the Hubs.

The CCG will identify the financial implications of all estate investment as part of the business case development process for each project.

5. S106 HEALTH CONTRIBUTIONS HELD BY THE COUNCIL

1. Appendix 1 attached to this report details all of the s106 health facilities contributions held by the Council as at 31st December 2016. The Council has not received any further contributions since the last report to the Board in December. As at 31st December 2016, the Council holds a total of £1,169,759 towards the provision of health care facilities in the Borough.

2. The CCG has "earmarked" the s106 health contributions currently held by the Council towards the provision of the health hubs as outlined in Appendix 1. To note, two contributions held at case references H/20/238F (£31.4K) and H/37/301E (£13K) have spend deadlines within the next 18 month period. These are currently earmarked towards the provision of a new health hub in the North of the Borough. A request to allocate individual contributions towards further schemes will be submitted as each scheme is brought forward.

HILLINGDON COUNCIL FINANCIAL IMPLICATIONS

As at 31st December 2016, there is £2,377,753 of Social Services, Housing, Health and Wellbeing S106 contributions available, of which £1,207,994 has been identified as a contribution for affordable housing. The remaining £1,169,759 is available to be utilised towards the provision of facilities for health and £536,895 of these contributions have no time limits attached to them.

Officers in conjunction with the CCG and NHSPS are actively working towards allocating the outstanding health contribution to eligible schemes. Funds totalling £1,134,138 are provisionally earmarked towards proposed health hub schemes as follows:

Proposed Health Hub Scheme	**Amount**
North Hub	175,983
Uxbridge / West Drayton Hub	520,593
New Yiewsley Health Centre	433,660
Pine Medical Centre	3,902
Total Earmarked	**1,134,138**

HILLINGDON COUNCIL LEGAL IMPLICATIONS

Under the provisions of section 111 of the Local Government Act 1972, a local authority has the power to do anything which is calculated to facilitate, or is conducive or incidental to the discharge of any of its functions. The work to be carried out in accordance within this report would fall within the range of activities permitted by Section 111.

Regulation 122 (2) of the Community Infrastructure Levy Regulations 2010 states that a planning obligation may only constitute a reason for granting planning permission for the development if the obligation is:

1. necessary to make the development acceptable in planning terms;
2. directly related to the development; and
3. fairly and reasonably related in scale and kind to the development.

Any planning obligation must be relevant to planning and reasonable in all other respects.

The monies must not be used for any other purpose other than the purposes provided in the relevant section 106 agreement. Where monies are not spent within the time limits prescribed in those agreements, such monies should be returned to the payee.

When the Council receives formal bids to release funds, each proposed scheme will need to be assessed and reported to the Leader and Cabinet Member for Finance, Property and Business Services in order for the monies to be released. As part of that process, the Council's Legal Services will review the proposal and the section 106 agreement that secures the funding, to ensure that the Council is permitted to spend the section 106 monies on each proposed scheme.

The use of section 106 monies for future schemes mentioned in the report will need to be assessed against their respective agreements when these are finalised on a case by case basis.

