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A

Social Services, Housing and Public Health Policy Overview Committee

Date: **WEDNESDAY, 2 NOVEMBER 2016**

Time: **7.00 PM**

Venue: **COMMITTEE ROOM 4 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

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

Councillors on the Committee

Wayne Bridges (Chairman)
Jane Palmer (Vice-Chairman)
Beulah East (Labour Lead)
Shehryar Ahmad-Wallana
Teji Barnes
Peter Davis
Tony Eginton
Becky Haggar
Peter Money

Co-Opted Member

Mary O'Connor

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SOCIAL SERVICES, HOUSING & PUBLIC HEALTH

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

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

Agenda

CHAIRMAN'S ANNOUNCEMENTS

1	Apologies for Absence and to report the presence of any substitute Members	
2	Declarations of Interest in matters coming before this meeting	
3	To receive the minutes of the meeting held on 4 October 2016	1 - 6
4	To confirm that the items of business marked in Part I will be considered in Public and that the items marked Part II will be considered in Private	
5	Major Review - Hospital Discharges	7 - 24
6	Update on Hillingdon Shared Lives Scheme	25 - 30
7	Stroke Prevention Review - Update To be given an oral update on the Committee's review into Stroke Prevention.	
8	Forward Plan	31 - 34
9	Work Programme	35 - 38

Minutes

SOCIAL SERVICES, HOUSING AND PUBLIC HEALTH POLICY OVERVIEW COMMITTEE

Tuesday 4 October 2016
Meeting held at Committee Room 6- Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillors Wayne Bridges (Chairman), Shehryar Ahmad-Wallana, Teji Barnes, Peter Davis, Beulah East, Tony Eginton, Becky Haggar, Michael Markham and Peter Money. **Apologies for Absence:** Councillor Jane Palmer (Substitute for Councillor Michael Markham) and Co-opted Member, Mary O'Connor. **Officers:** Gary Collier (Health & Social Care Integration Manager), Nina Durnford (Head of Social Work, Adult Social Care Services), Dr Steve Hajioff (Director of Public Health) and Khalid Ahmed (Democratic Services Manager). **Also Present:** Tristan Brice (Programme Manager, LondonADASS).	
17.	**MINUTES OF THE MEETING HELD ON 6 SEPTEMBER 2016** Agreed as an accurate record.	
18.	**TO CONFIRM THAT ALL ITEMS MARKED PART I WILL BE CONSIDERED IN PUBLIC AND THAT ANY ITEMS MARKED PART II WILL BE CONSIDERED IN PRIVATE** It was confirmed that all items on the agenda would be considered in public.	
19.	**MAJOR REVIEW - HOSPITAL DISCHARGES** Consideration was given to a draft scoping report on the Committee's major review on Hospital Discharges. The Council's Health & Social Care Integration Manager and Head of Social Work attended the meeting and provided Members with the context to the review. The aim of the review was to examine the discharge process from hospital and how people were supported into the least restrictive care setting in order to maximise their independence and safely meet their needs. The focus of the review would be on Hillingdon Hospital where	**Action By:**

around 80% of the people admitted were from within the Borough of Hillingdon. Of those admitted as emergencies, almost 30% were of people aged 65 and over and registered with Hillingdon GPs.

The Committee agreed that this age profile would be the focus of the review.

Current context

The Committee was informed that changes in the levels of activity in the last two years had increased patients delayed transfer to care. Reference was made to research which showed that the longer an elderly person was in hospital, they were more likely to become increasingly confused, and there was also an increasing risk of them contracting a hospital acquired infection.

In addition, delays in discharging people who were medically fit added increasing pressure on hospital bed provision, which could lead to higher costs.

Reference was made to NHS England (NHSE) who had reported that nationally, everyday more than 6,000 patients who were well enough to leave hospital were unable to do so because of insufficient local care models. With a 23% rise of delays in discharge nationally since June 2015, “joined-up care” remained the single most important feature for ensuring greater patient safety and efficient hospital discharge planning.

The National Audit Office (NAO) estimated the cost to the NHS of older patients in hospital beds, no longer in need of acute treatment, totalled £820 million every year. Longer stays in hospital also led to increased social care costs.

Preventative Initiatives

The most effective method for addressing hospital admission was to prevent hospital admissions from occurring in the first place.

- Development of an anticipatory model of care for older people

This was where older people who had been identified as being at risk of hospital admission, were invited into their GP surgery to explore the completion of a care plan.

	This was to identify any interventions which might prevent an escalation of need. For people with more complex needs, a multi-disciplinary team (MDT) approach was taken. For example, an approach which would involve professionals from different health and care organisations, seeking to identify solutions which would prevent or delay further escalation of need and enable the management of the person in their usual place of residence. H4All (a consortium of local third sector organisations) played a crucial role in this initiative. • Better Care Fund Plan (BCF*)* A key priority of Hillingdon's 2016/17 BCF was the prevention of admission to hospital and this was reflected in its eight schemes that looked at issues such as addressing the needs of older people at risk of falls, stroke, dementia and/or social isolation, preventing admissions to hospital from care homes and supporting people at home who have had an escalation of need but did not require admission to hospital. This initiative involved cross over work with what was happening in GP surgeries. The Committee was informed that delayed transfer of care occurred when a patient was ready for transfer from a hospital bed, but was still occupying such a bed. This was a joint health and social care issue. Reference was made to improvements being made in acute care which were helping support discharges from hospital. These were included in the draft scoping report for Members information. Members were informed that discharges from hospital were complex issues and increased integrated working was required from both health and social care professionals. Reference was made to the work of LondonADASS, who were working in collaboration with NHSE and the Local Government Association to support local systems to improve the performance of hospital discharges. The Hospital Admission and Discharge Pathways Network had been created which	

