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A

Social Services, Housing and Public Health Policy Overview Committee

Date: **MONDAY, 6 NOVEMBER 2017**

Time: **7.00 PM**

Venue: **COMMITTEE ROOM 5 - 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)
Teji Barnes
Peter Davis
Becky Haggar
Shehryar Ahmad-Wallana
Tony Eginton
Peter Money, Labour Lead
June Nelson

Co-Opted Member

Mary O'Connor

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Putting our residents first

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SOCIAL SERVICES, HOUSING & PUBLIC HEALTH

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

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

Agenda

CHAIRMAN'S ANNOUNCEMENTS

Minutes

SOCIAL SERVICES, HOUSING AND PUBLIC HEALTH POLICY OVERVIEW COMMITTEE

2 October 2017

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

	MEMBERS PRESENT: Councillors: Wayne Bridges (Chairman) Jane Palmer (Vice-Chairman) Teji Barnes Peter Davis Becky Haggar Shehryar Ahmad-Wallana Peter Money June Nelson Janet Gardner Mary O'Conner (Co-Opted Member)
	OFFICERS PRESENT: Tony Zaman - Corporate Director, Adults, Children and Young People Andrea Nixon - LSCB and SAB Business Manager Sarah Durner - Senior Officer, Sport and Physical Activities Daniel Waller - Senior Library Services Manager Neil Fraser - Democratic Services Officer **EXTERNAL ATTENDEES:** Stephen Ashley - LSCB and SAB Independent Chair Jackie Westbrook - Manager, Yiewsley and West Drayton Community Centre Vivian Ellis - Arts and Health Researcher Christopher Geake - Director, Hillingdon MIND
22.	**APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS** *(Agenda Item 1)* Apologies were received from Councillor Eginton. Councillor Gardner was present as his substitute.
23.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* None.
24.	**TO RECEIVE THE MINUTES OF THE MEETING HELD ON 5 SEPTEMBER 2017** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 5 September 2017 be approved as a correct record.**

25.	**TO CONFIRM THAT THE ITEMS OF BUSINESS MARKED IN PART I WILL BE CONSIDERED IN PUBLIC AND THAT THE ITEMS MARKED PART II WILL BE CONSIDERED IN PRIVATE** *(Agenda Item 4)* It was confirmed that there were no Part II items, and that all business would therefore be conducted in public.
26.	**ADULT SAFEGUARDING BOARD ANNUAL REPORT** *(Agenda Item 5)* Consideration was given to the Adult Safeguarding Board's Annual Report, introduced by Stephen Ashley, Chairman of the Board, and supported by Tony Zaman, Corporate Director - Adults, Children and Young People, and Andrea Nixon - LSCB and SAB Business Manager. The Committee was informed that the report had been published later than expected, due to difficulties in obtaining data from partner agencies. As a consequence, the data contained within the report was now somewhat historic, and the value of that data was therefore reduced. Executive and Board Members had since met and spoken to partner agencies to impress upon them the importance of timely reporting, and it was expected that this would be improved moving forward. In comparison to the previous year's report, there was a renewed focus on good governance and regular assessment of the work being undertaken. To enable this, a new performance management framework had been implemented, which would allow for a detailed review of the work being undertaken by partners. Such reviews would allow for the identification of potential problems, which would then instigate the necessary actions to address those problems. Results of performance auditing would be submitted to the Executive Board Members for review. Partners would then be held to account, in cases of underperformance. The Board's priorities for the next 12 months were set out within the report. These included an increased emphasis on addressing domestic abuse. Following the completion of two domestic homicide reviews, the Board was working closely with the Safer Hillingdon Partnership to ensure awareness and engagement across the Borough. A new strategic lead for domestic abuse was now in post. In terms of working practices, the Board's approach was moving towards targeting specific areas of focus, such as suicide prevention or modern day slavery. It had been recognised that slavery in particular was an issue prevalent within the local area, due to the regular entry of people into the UK. As a result of the newly implemented performance management framework it would be easier to review the impact of the work being undertaken, and it was expected that the next annual report would predominantly be a performance report. Members asked a number of questions, and sought clarity on the following points: Regarding section 5.3 of the report, and the encouraging of disabled clients

to keep themselves safe, how was this being carried out?

A self-assessment audit was now used to determine the accuracy of what clients were saying versus what they were doing. Detail of this would be collected over the next 12 months, for reporting within the next annual report. This would include more robust information on what training was being conducted, and by whom. It was agreed that further detail on this matter be shared with Members following the meeting.

Training in general was an issue. Training was not always mandatory, and the commonly used e-learning was not felt to be the most effective training method, as it often devolved into a 'box-ticking' exercise. Difficulties in budgeting for training, which could be expensive, were recognised, and in addition, certain partners were reluctant to release staff for training, as this would result in them missing important working hours (e.g. A&E nurses). It was felt that leveraging the Care Governance Committee could help promote training, particularly within care homes.