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CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid February 2017)
			AS AT 31/12/16	AS AT 31/12/16			
H/11/195B *57	Ruislip	Highgrove House, Eascote Road, Ruislip. 10622/APP/2006/2494	3,156.00	3,156.00	No time limits	North Hub	Funds to be used to support the provision of local healthcare facilities arising from the needs of the development. No time limits.
H/20/238F *72	West Ruislip	Former Mill Works, Bury Street, Ruislip. 6157/APP/2009/2069	31,441.99	31,441.99	2018 (Feb)	North Hub	Contribution received as the health facilities contribution towards providing health facilities in the Authority's Area. Funds to be spent towards (but not limited to); expansion of health premises to provide additional facilities and services to meet increased patient or user numbers or, new health premises or services at local level or, any new facility required to compensate for loss of health facility caused by the development. First instalment to be spent by February 2018. Second instalment to be spent by June 2018.
H/22/239E *74	Eastcote	Highgrove House, Eascote Road, Ruislip. 10622/APP/2006/2494 & 10622/APP/2009/2504	7,363.00	7,363.00	No time limits	North Hub	Funds received towards the cost of providing health faciities in the Authority's Area including (but not limited to); expansion of health premises to provide additional facilities and services to meet increased patient numbers or, any new facility required to compensate for the loss of a health facility caused by the development. No time limits.
H/28/263D *81	South Ruislip	Former South Ruislip Library, Victoria Road, Ruislip (plot A). 67080/APP/2010/1419	3,353.86	3,353.86	No time limits	North Hub	Funds received towards the cost of providing health facilities in the Authority's area including (but not limited to); the expansion of health premises to provide additional facilites and services to meet increased patient or user numbers or, new health premises or services at the local level or, any new facility required to compensate for the loss of a health facility caused by the development. No time limit for spend
H/36/299D *94	Cavendish	161 Elliot Ave (fmr Southbourne Day Centre), Ruislip. 66033/APP/2009/1060	9,001.79	9,001.79	No time limits	North Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of of a health facility caused by the development.
H/37/301E *95	Northwood	37-45 Ducks Hill Rd, Northwood 59214/APP/2010/1766	12,958.84	12,958.84	2018 (July)	North Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development.
H/44/319D *44	Northwood Hills	117 Pinner Road, Northwood 12055/APP/2006/2510	24,312.54	24,312.54	No time limits	North Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development.
H/46/323G *104	Eastcote	150 Field End Road, (Initial House), Eastcote 25760/APP/2013/323A	14,126.88	14,126.88	No time limits	North Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development.

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid February 2017)
			AS AT 31/12/16	AS AT 31/12/16			
H/34/282F *92	West Ruislip	Lyon Court, 28-30 Pembroke Road, Ruislip 66985/APP/2011/3049	15,031.25	15,031.25	2019 (estimated)	North Hub	Towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. Funds to be spent within 5 years of completion of development. Estimated spend deadline 2019.
H/48/331E *107	Eastcote	216 Field End Road, Eastcote 6331/APP/2010/2411	4,320.40	4,320.40	No time limits	North Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development.
H/51/205H *110	Eastcote	Former RAF Eastcote (Pembroke Park), Lime Grove, Ruislip 10189/APP/2014/3354 & 3359/3358 & 3360	17,374.27	17,374.27	No time limits	North Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development.
H/54/343D *112	Harefield	Royal Quay, Coppermill Lock, Harefield. 43159?APP/2013/1094	8,698.77	8,698.77	No time limits	North Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development.
H/53/346D *113	Northwood	42-46 Ducks Hill Road, Northwood 49987/APP/2013/1451	8,434.88	8,434.88	No time limits	North Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. No time limits
H/63/385D *129	Northwood Hills	Frank Welch Court, High Meadow Close, Pinner. 186/APP/2013/2958	10,195.29	10,195.29	No time limits	North Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. No time limits for spend.
H/57/351D *	Northwood	103,105 & 107 Ducks Hill Road, Northwood 64345/APP/2014/1044	6,212.88	6,212.88	No time limits	North Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. No time limits
Total "earmarked " towards North Hub			**175,982.64**	**175,982.64**			
H13/194E *59	Uxbridge	Frays Adult Education Centre, Harefield Road, Uxbridge. 18732/APP/2006/1217	12,426.75	12,426.75	No time limits	Ux/WD Hub	Funds received towards the provision of healthcare facilities in the Borough. No time limits.