	aimed at developing and sharing good practise in addressing delayed transfers. Discussion took place on the information provided and the Director of Public Health reiterated that patients leaving hospital was often a complex issue. Additionally there were instances where people had been admitted to Hillingdon Hospital who need not have been admitted in the first place. The Committee noted that progress was being made, but it was recognised that there were inconsistencies, which would only be eradicated once changes in working practices had been given time. Discussion took place on communications with the family of the patient and whether families were given details of options in terms of different care homes. The Head of Social Work reported that there was on-line information available for families and early discussions took place on patient pathways. The draft scoping report provided details on the issues and challenges to a smoother discharge process and pathway in Hillingdon. Some of these were discussed, particularly around the need to align hospital processes. This would require the alignment of decisions on availability of medication and transport home, which was not consistently occurring across all wards at Hillingdon Hospital. The fragmentation of out of hospital services created a problem of multiple hand-offs between organisations which on occasions meant that the needs of residents were not being addressed by the most appropriate professional. Members asked that data be provided on what the over 65 year olds were in hospital for to enable a focus on the key health issues. It was noted that during the winter months that hospital admissions were higher, with respiratory conditions increasing and potentially more falls taking place. Particular reference was made to the quarter 1 2016/17 statistics which showed there had been 430 emergency admissions to Hillingdon Hospital from care homes, with many of these being older people suffering from dementia. Members thanked officers and witnesses for the information	

	provided and agreed that for the next witness session representatives from Hillingdon Hospital and Hillingdon Clinical Commissioning Group be invited to attend to help with the review. In addition, the Committee was informed that Healthwatch would be invited to a future witness session to provide details of their findings into the patient experience of hospital discharges. **RESOLVED –** **1. That approval be given to the scoping report and it was agreed that the review would focus on Hillingdon Hospital and people 65 years old and over and who were registered with Hillingdon GPs.**	
20.	**UPDATE ON STROKE PREVENTION REVIEW** Members were informed that officers were in the process of summarising the information which had been provided for the review, and establishing gaps which required further investigation from the Committee. For the next meeting, the Committee would be provided with a progress report on the review so far.	**Action By:**
21.	**SAFEGUARDING ADULTS PARTNERSHIP BOARD ANNUAL REPORT 2015/16** The Committee was provided with responses from the Chair of the Board to a number of questions which were asked on details provided in the Annual Report. The Committee asked if the Chair of the Safeguarding Adults Partnership Board be invited to a future meeting to provide more details on some of the areas raised by Members.	
22.	**FORWARD PLAN** Noted.	
23.	**WORK PROGRAMME** Noted.	
	Meeting commenced at 7.00pm and closed at 7.50pm **Next meeting: 2 November 2016 at 7.00pm**	

These are the minutes of the above meeting. For more information on any of the resolutions

please contact Khalid Ahmed on 01895 250833. These minutes are circulated to Councillors, Officers, the Press and Members of the Public.

Social Services, Housing and Public Health Policy Overview Committee - Major Review 2016/17 - Hospital Discharges

Contact Officers: Khalid Ahmed
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REASON FOR ITEM

The Committee is continuing its review into Hospital Discharges from Hillingdon Hospital for people 65 years old and over and who were registered with Hillingdon GPs.

OPTIONS OPEN TO THE COMMITTEE

The Committee is asked to hear the evidence given by the witnesses invited to the meeting and to ask questions on the information provided and make suggestions to help the Committee with its review

INFORMATION

1. At the last meeting of the Committee held on 4 October 2016, the Committee agreed the scoping report for its Major Review into Hospital Discharges **(Appendix1)**. The Council's Health & Social Care Integration Manager, Head of Social Work, Adult Social Care Services and Director of Public Health attended the meeting and provided the background to the review.

2. The Committee agreed that the focus of the review would be on Hillingdon Hospital where around 80% of the people admitted were from within the Borough. Of those admitted as emergencies, almost 30% were of people aged 65 and over and registered with Hillingdon GPs. The Committee agreed that this age profile would be the focus of the review.

3. More detail of what the Committee discussed at the last meeting are included in the minutes which is an earlier item on this agenda.

Witnesses

3. For this meeting, the Committee will be provided from expert evidence from the following invited witnesses:

   Graham Hawkes, Healthwatch CEO - Graham will provide a general overview of the Healthwatch Hospital Discharge Review for the Committee

   Nina Durnford, Head of Older People's Services, Occupational Therapy and Mental Health, Adult Social Care

   Gary Collier, Health and Social Care Integration Manager

Nina and Gary will provide the Adult Social Care perspective and response to issues identified in the Healthwatch review.

Caroline Morison, Chief Operating Officer, Hillingdon Clinical Commissioning Group (CCG)- Caroline will provide the CCG perspective on hospital discharges.

Nicky Yiasoumi, Head of Continuing Healthcare and Complex Care, HCCG - Nicky will provide an overview of continuing healthcare and related issues.