How was the apparent lack of engagement with partner agencies being addressed?

To an extent this was due to a lack of understanding from agencies over the importance of engaging with the Board, as well as more specific reporting issues. For example, there were difficulties ensuring that GP's were sharing information, due to concerns around confidentiality. A recent seminar with GP's had focussed on this issue, and improvements were being discussed.

Information relating to the Immigration Removal Centre was governed by the Home Office. The Home Office would need to agree to the sharing of information at Board level. A request had been made, and their decision was awaited. It was noted that Hillingdon was the only Local Authority with a member of the Centre also sitting on the Board.

It was agreed that further detail on this matter, including detail of the partnership working with Brunel University, be forwarded to Members following the meeting.

Was further information available on the case review set out in section 8 of the report?

The case review was still ongoing, and a final report was due to be published by the end of November.

RESOLVED:

1. **That the report be noted;**

2. **That the officers be invited to provide a more up-to-date report at the Committee meeting scheduled for December;**

3. **That officers forward the requested information, as set out above, to Committee Members; and**

4. **That delegated authority be given the Chairman, Labour Lead**

	and clerk to agree the Committee's comments on the report, for submission to Cabinet.
27.	**WITNESS SESSION FOR MAJOR REVIEW - LONELINESS AND SOCIAL ISOLATION: LOCAL PARTNERSHIP EFFORTS TO MITIGATE SOCIAL ISOLATION AMONGST OLDER RESIDENTS, INCLUDING THOSE WITH MENTAL HEALTH ISSUES** *(Agenda Item 6)* For this witness session, the Committee was provided with evidence from Sarah Durner - Senior Officer, Sport and Physical Activity, Daniel Waller - Senior Library Services Manager, Jackie Westbrook - Manager, Yiewsley and West Drayton Community Centre, Vivian Ellis - Arts and Health Researcher, and Christopher Geake - Director, Hillingdon Mind. **Reducing loneliness in older people through wellbeing activities and events. Sarah Durner - Senior Officer, Sport and Physical Activity** The Committee was informed that the current Wellbeing events model began in 2012, with tea dances held at the Civic Centre. Feedback to the dance was good, and efforts were then made to look for creative ways to further engage with older people. Following focussed promotion within sheltered housing, care homes, social care and local organisations such as Age UK and Hillingdon Carers, the programme of events was expanded and a database of older people was compiled, to enable residents to be invited to future events. The database was maintained and added to, and currently held details of over 300 people, of whom approximately 180 regularly attended events each month. The aim of such events was to promote local opportunities and provide access to try new things in a fun, safe, and socially engaging way, to offer information and advice about other services available, and to develop new locally based activities such as chair exercise and dementia coffee mornings. A more targeted approach included events for the housebound, the Ghurka community, and for residents living with dementia or Alzheimer's. Attendees were often invited via referrals from partners and agencies such as social care, and if necessary, transport to the venue was included. Venues included libraries, community centres, and the Civic Centre. Events included: • Tea dances • Day of the Older Person • Dance for the over 65's • Art Workshops • Drumming sessions • Coffee mornings • Healthy walks • Intergenerational reminiscence • Music and flower festivals Variety of events was felt to be key. From experience running the events, and feedback from attendees, officers

had learned that older people wanted a regular, safe, local and fun activity, where they got to know people, and where they were not asked too many questions. In addition, it was requested that older residents receive assistance when they wanted it, and when they needed it, with particular reference to receiving help with booking event attendance, arranging transport, inviting friends, being referred, or obtaining information on other available services. Continuity of attendance was key, as it was important for the older people to see the same faces and forge lasting relationships.

Flexible booking systems were of paramount importance, and while online booking forms were available, it was understood that older people may not have access to a computer, or have the confidence in using online tools. Additional telephone booking was therefore available, whilst officers would also accommodate verbal requests in person, which was useful in building rapport and trust between the Council and its residents.

Officers had noted that transport was not always needed, for example transport provision had been made available for a number of tea dances, but the uptake was small. However, for events targeted at housebound residents, transport was required. Officers recognised that once someone had made the initial step to come to one activity, it was likely that they would come to more activities, and that making an attendee feel welcome was most important. The Council was actively promoting opportunities to those residents who were the most isolated, for example through GP navigators, social care referrals, or word of mouth. It was important that older people had something to look forward to.

The Committee was shown feedback from a number of older people, including video testimony, all of which was very positive. Highlights showed that attendees valued laughter, physical exercise, meeting former friends, and making new friends. The events were particularly valued in instances where attendees had experienced the loss of a partner. Feedback to activities such as intergenerational reminiscence had shown that the older people liked to feel valued, and to feel that their knowledge and experience was useful in helping younger people to learn skills.