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid February 2017)
			AS AT 31/12/16	AS AT 31/12/16			
H/27/262D *80	Charville	Former Hayes End Library, Uxbridge Road, Hayes. 9301/APP/2010/2231	5,233.36	5,233.36	No time limits	Ux/WD Hub	Funds received towards the cost of providing health facilities in the Authority's area including (but not limited to); the expansion of health premises to provide additional facilites and services to meet increased patient or user numbers or, new health premises or services at the local level or, any new facility required to compensate for the loss of a health facility caused by the development. No time limit for spend.
H/39/304C *97	Yeading	Fmr Tasman House, 111 Maple Road, Hayes 38097/APP/2012/3168	6,448.10	6,448.10	2020 (Aug)	Ux/WD Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development.
H/55/347D *114	North Uxbridge	Honeycroft Day Centre, Honeycroft Hill, Uxbridge 6046/APP/2013/1834	12,162.78	12,162.78	2022 (May)	Ux/WD Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. Funds to spent/committed within 7 years of receipt (May 2022).
H/47/329E *106	Townfield	Land at Pronto Industrial Estate, 585-591 Uxbridge Road, Hayes 4404/APP/2013/1650	14,066.23	14,066.23	2024 (July)	Ux/WD Hub	Funds received the cost of providing healthcare facilites within the London Borough of Hillingdon. Contribution to be spent within 10 years of receipt.
H/49/283B *108	Uxbridge North	Former RAF Uxbridge, Hillingdon Road, Uxbridge 585/APP/2009/2752	624,507.94	447,149.63	2024 (Aug)	Ux/WD Hub	Funds to be used towards the provison of healthcare facilities serving the development in line with the Council's S106 Planning Obligations SPD 2008. Funds to be spent within 10 years of receipt. £177,358 from this contribution is allocated towards capacity improvements at Uxbridge Health Centre (Cabinet Member Decision 12/06/2015). £177,358 transferred to HCCG July 2015.
H/58/348B	North Uxbridge	Lancaster & Hermitage centre, Lancaster Road, Uxbridge 68164/APP/2011/2711	7,587.72	7,587.72	No time limits	Ux/WD Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. No time limits
H/64/387E *136	Uxbridge North	Norwich Union House, 1-2 Bakers Road, Uxbridge. 8218/APP/2011/1853	15,518.40	15,518.40	2023 (Sept)	Ux/WD Hub	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. Funds to be spent within 7 years of receipt.
Total "earmarked" towards Uxbridge/West Drayton Hub			**697,951.28**	**520,592.97**			

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid February 2017)
			AS AT 31/12/16	AS AT 31/12/16			
H/32/284C *89	Yiewsley	Former Honeywell site, Trout Road, West Drayton (live/work units). 335/APP/2010/1615	5,280.23	5,280.23	No time limits	New Yiewsley HC	Towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. No time limits for spend. Earmarked towards the provision of a new health centre facility in the Yiewsley area, subject to formal allocation.
H/33/291C *91	West Drayton	Former Swan PH, Swan Road, West Drayton. 68248/APP/2011/3013	5,416.75	5,416.75	No time limits	New Yiewsley HC	Funds received towards the cost of providing health facilities in the Authority's area including (but not limited to); the expansion of health premises to provide additional facilites and services to meet increased patient or user numbers or, new health premises at local level. Any new facility required to compensate for loss of a health facility caused by the development. Earmarked towards the provision of a new health centre facility, subject to formal allocation.
H/42/242G *100	West Drayton	West Drayton Garden Village off Porters Way West Drayton. 5107/APP/2009/2348	337,574.00	337,574.00	No time limits	New Yiewsley HC	contribution received towards providing additional primary healthcare facilities in the West Drayton area (see agreement for details) . Earmarked towards the provision of a new heath centre facility in the Yiewsley/West Drayton area, subject to request for formal allocation.
H/50/333F *109	Yiewsley	39,High Street, Yiewsley 24485/APP/2013/138	12,444.41	12,444.41	No time limits	New Yiewsley HC	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. Earmarked towards the provision of a new health centre facility in the Yiewsley area, subject to formal allocation.
H/59/356E *120	Yiewsley	Packet Boat House, Packet Boat Lane, Cowley 20545/APP/2012/2848	14,997.03	14,997.03	No time limits	New Yiewsley HC	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. No time limits
H/60/359E *121	Yiewsley	26-36 Horton Rd, Yiewsley 3507/APP/2013/2327	25,273.45	25,273.45	2023 (Jan)	New Yiewsley HC	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. Spend within 7 years of receipt (Jan 2023).
H/61/382F *128	West Drayton	Kitchener House, Warwick Rd, West Drayton. 18218/APP/2013/2183	8,872.64	8,872.64	2026 (April)	New Yiewsley HC	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. Spend within 10 years of receipt (April 2026).