Social Services, Housing & Public Health Policy Overview & Scrutiny Committee Review Scoping Report

Hospital Discharge

REVIEW OBJECTIVES

Aim and background to the Review

1. This review aims to examine the discharge process from hospital and how people are supported into the least restrictive care setting in order to maximise their independence and safely meet their needs.

Terms of Reference

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

a) To gain a comprehensive understanding of current discharge activity in respect of the 65 and over population and focusing on Hillingdon Hospital.

b) To investigate best practice on what the ideal discharge pathway would look like.

c) To gather evidence from Healthwatch Hillingdon about the resident/patient experience of hospital discharge.

d) To explore the key issues and challenges that inhibits a smooth hospital discharge process and pathway.

e) To particularly examine the issues faced in meeting the needs of residents/patients with mental health needs and the impact on the broader discharge process.

f) To consider national and regional initiatives, e.g. London and North West London, being undertaken to improve the hospital discharge process and pathway.

g) To examine the work being undertaken by the Council and NHS and third sector partners to improve the resident/patient experience of hospital discharge.

h) To report to Cabinet any positive recommendations or conclusions arising from the review.

Reasons for the Review

3. Delays in hospitals being able to discharge people, whose medical needs no longer require them to be cared for in a hospital setting, has a very high national profile.

4. During 2015/16 there were 50,696 admissions to The Hillingdon Hospitals NHS Foundation Trust's (THH) beds. Whilst 25,256 admissions were planned for (also known as elective procedures), 25,440 were admitted as emergencies (also known as non-elective admissions) and of these nearly 30% (7,593) were of people aged 65 and over registered with a Hillingdon GP.

5. Approximately 80% of the people admitted to THH are Hillingdon residents and for admissions of people aged 65 and over nearly 83% are borough residents. Other admissions come mainly from other parts of North West London . 85% of Adult Social Care hospital-related activity comes from Hillingdon Hospital and the remainder comes mainly from Northwick Park and Ealing Hospitals.

6. In 2015/16 there were 4,196 delayed days for Hillingdon residents and/or people registered with a Hillingdon GP aged 18 and over. Research shows that the longer an older person is in hospital not only are they likely to become increasingly

confused but there is also an increasing risk of them contracting a hospital acquired infection. In addition, delays in discharging people who are medically fit or medically stable adds increasing pressure on hospital bed provision, which can lead to higher costs due to the necessity of opening escalation wards. This also increases hardship on other residents due to cancellation of planned health procedures as bed capacity is used to support admissions through A & E.

7. This Committee's Terms of Reference state that some of its core areas of responsibility include: Adult Social Care, Older People's Services, care and support for people with physical disabilities, mental health problems and learning difficulties

8. As will be seen from the information contained below, it is clear that the implementation of an effective discharge process and pathway touches upon many areas of the Committee's remit and, therefore, is an appropriate topic for its consideration.

INFORMATION AND ANALYSIS

Current context

9. About 80% of patients nationally will experience a simple discharge process. These patients are usually discharged to their homes and require minimal ongoing care. The other 20%, however, (predominantly people over 65), will have more complex ongoing health and care needs. NHS England (NHSE) has reported that everyday more than 6,000 patients who are well enough to leave hospital are unable to do so because of insufficient local care models. With a 23% rise of delays in discharge nationally since June 2015, "joined-up care" remains the single most important feature for ensuring greater patient safety and efficient hospital discharge planning.

10. The National Audit Office (NAO) estimates the cost to the NHS of older patients in hospital beds, no longer in need of acute treatment, totals £820 million every year. Longer stays in hospital also lead to increased social care costs.

11. The Public Accounts Committee published the *Discharging Older People from Acute Hospitals* report in July 2016, highlighting that many older people find themselves unable to leave hospital even though their treatment has been completed. This report also identified that older people lose approximately 5% of their muscle strength per day of treatment in hospital, thus emphasising the importance of early discharge.

12. The number of emergency admissions of people aged 65 and over fell by 486 admissions in 2015/16 from 10,696 in 2014/15 in response to a range of Local admissions avoidance initiatives. However, older people tend to have a longer length of stay in hospital following admission which helps to explain the higher average cost of £1,700 compared to £1,400 for emergency admissions of other age groups. The estimated cost to the NHS of these admissions in 2015/16 was £18m. 763 of these admissions were falls-related and a further 1,700 were of people admitted to hospital from care homes in the Borough.

13. In Quarter 1 2016/17 there were 2,537 emergency admissions and this level of activity is broadly comparable with the same period in 2015/16 when there were 2,570 admissions, although it was above the ceiling set within the 2016/17 Hillingdon's Better Care Fund Plan of 2,442. During this period there were 208 falls-related emergency admissions which compares unfavourably with same period in 2015/16 when there were 186 falls-related emergency admissions. There were also 430 emergency admissions from care homes in Q1 against a ceiling of 427, is broadly on target.

14. Statutory requirements concerning the discharge of people from hospital who have social care needs are set out in Schedule 3 of the Care Act, 2014, the related Care and Support (Discharge of Hospital Patients) Regulations 2014 and the statutory guidance.

Key Information

<u>Avoiding Hospital Admission</u>

15. As the Committee identified at its meeting on 6 September 2016, the most effective method for addressing a hospital admission is to prevent it from occurring in the first place. There are many initiatives currently in progress that are intended to achieve this and these include:

a) *Development of an anticipatory model of care* for older people - Under this new model older people identified as being at risk of hospital admission are invited into their GP surgery to explore completion of a care plan. The process if care planning is intended to identify what interventions may prevent an escalation of need. A multi-disciplinary team (MDT) approach for people with more complex needs, e.g. an approach that involves professionals from different health and care organisations, seeks to identify solutions that will prevent or delay further escalation of need and enable management of the person in their usual place of residence.