Officers made recommendations for further improvement to events, which included:

- More regular wellbeing events for older people (e.g. targeting Housebound, Dementia)
- Leveraging services that provide transport, e.g. Dial-A-Ride
- Continuing to develop more social and fun activities that link into services without any obligation, (such as coffee mornings)
- Developing volunteering opportunities for young people to engage with older people, (e.g. through the Scouts, Duke of Edinburgh Award, links to school curriculum)
- More events held within schools (e.g. Coffee Mornings)
- Exploring how Spare Chair Sunday could work in Hillingdon
- Exploring opportunities with animals (e.g. Hen Power - animal therapies within care homes had been shown to effective in lowering violent incidents and the end to for medication.)
- Continuing to promote existing activities (Group cycling, allotments, adult education, volunteering)

Members sought further information on a number of points, including:

How was Hillingdon targeting the lonely early, and could this be sped up?

Targeted events had been developed within the last five years. Engagement was now in place with bereavement services, GP's, Hillingdon 4 All, and via newspapers, leaflets, flyers, and transport services. School engagement was felt to be a big opportunity for further improvements, and schools were interested in engaging with the Council with a view to increasing intergenerational events. However, this needed more promotion.

How was the Council engaging with different community groups, e.g. the Somali community?

The Safer Neighbourhoods team was helping to engage with such communities. In Hayes, the Somali community was approached and invited to coffee mornings, whilst contact had been made with Asian women's groups. In addition, targeted events were being promoted to appeal to specific cultural groups, such as Bollywood Dances as an alternative to the tea dances. Groups who had limited English language were challenging to engage with, and it was recognised that further work to engage with these communities was required.

Members suggested that the Telecare line could be used to promote events and services, together with increased contact with Brunel University to obtain student volunteers.

Jackie Westbrook - Manager, Yiewsley and West Drayton Community Centre (YWDCC)

Ms Westbook confirmed that her presentation was supplemental to the comprehensive information provided by Sarah Durner, and would therefore focus on YWDCC.

Members were advised that community centres were important social hubs for older residents. Attendees would often promote the Centres via word of mouth, for example when speaking to people they had met on public transport. In the last two months, YWDCC had registered 4 new members.

Brunel University had recently supplied four student volunteers who had attended one of the tea dances held at TWDCC. The older people had enjoyed the students' company, and had encouraged them to dance. In instances where the students did not know how to dance, the older people had taught them. Feedback from the older people was that this had made them feel useful, and that their contribution was valued.

Recommendations for Hillingdon Council:

- It was recommended that consideration be given to how to leverage other skills that the older people may have
- Use of the Telecareline to find volunteers

- Exploration of befriending services, such as Age UK's telephone service
- Increased intergenerational events, such as Stockley Academy 6th Form singing groups

How Libraries activities and events mitigate social isolation amongst older residents including those with mental health issues - Daniel Waller, Senior Library Services Manager

The Committee was given an introduction to Hillingdon's Library services. This comprised 17 Libraries, a Mobile Library, and a Home Library Service. The libraries contain free computer use and wi-fi, together with a wide range of stock including large print, talking books, e-books, newspapers and magazines. Libraries were open 6 days a week, for long hours. Two libraries were open on Sundays, and many online services were accessible from home.

Library usage was not specific to age or communities. General usage figures showed total visits of 1.6 million per year, with an active membership of 67,000 (22% of population). Over 5,000 events were hosted by Libraries per annum, attended by over 100,000 people (many of whom were older people.) Data on the ethnic diversity of attendees was not available, though it had been recognised that events were appealing to a wide variety of residents.

Libraries were popular due to being a safe, trusted, accessible space, that promoted a sense of community and belonging that often became a community hub. Staff would get to know and forge relationships with regular attendees. Staff were provided with training to ensure an awareness of mental health and dementia, in order to better help residents.

Partners using libraries to hold events included:

- Adult Learning
- Sport and Physical Activity Team
- Green Spaces
- Hillingdon Dementia Alliance
- Mind
- Dash
- Alzheimer's Society
- Other council services needing to meet residents

Events held at libraries included:

- Coffee mornings
- Knit and Natter groups
- Chairobics
- Zumba
- IT for older people
- Reading Groups
- Writing Groups
- Author talks – including Culture Bite
- Reminiscence sessions

- Local History Talks
- Healthy heart month

The Silver Sunday, held at Botwell Green library, was part of a national campaign to combat social isolation in older people and celebrate their contribution to society. Held on the first Sunday in October, a group of 30 older residents from Age Link were invited. Children made cards for the older people which were gratefully received. The event included singing, refreshments and health checks from a local pharmacy.