CASE REF.	WARD	DEVELOPMENT / PLANNING REFERENCE	TOTAL INCOME	BALANCE OF FUNDS	SPEND BY	PROPOSED PROJECT	DETAILS OF OBLIGATION (as at mid February 2017)
			AS AT 31/12/16	AS AT 31/12/16			
H/62/384F *128	Yiewsley	Caxton House, Trout Road, Yiewsley. 3678/APP/2013/3637	15,482.07	15,482.07	No time limits	New Yiewsley HC	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. No time limits for spend.
H/66/390D *137	West Drayton	Fmr Anglers Retreat, Cricketfield Road, West Drayton (11981/APP/2013/3307)	8,319.90	8,319.90	2021 (Sept)	New Yiewsley HC	Funds received towards the cost of providing health facilities in the Authority's area including expansion of health premises to meet increased patient numbers, new health services at local level, any new facilities required to compensate for the loss of a health facility caused by the development. Funds to be spent within 5 years of receipt.
Total "earmarked" towards New Yiewsley Health Centre			**433,660.48**	**433,660.48**			
H/18/219C *70	Yeading	Land rear of Sydney Court, Perth Avenue, Hayes. 65936/APP/2009/2629	3,902.00	3,902.00	No time limits	Pine Medical Centre	Funds received towards the cost of providing health facilites in the Authorities Area. No time limits. £1,800 earmarked towards improvements to Pine Medical Centre, subject to formal approval. Confirmation received from NHS PS to confirm that the scheme is still valid. £1,800 allocated towards Pine Medical Centre improvements (Cabinet Member Decision 29/05/2015).
H/30/276G * 85	Townfield	Fmr Hayes FC, Church Road, Hayes. 4327/APP/2009/2737	104,319.06	35,620.80	2022 (Feb)	To be determined	Funds received as the first and second instalment towards the cost of providing health facilities in the Authority's area including the expansion of health premises to provide additional facilities, new health premises or services (see legal agreement for details). Funds to be spent within 7 years of receipt (July 2019). £68,698.86 allocated towards HESA extension (Cabinet Member Decision 4/12/2014). Formal request from NHS PS received to transfer funds. £68,698.86 transferred to NHS PS 24/02/2015. Final instalment (£35,620.80) received this quarter. Remaining balance to be spent by February 2022.
Other			**108,221.06**	**39,522.80**			
		TOTAL CONTRIBUTIONS TOWARDS HEALTH FACILITIES	**1,415,815.46**	**1,169,758.89**			

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Access to a GP surgery is very good across the entire borough. Very few people live more than 10 minutes drive away from a practice