The new model includes a critical role for the third sector through the H4All (a consortium of local third sector organisations) Wellbeing Service. This new service seeks to support older people who are less motivated to manage their own long-term condition (s) and are therefore at risk of escalating needs.

b) *Better Care Fund Plan (BCF)* - A key priority of Hillingdon's 2016/17 BCF is the prevention of admission to hospital and this is reflected in its eight schemes that look at issues such as addressing the needs of older people at risk of falls, stroke, dementia and/or social isolation, preventing admissions to hospital from care homes and supporting people at home who have had an escalation of need but do not require admission to hospital. The full details of the 2016/17 can be found through the following link http://www.hillingdon.gov.uk/article/28647/Introducing-the-Better-Care-Fund

The Ideal Discharge Pathway Summarised.

16. In December 2015, the National Institute of Health and Care Excellence published guidance on the transition between inpatient hospital settings and community or care home settings-for-adults-with-social-care-needs https://www.nice.org.uk/guidance/ng27 . This identifies the key components of good discharge practice as being:

a) Starting discharge planning early;

b) Maintaining the momentum of treatment while in hospital, e.g. increasing the number of people discharged before midday and at weekends;

c) Multi-disciplinary assessments between health and social care providers; and

d) Undertaking assessments of older person's long-term care needs in the most appropriate setting, ideally in their own home.

17. If local systems are working well then there will be low levels of delayed transfers of care and also low levels of readmissions.

Delayed Transfers of Care (DTOC)

18. A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when:

a) A clinical decision has been made that the patient is ready for transfer; AND

b) A multi-disciplinary team decision has been made that the patient is ready for transfer; AND

c) The patient is safe to discharge/transfer.

19. The Care Act sets out a formal process for the notification of local authorities where a person with potential social care needs requires an assessment prior to discharge. This is the assessment notice and discharge notice process that was previously known as the 'section 2s' and '5s' process under the Community Care (Delayed Discharge) Act, 2003. The purpose of the discharge notice is to confirm the date of discharge. The Council can be fined where it is responsible for appropriate measures to facilitate a discharge on the discharge date not being in place. The Care Act makes fines discretionary and the Council is working with Hillingdon Hospital to establish a no fine agreement.

20. Table 1 below provides a DTOC breakdown for 2015/16 and the Q1 2016/17 outturn position.

Table 1: 2015/16 DTOC Breakdown and Q1 2016/17 Position

	2015/16 DTOC Breakdown	Q1 2016/17 DTOC Breakdown		
Delay Source	**Total**	**Acute**	**Non-acute**	**Total**
NHS	2,590	521	395	916
Social Care	1,293	230	97	327
Both NHS & Social Care	313	11	193	204
Total	**4,196**	**762**	**685**	**1,447**

21. '*Acute'* in the table above refers to NHS trusts that provide acute care, which is defined in Schedule 3 of the 2014 Care Act as being *'intensive medical treatment provided by or under the supervision of a consultant that lasts for a limited period, after which the person receiving the treatment no longer benefits from it'*.

22. Hillingdon Hospital, London North West Hospitals (Northwick Park and Ealing Hospitals), Imperial College Hospital, Chelsea and Westminster and the Royal Brompton and Harefield are examples of NHS trusts providing acute care.

23. Mental health is specifically excluded from the definition of 'acute care' for the purposes of the discharge from hospital provisions of the Care Act and its supporting regulations.

24. Table 2 below provides a breakdown of the main DTOC reasons during 2015/16 and in Q1 2016/17. The reasons below are those identified by NHSE and set out in guidance on monthly situation reporting which all acute and non-acute providers are required to undertake each month to NHS Digital (formerly the Health and Social Care Information Centre HSCIC).

Table 2: DTOC Reasons 2015/16 and Q1 2016/17

DTOC Reason	2015/16 Total Delayed Days	Q1 2016/17 Total Delayed Days
1. Residential Home	2,226	470
2. Nursing Home	909	567
3. Completion of Assessment	281	74
4. Further Non-acute NHS	212	103
5. Care Package in Home	250	110
6. Public Funding	173	56
7. Disputes	0	0
8. Patient/Family Choice	86	51
9. Equipment & Adaptations	3	6
10. Housing	56	10
TOTALS	**4,196**	**1,447**

25. In 2015/16 Hillingdon had the 12th lowest level of delayed transfers of care in London and the lowest out of the eight boroughs in North West London. In Q1

2016/17 Hillingdon's position had changed to having the 13th highest in London and the fourth highest in North West London. A contributory factor to this revised position is a change in reporting practice, e.g. reporting as DTOCs delays that do not fall within the DTOC definition and partners are currently looking at this.

26. In Q1 2016/17 Hillingdon Hospital had a readmission rate of 7.2% against a ceiling for the year of 8%, which is positive. The readmission rate in 2015/16 was 7.9% (10.8% for people aged 65 and over).

Services Supporting Timely Hospital Discharge

27. There is a range of services currently in place to support discharge from hospital and these include the services below. This information is summarised in **Appendix 1**.

a) *Integrated Discharge Team* - During 2015/16 an integrated discharge team was set up in the Acute Medical Unit (AMU) to identify adults with care needs as soon as they are admitted to hospital and to take a more proactive and joint approach between health and social care to discharge management. The team includes Hospital discharge coordinators, an occupational therapist, social workers and admin support. Social work staff within this team now actively visit other adult wards within THH seeking to identify people who may have social care needs in order to expedite the discharge planning process.

Acute Medical Unit Explained

This is a 46-bed facility on the Hillingdon Hospital main site that provides the first point of entry for older patients referred to the Hospital by their GPs as emergency cases, as well as those moving from the emergency department. These patients will usually be discharged within 72 hours or transferred to a specialty within THH.

b) *Homesafe* - This is led by Hillingdon Hospital through the Care of the Elderly Team (COTE). The service entails older people aged 65 and over who are admitted through the Emergency Department being screened and receiving a comprehensive geriatric assessment (CGA).

Comprehensive Geriatric Assessment (CGA) Explained

This is a diagnostic process that is led by a consultant geriatrician and is designed to determine a frail older person's medical conditions, mental health, functional capacity and social circumstances.

c) *Community Homesafe* - The nursing, therapeutic and care needs for people aged 65 and over who have undergone a CGA are met for up to 10 days by the Community HomeSafe clinicians (the service is provided by CNWL) to facilitate clinically appropriate and timely discharge from acute care. People with lower level support needs are referred to the Age UK Take Home and Settle element of HomeSafe.

d) *Reablement* - The Reablement Service is provided by the Council and is intended to assist people to learn or relearn day to day living tasks following an escalation of needs. The service is provided for up to six weeks and is non-chargeable.

During Q1 2016/17 the Reablement Team received 227 referrals, and of these 176 were from hospitals, primarily Hillingdon Hospital. During this period, 102 people were discharged from Reablement with no ongoing social care needs.

e) *Rapid Response* - This service is provided by CNWL, is based in the community and provides 'in reach' to the Emergency Department at THH. It provides nursing, therapeutic and care needs for up to 10 days and has a fast track referral process to the LBH to establish packages of care or reablement.

In Q1 2016/17 the Rapid Response Team received 886 referrals and 56% (500) of these came from Hillingdon Hospital. The remaining 44% came from a variety of sources within the community, e.g. 19% (169) from GPs, 11% (99) from community services such as District Nursing and the remaining 13% (118) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 500 referrals received from Hillingdon Hospital, 340 (68%) were discharged with Rapid Response input, 138 (28%) following assessment were not medically cleared for discharge and 22 (4%) were either out of area or inappropriate referrals.

f) *Hawthorne Intermediate Care Unit (HICU)* - This 22-bed unit on the Hillingdon Hospital main site is provided by CNWL and provides short-term rehabilitation, typically for up to 6 weeks. Medical input is from the THH COTE consultants and the unit is staffed by a multidisciplinary team, including nurses, physiotherapists, occupational therapists, a ward pharmacist and an activities coordinator.

g) *Bridging Care Service* - This service is provided by Harlington Hospice and enables people with stable health needs to be discharged from Hospital pending an assessment to determine their ongoing care needs.

h) *Franklin House Step-down beds* - These beds are provided by Care UK for people who are medically stable and are a) on a rehabilitation pathway, need a bed-based service but are unable to weight bear for 3 weeks or more; or b) are undergoing an assessment for continuing healthcare (CHC) which has not yet been completed.

i) *Cottesmore Step-down Flat* - Run by the Council in Cottesmore House extra care scheme, this flat provides an alternative setting to a care home to enable older people to step down from hospital and relearn daily living skills before returning home. The stay in this flat is for up to six weeks.

j) *Home Treatment Service* - This service is provided by CNWL and is intended to support people with severe mental health conditions, including dementia, at home for up to 14 weeks.

k) *Community Rehab* - This service is provided by CNWL and comprises of nurses, physiotherapists, occupational therapists, speech and language therapists, dieticians and rehabilitation assistants.

l) *Take Home and Settle* - This service is provided by Age UK and is intended to take people home, get them settled in and provide support for three days after discharge.

m) *Community Equipment Service* - This service provides aids of daily living ranging from bath boards to electric hoists and is jointly funded by the Council and the CCG and is provided by Medequip Assistive Technology Ltd.

Issues and Challenges

28. The following describes some of the issues and challenges that currently pose obstacles to a smoother discharge process and pathway in Hillingdon:

a) *Discharge planning on admission* - There is currently inconsistency in how quickly the discharge planning process starts, which means that complexities about a person's personal circumstances and their health and care needs are not identified at an early enough stage to enable them to be discharged as soon as they no longer need to be in hospital. For example, a person

requiring adaptations or with other complex accommodation issues that can take a considerable amount of time to resolve.

b) *Continuing Healthcare (CHC) Assessment Completion* - Assessment for continuing healthcare may be triggered following a screening when a person is admitted to hospital. A person is likely to be eligible for CHC funding if they have a complex health condition that requires the intervention of a health professional. A person who is eligible for CHC will have all of their care needs met by the NHS. Delays in securing timely assessments is a contributory factor in delaying discharge and in freeing up step-down provision provided to facilitate discharge.

c) *An agreed discharge policy and procedure* - An agreed policy and procedure that clarifies the roles and responsibilities of all agencies involved in the discharge process is not yet in place.