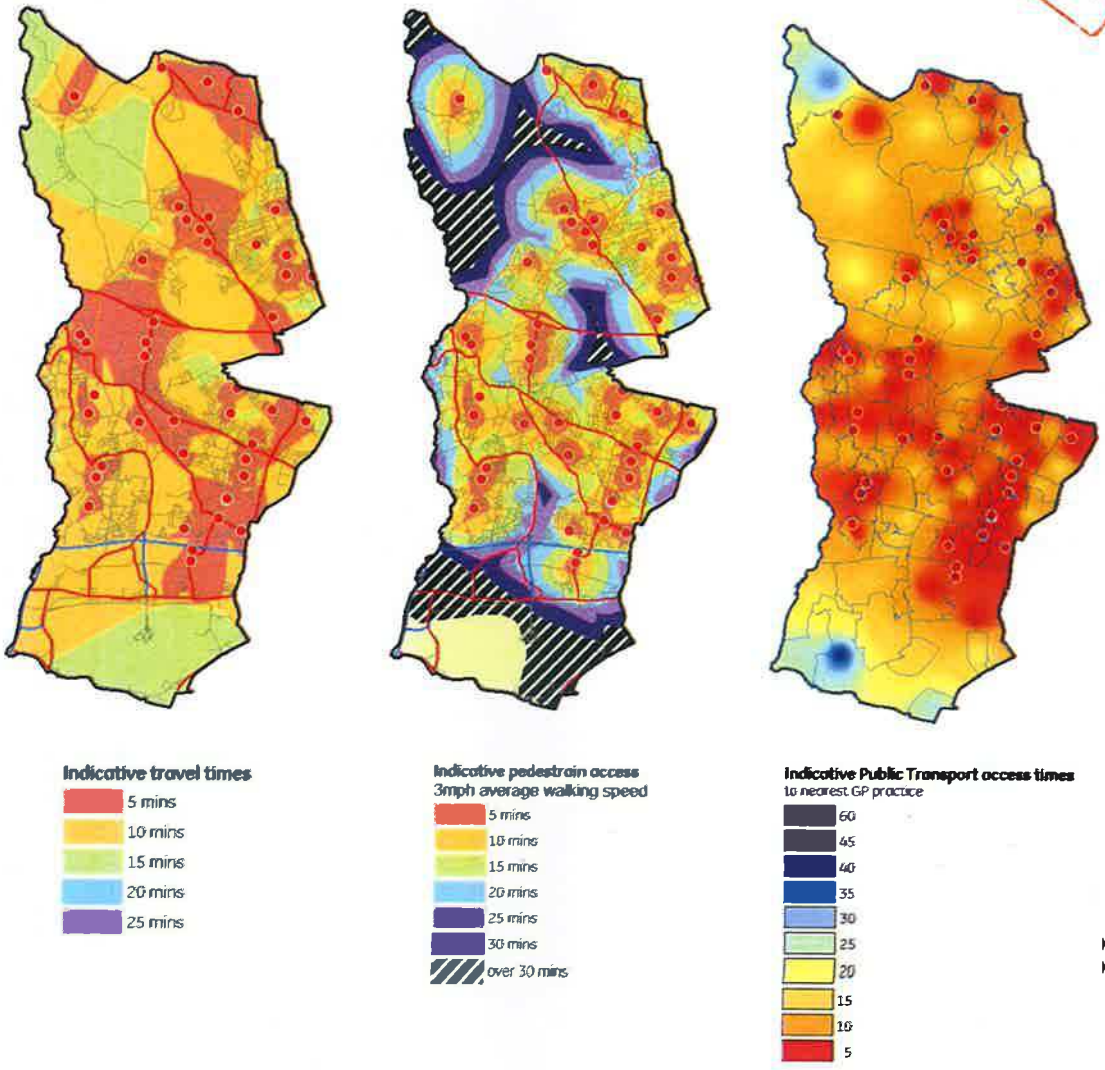
DRAFT

Access to General Practice is relatively good across the whole of the borough.

There are very few areas which would require a journey of more than 10 minutes by car. Areas which would require a journey of greater than 10 minutes are typically those with low population density.

A large proportion of the borough is within 10-15 minutes walking distance of a GP practice (based on an average walking speed of 3mph)

The vast majority of the borough is able to access a GP surgery within 20 minutes using public transport (this analysis is based on point to point data, so is an indicative assessment only)



A recent estates review concluded that the majority of properties were already fully utilised, limiting scope to increase capacity within the existing footprint

DRAFT

If the number of GPs were increased in line with the national average and/or the NHSE model, it is important to consider where these GPs would be needed.