d) *Patient information* - Clear information for patients about what to expect so that health and social care staff give a consistent message to enable patients, their Carers and families to make informed choices, would help to address unrealistic expectations. This could help to prevent difficulties later over choices that may or may not be available.

e) *Aligning Hospital processes* - Alignment of consultant decisions with availability of medication and transport home is not consistently occurring across wards at THH, thus preventing some more timely discharges from occurring.

f) *Fragmentation of out of hospital services* - The Committee will be able to see from paragraph 27 that there is a large range of services delivered by different providers. This current arrangement leads to multiple hand-offs between organisations and the needs of residents not necessarily being addressed by the most appropriate professional first time.

g) *Market capacity and capability* - An increasing reluctance on the part of care homes to accept people with more complex needs, particularly people with challenging behaviours, is a significant cause of delays in Hillingdon. The difficulties faced by care home providers, especially nursing homes, in securing and retaining suitably qualified staff is a contributing factor to this.

29. One of the national conditions for the 2016/17 BCF plan was the development of local action plans to address DTOCs and deliver the out of hospital seven day working standard. These action plans address many of the points above and are

attached as **Appendices 2** and **3** respectively. A group comprising of senior officers from partner organisations has been established to monitor delivery of these plans.

Responsibilities

30. This review will cover matters within the remit of the Cabinet Member for Social Services, Housing, Health and Wellbeing and the Social Care Directorate.

Connected Activity

30. Healthwatch Hillingdon is currently undertaking a project looking into the patient experience of the hospital discharge process. The findings and recommendations arising from this project will be presented to the Committee at its November meeting.

31. NHSE, the Local Government Association and the Association of Directors of Adult Social Services (ADASS) have collaborated to support local systems to improve discharge-related performance. In London this has led to the creation of the Hospital Admission and Discharge Pathways Network, which includes representatives from health and social care across London boroughs, CCGs and acute and community health trusts and is chaired by the Director of Adult Social Services (DASS) in Croydon. The Newham DASS chairs the London DTOC roadshow which aims to develop and share good practice in addressing delayed transfers.

Further Information

32. The following reports provide analysis of the issues in respect of hospital discharge and make recommendations:

a) National Audit Office report: *Discharging Older Patients from Hospital (May 2016)* https://www.nao.org.uk/report/discharging-older-patients-from-hospital/

b) Public Accounts Committee report: *Discharging Older People from Acute Hospitals* (July 2016) http://www.publications.parliament.uk/pa/cm201617/cmselect/cmpubacc/76/7602.htm

EVIDENCE & ENQUIRY

33. Proposed timeframe & milestones for the review up to Cabinet and beyond in terms of monitoring:

APPENDIX 1

Meeting Date	Action	Purpose / Outcome
4 October 2016	Agree Scoping Report and to be provided with background information Tristan Brice Programme Manager LondonADASS Improvement Programme Nina Durnford Head of Older People's Services - LBH Gary Collier, Health & Social Care Integration Manager - LBH	Evidence & Enquiry
2 November 2016	Witness Session - Healthwatch Hillingdon Hillingdon Hospital HCCG	Evidence & enquiry
14 December 2016?	Witness Session 2 - Healthwatch Hillingdon CNWL Community health CNWL Community Mental Health	Evidence & enquiry
18 January 2017	Draft Final Report and suggested recommendations	Proposals – agree recommendations and final draft report

Witness testimony

34. Below are possible witnesses who may be called upon to help the Committee with their review

APPENDIX 1

Name	Title	Suggested Topic
Graham Hawkes	CEO, Healthwatch Hillingdon	Findings and recommendations of Hospital Discharge Project Patient/service user perspective
Tristan Brice	Programme Manager LondonADASS Improvement Programme	London regional initiatives
Nina Durnford	Head of Older People's Services	Operational Adult Social Care perspective
Gary Collier	Health and Social Care Integration Manager, LBH	BCF Plan schemes
Julie Wright	Director of Integration	Hillingdon Hospital perspective
Melissa Mellett	Director of Operations	Hillingdon Hospital perspective
Nicky Yiasoumi	Head of Continuing Healthcare and Complex Care, Brent, Harrow and Hillingdon CCGs	CHC assessment NHS perspective on care market
Caroline Morison	Chief Operating Officer, Hillingdon Clinical Commissioning Group	Role of A & E Delivery Board CCG perspective
Claire Eves	Head of Adults Services, CNWL	Community Health perspective. Interrelationship with Reablement/homecare
Kim Cox	Borough Director, CNWL	Mental health perspective

Resource requirements

35. None.

Equalities impact

36. The review will hope to make suggestions and recommendations to improve the processes for hospital discharges primarily for older people but including people with physical disabilities, mental health problems and/or learning disabilities.

Appendix 1

Summary of Services Supporting Hospital Discharge

Service Area	Service	Commissioner	Provider	Service Duration
Home Based Services	Rapid Response	HCCG	CNWL	10 days
	Community Home Safe	HCCG	CNWL	10 days
	Community Rehab	HCCG	CNWL	Dependent on need.
	Reablement	LBH	LBH	6 weeks
	Take Home and Settle	HCCG	Age UK	3 days
	Home from Hospital	HCCG/LBH	Age UK	6 weeks
Bed-based Services	Hawthorne Intermediate Care Unit (HICU)	HCCG	CNWL	6 weeks
	Cottesmore House Step-down Flat	LBH	Seva Care	6 weeks
	5 x step-down flats - Franklin House	HCCG	Care UK	6 weeks

Update on the Hillingdon Shared Lives Scheme - January 2015 - September 2016

Contact Officers: Sandra Taylor

Telephone: 01895 250415

REASON FOR ITEM

The Committee requested an update on the Shared Lives Scheme which this Committee reviewed in 2014/15.