Two major considerations which would inform this are:

1. The extent to which the existing estate can be redeveloped
2. The utilisation of the current estate

In terms of development, the recent survey concluded that in the case of a small number of properties, there were no options to redevelop the estate, which limits the ability to add in additional GPs at these locations. For those were development opportunities exist, ETFF (Estates, Technology and Transformation Fund) bids totalling **£3.1m** have been submitted for 2016/17

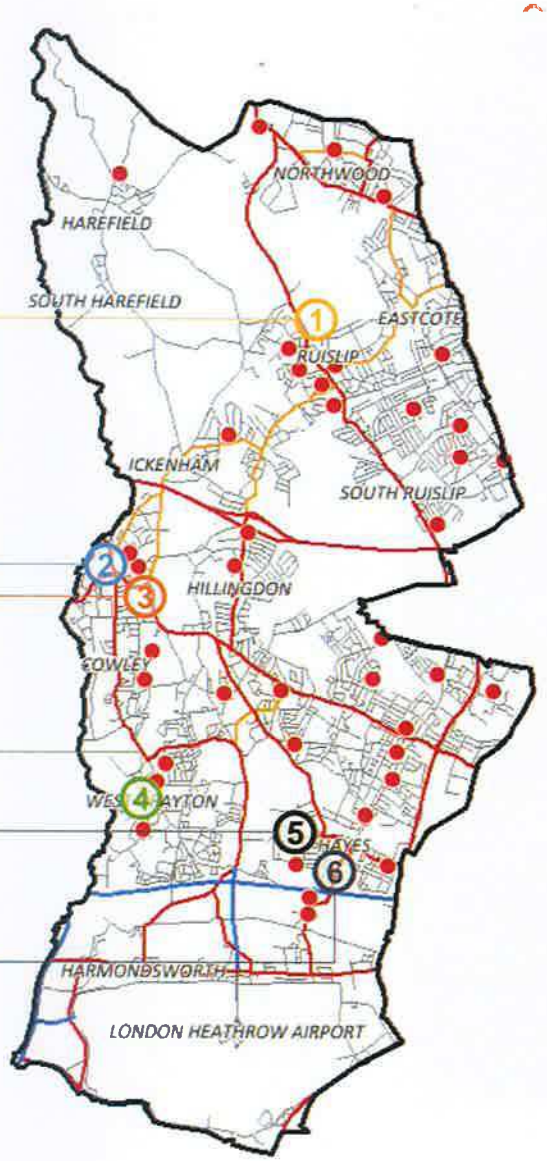
In terms of current utilisation, the survey concluded that the majority of properties were already fully or over utilised, which would again limit the ability of the estate to cope with additional GPs.

Six key development sites have been identified across Hillingdon

As there is limited scope to increase utilisation within the existing footprint, it is necessary to consider new development options. The map shows key development sites across Hillingdon, where the s106 allocation is greater than £30,000.

The six sites list have a **total allocation of £1.13m**

1	Former Mill Works, Ruislip	£31k
2	Armstrong House	£43k
3	Former RAF Uxbridge	£625k
4	West Drayton Garden Village	£338k
5	Former Hayes FC, Church Road	£69k
6	Former Glenister Hall	£33k



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BOARD PLANNER & FUTURE AGENDA ITEMS

Relevant Board Member(s)	Councillor Philip Corthorne
Organisation	London Borough of Hillingdon
Report author	Nikki O'Halloran, Administration Directorate
Papers with report	Appendix 1 - Board Planner 2016/2017 Appendix 2 - Board Membership

1. HEADLINE INFORMATION

Summary	To consider the Board's business for the forthcoming cycle of meetings.
Contribution to plans and strategies	Joint Health & Wellbeing Strategy
Financial Cost	None
Relevant Policy Overview & Scrutiny Committee	N/A
Ward(s) affected	N/A

2. RECOMMENDATIONS

That the Health and Wellbeing Board:

1. **considers and provides input on the Board Planner, attached at Appendix 1; and**
2. **notes the updated Board membership at Appendix 2.**

3. INFORMATION

Supporting Information

New regular agenda item

Starting with the 12 April meeting, a new regular non-decision item has been added to Board agendas in Part 2, to enable a private opportunity for Board Members to discuss current or emerging issues in relation to health, wellbeing and social care services within Hillingdon that may or may not be sensitive, in commercial confidence or confidential in nature. It will be the last item on the agenda.