OPTIONS OPEN TO THE COMMITTEE

The Committee is asked to note the report and to request clarification if required from the Head of Early Intervention & Prevention who will be in attendance.

INFORMATION

1. This Policy Overview Committee carried out a review into Hillingdon's Shared Lives Scheme in 2014/15. The objective of the review was to examine the effectiveness of the current arrangements for The Shared Lives Scheme and to propose improvements which could be made to enhance this important aspect of independent living to the Borough's residents.

2. Cabinet at its meeting held on 12 February 2015 endorsed the Committee's findings and recommendations as follows:

   "That the Committee commend the Shared Lives Scheme to Cabinet and recognise the good work undertaken by officers to develop a successful scheme that delivers much improved quality of life to the participants and has the capacity to deliver modest financial savings.

   a) That there are potential challenges in the Scheme, including safeguarding, and that any proposal to develop the scheme should ensure robust management such as is currently in place.

   b) That the Cabinet Member for Social Services, Health and Housing and the Leader of the Council, consider extending the scheme, as identified in the review, in the first instance by 100% (i.e. to total 40 Service Users) and that

potential savings arising from this be investigated for inclusion in the MTFF from 2016/17.

c) That consideration be given to further development up to the optimal size (80 service users) once the initial extension has been successfully undertaken.

d) That any extension of the Scheme is dependent upon appropriate matches being found in the community and that consequently the time frame needs to be flexible.

Summary of the scheme

3. Hillingdon Shared Lives Scheme was established in 1987 providing support for vulnerable adults aged 18 plus and from 2016 for young people aged 16 plus with learning disabilities.

4. The Scheme extends the range of residential services in Hillingdon, by providing a more personal form of care in small family homes. The scheme can be accessed:

- As a means of support for families who are caring for a dependant relative by offering periods of respite care.
- To assist in rehabilitation or for light convalescence.
- For people who do not need medical attention, but would benefit from a supportive caring environment as a step towards moving on towards independence.
- To offer a long-term stay for people who wish to live with a family as part of the community and as an alternative to living in a large residential home, hospital setting, or alone.
- To support young adults transition into adult services.

Current Status of Carers:

5. The scheme currently has a total of 46 registered carers. They are comprised of:
8 Single Main carers
28 Joint Main carers
4 Joint Relief carers.
6 Single Relief carers

Carer Development Days

6. Development days are now offered 2 times a Year. They are comprised of a comprehensive day of Induction and Training which is relevant for both new and existing carers. The first day was offered on 26/04/16 and the next is scheduled for 11/10/16. Feedback from carers on the first training day was that the information was helpful and relevant.

New Carers:

7. During this entire period we have recruited 5 Main carers (2 Joint) and (1 Single) 8 Relief carers. These numbers are included in the current status above.

New Applicants:

8. Currently there are 4 new carer applications in progress.

Current Status of service users placed within the scheme:

9. The scheme currently has 33 service users accessing the scheme. This includes 10 service users who access it via external respite. From January 2015 to present time 42 service users have accessed the scheme.

Referrals:

10. In this entire period we received 90 referrals. We have matched and placed 15 of these Referrals. An additional 2 placements were offered by HSL but declined by the service user/ family. Referrals which were not matched were due to the following reasons:

- Level of care needs requiring Ground Floor Accommodation and /or major adaptations to the home
- Availability of stay at home carers during the day
- Waking nights / 24 hour support
- Alcohol and Substance Misuse
- Continence Needs
- Recent History of violence/ aggression
- Refusal by service user to consider placement
- No Further Contact from Care management

Scheme Promotion & Marketing:

11. We continue with the scheme promotions and key events have included:

- Presentation to parent / carers at Queenswalk Day Centre 13/04/2016
- Stall at Carers Fair in the Pavilions 07/06/2016
- Presentation at the Older People's Care Manager'sTeam at the Civic Centre 04/07/2016
- HSL 1st Annual Summer Fete 02/07/2016 which raised almost £1000!
- Presentation to Mental Health Care Manager's Team 10/10/2016 and Continuation of joint working with mental health referrals

12. We hope these promotions will bring more interest for recruitment and referrals. In addition we continue to use testimonies from our current carers and service users to utilise within advertising. We have updated our website page to include the service offer to people aged 16 plus with learning disabilities.

16+ Young Adults with Learning Disabilities:

13. Vanessa continues to signpost potential referrals from Merrifield's Children's Respite to Hillingdon Shared Lives. 1 Young Adult referral is in progress.

CQC Inspection for Hillingdon Shared Lives August 2016

14. Hillingdon Shared Lives had a CQC Inspection in August. The inspection was conducted over 2 days and included feedback from carers and service users as well as Shared Lives Officers/ Manager. The feedback from the Inspection has been received and it has been incredibly positive with many comments on the caring nature and effectiveness of the scheme. The report commented that people using the service stated 'they felt safe and Shared Lives Carers treated them very well'.