Reporting to the Board

The draft Board Planner for 2017/2018, attached at Appendix 1, is presented for consideration and development in order to schedule future reports to be considered by the Board. Members

may also wish to consider any standing items (regular reports) and on what frequency they are presented.

The Board Planner is flexible so it can be updated at each meeting or between meetings, subject to the Chairman's approval.

Board agendas and reports will follow legal rules around their publication. As such, they can usually only be considered if they are received by the deadlines set. Any late report (issued after the agenda has been published) can only be considered if a valid reason for its urgency is agreed by the Chairman.

Advance reminders for reports will be issued by Democratic Services but report authors should note the report deadlines detailed within the attached Board Planner. Reports should be presented in the name of the relevant Board member.

With the Chairman, Democratic Services will review the nature of reports presented to the Board in order to ensure consistency and adequate consideration of legal, financial and other implications. It is proposed that all reports follow the in-house "cabinet style" with clear recommendations as well as the inclusion of corporate finance and legal comments.

The agenda and minutes for the Board will be published on the Council's website, alongside other Council Committees.

Board meeting dates

The Board meeting dates for 2017/2018 were considered and ratified by Council at its meeting on 23 February 2017 as part of the authority's Programme of Meetings for the new municipal year. The dates and report deadlines for the 2017/2018 meetings have been attached to this report as Appendix 1.

Board Membership

At the Health and Wellbeing Board meeting on 8 December 2016, changes were proposed to the statutory voting membership. These changes were agreed at Council on 19 January 2017 and have been attached to this report at Appendix 2.

Financial Implications

There are no financial implications arising from the recommendations in this report.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

Consultation Carried Out or Required

Consultation with the Chairman of the Board and relevant officers.

5. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

There are no financial implications arising from the recommendations in this report.

Hillingdon Council Legal comments

Consideration of business by the Board supports its responsibilities under the Health and Social Care Act 2012.

6. BACKGROUND PAPERS

NIL.

APPENDIX 1

BOARD PLANNER 2017/2018

27 June 2017 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Friday 9 June 2017 **Agenda Published:** 19 June 2017
	Health and Wellbeing Strategy: Performance Report (SI)	LBH	
	Better Care Fund: Performance Report (SI)	LBH	
	Draft Digital Roadmap	LBH	
	Hillingdon CCG Update (SI) - *to include update on Financial Recovery Plan / QIPP Programme savings update*	HCCG	
	Healthwatch Hillingdon Update (SI)	Healthwatch Hillingdon	
	Update: Strategic Estate Development (SI)	HCCG / LBH	
	Board Planner & Future Agenda Items (SI)	LBH	
	CAMHS Progress Report (SI)	HCCG / LBH	
	Final Sustainability and Transformation Plan (STP)	LBH / CCG	
	PART II - Update on current and emerging issues and any other business the Chairman considers to be urgent	All	

26 Sept 2017 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Friday 8 September 2017 **Agenda Published:** 18 September 2017
	Health and Wellbeing Strategy: Performance Report (SI)	LBH	
	Better Care Fund: Performance Report (SI)	LBH	
	Hillingdon CCG Update Report (SI) - *to include update on Financial Recovery Plan / QIPP Programme savings update*	HCCG	
	Healthwatch Hillingdon Update (SI)	Healthwatch Hillingdon	
	Update: Strategic Estate Development (SI)	HCCG / LBH	
	Board Planner & Future Agenda Items (SI)	LBH	
	HCCG Commissioning Intentions 2018-19	HCCG	
	CAMHS Progress Report (SI)	HCCG / LBH	
	PART II - Update on current and emerging issues and any other business the Chairman considers to be urgent	All	