15. The CQC Ratings were given as follows:

Overall rating for this service	Good ●

Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Outstanding ☆

16. The HSL Team are extremely proud of the Feedback and Ratings from the recent inspection and continue to strive for excellence in the work they do.

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CABINET FORWARD PLAN

Contact Officer: Khalid Ahmed
Telephone:01895 250833

REASON FOR ITEM

The Committee is required to consider the Forward Plan and provide Cabinet with any comments it wishes to make before the decision is taken.

OPTIONS OPEN TO THE COMMITTEE

1. Decide to comment on any items coming before Cabinet

2. Decide not to comment on any items coming before Cabinet

INFORMATION

1. The Forward Plan is updated on the 15th of each month. An edited version to include only items relevant to the Committee's remit is attached below. The full version can be found on the front page of the 'Members' Desk' under 'Useful Links'.

SUGGESTED COMMITTEE ACTIVITY

1. Members decide whether to examine any of the reports listed on the Forward Plan at a future meeting.

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Ref	Upcoming Decisions	Further details	Ward(s)	Final decision by Full Council	Cabinet Member(s) Responsible	Officer Contact for further information	Consultation on the decision	NEW ITEM	Public / Private Decision & reasons
	SI = Standard Item each month				Council Departments: RS = Residents Services	SC = Social Care	AD = Administration		FD= Finance
Cabinet - 17 November 2016									
129b	**Housing Allocation Policy**	Following a full consultation process approved by Cabinet in July, Cabinet will consider the responses and the way forward for the Council's Social Housing Allocation Policy.	All		Cllr Philip Corthorne	AD / RS - Raj Alagh / Dan Kennedy	Full consultation		Public
138	**Older People's Plan update**	Cabinet will receive it's twice yearly update on progress on the Older People's Plan (May and November annually).	All		Cllr Ray Puddifoot MBE / Cllr Philip Corthorne	AD - Kevin Byrne	Older People, Leader's Initiative		Public
SI	**School Capital Programme Update**	This report will update Cabinet and request any necessary decisions in order to progress the School Capital Programme in order to upgrade facilities and keep on track to deliver sufficient places for children educated in the Borough.	Various		Cllr David Simmonds CBE & Cllr Jonathan Bianco	RS - Jean Palmer OBE / Bobby Finch	Corporate consultees		Public / Private (3)
Cabinet - 15 December 2016									
145a	**The Council's Budget - Medium Term Financial Forecast 2017/18 - 2021/22 BUDGET & POLICY FRAMEWORK**	This report will set out the Medium Term Financial Forecast (MTFF), which includes the draft General Fund reserve budget and capital programme for 2017/18 for consultation, along with indicative projections for the following four years. This will also include the HRA rents for consideration.	All	23-Feb-17	Cllr Ray Puddifoot MBE & Cllr Jonathan Bianco	FD - Paul Whaymand	Public consultation through the Policy Overview Committee process and statutory consultation with businesses & residents	NEW	Public

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WORK PROGRAMME 2016/17

Contact Officer: Khalid Ahmed
Telephone: 01895 250833

REASON FOR ITEM

This report is to enable the Committee to review meeting dates and forward plans. This is a standard item at the end of the agenda.

OPTIONS AVAILABLE TO THE COMMITTEE

1. To confirm dates for meetings

2. To make suggestions for future working practices and/or reviews.

INFORMATION

All meetings to start at 7.00pm

Meetings	Room
21 June 2016	**CR 4**
28 July 2016 (CANCELLED)	**CR 6**
6 September 2016	**CR 5**
4 October 2016	**CR 6**
2 November 2016	**CR 4**
14 December 2016	**TBC**
18 January 2017	**CR 6**
21 February 2017	**CR 6**
23 March 2017	**CR 5**
19 April 2017	**CR 5**

Social Services, Housing and Public Health Policy Overview Committee

2016/17 - DRAFT Work Programme

Meeting Date	Item
21 June 2016	Major Reviews Topics 2016/17
	Work programme for 2016/17
	Cabinet Forward Plan

28 July 2016 (CANCELLED)	Budget Planning Report for SS,Hsg&PH
	Scoping Report for Major Review
	Work Programme
	Cabinet Forward Plan

6 September 2016	Major Review - Hospital Discharges - background information
	Cabinet Forward Plan
	Annual Report: Adult Safeguarding Board
	Annual Complaints Report
	Work Programme

4 October 2016	Presentation and Scoping Report for Major Review - Hospital Discharges
	Update on Stroke Prevention review
	Annual Report: Adult Safeguarding Board - Officer responses to questions from Members
	Cabinet Forward Plan
	Work Programme

2 November 2016	Major Review - Hospital Discharges - Witness Session
	Update on previous review recommendations (Shared Lives Review)
	Cabinet Forward Plan
	Work Programme

14 December2016	Major Review - Hospital Discharges - Witness Session
	Minor Review - Employment of People with Disabilities
	Consideration of Second Major Review
	Cabinet Forward Plan
	Work Programme

18 January 2017	Budget Proposals Report for 2016/17
	Major Review - Hospital Discharges - Draft Final Report
	Cabinet Forward Plan
	Scoping report for Second Review
	Work Programme

21 February 2017	Cabinet Forward Plan
	Work Programme
	Witness Session

23 March 2017	Cabinet Forward Plan
	Work Programme
	Witness Session

19 April 2017	Cabinet Forward Plan
	Major Review Second Final report