7 Dec 2017 2.30pm Committee Room 6	Business / Reports	Lead	Timings
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Friday 17 November 2017 **Agenda Published** 29 November 2017
	Health and Wellbeing Strategy: Performance Report (SI)	LBH	
	Better Care Fund: Performance Report (SI)	LBH	
	Hillingdon CCG Update Report (SI) - *to include update on Financial Recovery Plan / QIPP Programme savings update*	HCCG	
	Healthwatch Hillingdon Update (SI)	Healthwatch Hillingdon	
	Update: Strategic Estate Development (SI)	HCCG / LBH	
	Hillingdon's Joint Strategic Needs Assessment	LBH	
	Local Safeguarding Children's Board (LSCB) Annual Report	LBH	
	Safeguarding Adults Partnership Board (SAPB)	LBH	
	CAMHS Progress Report (SI)	HCCG / LBH	
	Board Planner & Future Agenda Items (SI)	LBH	
	PART II - Update on current and emerging issues and any other business the Chairman considers to be urgent	All	

8 Mar 2018 2.30pm Committee Room 6	Business / Reports	Lead	Timings
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Friday 17 February 2018 **Agenda Published:** 28 February 2018
	Health and Wellbeing Strategy: Performance Report (SI)	LBH	
	Better Care Fund: Performance Report (SI)	LBH	
	Hillingdon CCG Update Report (SI) - *to include update on Financial Recovery Plan / QIPP Programme savings update*	HCCG	
	Healthwatch Hillingdon Update (SI)	Healthwatch Hillingdon	
	Update: Strategic Estate Development (SI)	HCCG / LBH	
	CAMHS Progress Report (SI)	HCCG / LBH	
	HCCG Operating Plan	HCCG	
	Annual Report Board Planner & Future Agenda Items (SI)	LBH	
	PART II - Update on current and emerging issues and any other business the Chairman considers to be urgent	All	

** SI = Standing Item*

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HEALTH AND WELLBEING BOARD: *Outside of the overall calculation and subject to the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.*

Organisation	Name of Member	Substitute
STATUTORY MEMBERS (VOTING)		
Chairman	Councillor Corthorne	Any Elected Member
Vice-Chairman	Councillor Simmonds	Any Elected Member
Members	Councillor Puddifoot	Any Elected Member
	Councillor Mills	Any Elected Member
	Councillor Bianco	Any Elected Member
	Councillor Burrows	Any Elected Member
	Councillor Lewis	Any Elected Member
Healthwatch Hillingdon	Mr Stephen Otter	Mr Turkay Mahmoud
Clinical Commissioning Group	Dr Ian Goodman	Dr Kuldhir Johal
For information Membership also includes:		
STATUTORY MEMBERS (NON-VOTING)		
Statutory Director of Adult Social Services	Mr Tony Zaman	Mr Nick Ellender
Statutory Director of Children's Services	Mr Tony Zaman	Mr Tom Murphy
Statutory Director of Public Health	Dr Steve Hajioff	Ms Sharon Daye
CO-OPTED MEMBERS (NON-VOTING)		
The Hillingdon Hospitals NHS Foundation Trust	Mr Shane DeGaris	Mr Richard Sumray
Central and North West London NHS Foundation Trust	Ms Robyn Doran	Ms Maria O'Brien
Royal Brompton and Harefield NHS Foundation Trust	Mr Robert J Bell	Mr Nick Hunt
LBH	Mr Nigel Dicker	N/A
Clinical Commissioning Group (Officer)	Mr Rob Larkman	Mr Neil Ferrelly
Clinical Commissioning Group (Clinician)	Ms Alison Seidler	Dr Kuldhir Johal

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