IT for Older People was a free session held at Northwood Hills library, to help older people become proficient with computers. Run by volunteers, users were helped with hand and eye co-ordination (vital to use a tablet or computer mouse), before being helped to use the internet to explore their particular interests or hobbies. Information was provided to help guard against cyber-crime which may help to allay any fears that a newcomer might have about use of the internet. The sessions helped to create an opportunity for interaction between the participants, as well as the staff. Similarly, the Uxbridge Digital Drop-In Session provided informal help with computing and technology via volunteer students from Brunel University.

The Sow and Grow cross-generational scheme had been operating out of Yeading Library for the last 9 months, and allowed residents to grow their own fruit and vegetables. Public consultations were often held on library site, which gave older residents a chance to engage with their community, have their voice be heard, and make a contribution to the workings of the town.

Specialised library services, aiming to mitigate loneliness and isolation, included the Mobile Library, which delivered to 23 roadside sites every week, as well as schools, nurseries, day centres and residential and sheltered homes.

The home library service visited 150 housebound users, with visits every 4 weeks. The services provided vital social contact for the most isolated residents, and helps people to continue to live at home and maintain independent living.

Recommendations for further actions to address social isolation and loneliness via the library service included:

- Increase awareness among staff to enable more informed signposting
- More training in assisting with mental health issues
- Increase older male participation in library activities
- Increase inter-generational activities
- Explore opportunities to use new technology, for example the Tovertafel (Magic Table)
- Increase data capture to better assess impact of events held and actions taken

Members suggested that more libraries be open on Sundays. Mr Waller confirmed that limited Sunday openings were due to budgetary reasons. If further sites were opened on Sunday, it was likely that operating hours on the other days of the week would have to be reduced.

Members also requested that the feasibility of commissioning an additional mobile library vehicle be reviewed.

It was requested that figures for library membership of over 60's be circulated to Members.

Singing for Social Connection - Vivian Ellis, Arts and Health Researcher

The Committee was informed that Ms Elis was an arts & health researcher, choir leader and professional singer, and was an Associate of the Sidney De Haan Centre for Arts & Health Research at Canterbury Christchurch University.

Ms Ellis had been commissioned by the Director of Imperial College GP Training to run an education in arts for health for Hillingdon GP's. Originally trialled, the training was repeated for 48 student GPs in years 1, 2 and 3 at Guys & St Thomas (Nov 2016), as well as via workshops in arts for health with GP trainers from South London (Sept 2016) and South West London (June 2017).

Two monthly singing groups for health were being run in Northwood: 'Singing for the Soul' (singing for wellbeing) and 'Memory Matters' (for people with dementia living at home) both at Northwood and Pinner Liberal Synagogue.

A free, weekly drop-in singing group for mental health at The Dragon Cafe, is held in St George the Martyr Church in Southwark. The Dragon Cafe was user-led, and delivered by a small paid team plus volunteers, with the aim of providing a relaxed, social, non-medical, diverse, multi-generational setting.

The groups provided singing, dancing, and chatting, as well as chair-based yoga which had been seen to increase movement, which in turn allowed individuals to regain their independence. Health benefits of singing groups included fast social bonding and positive experiences, which helped to mitigate against loneliness, isolation, and the resulting depression that this caused.

Suggested recommendations for Hillingdon Council:

As the Council was aiming to reach as many older people as possible across the Borough in order to alleviate social isolation, GPs, with whom 90% of people were registered, could be well placed to guide patients towards beneficial interventions and activities.

For example, an arts hub for wellbeing in Hillingdon could be an effective forum and space to create more joined-up provision across the diversity of services and providers, to alleviate the suffering of social isolation, and provide pathways for people to access what they need. Such a hub could even be mobile, like a travelling library or arts & social wellbeing bus.

"Only Connect" - Loneliness, isolation, and mental health in later life - Christopher Geake, Director - Hillingdon Mind

Mr Geake, Director of Hillingdon Mind, set out the mental health in the context of social isolation and loneliness.

The Committer was informed that the World Health Organisation defined

mental health as:

- A state of complete physical, mental and social well-being,
- and not merely the absence of disease,
- in which every individual realizes his or her own potential,
- can cope with the normal stresses of life,
- can work productively and fruitfully,
- and is able to make a contribution to her or his community.

According to the Social Care Institute for Excellence (SCIE)'s report from 2016, mental health and emotional well-being were as important in older age as at any other time of life. Most older people had good mental health, but older people were more likely to experience events that affect emotional well-being, such as bereavement or disability.

The Department of Health estimated that:

40 % of older people seeing their GP
50 % of older people in general hospitals
60 % of care home residents

have a mental health problem.

For the purposes of the review, the mental health issues most commonly seen in older people, due to loneliness and isolation, were depression and anxiety.

According to a report titled *("Look after your mental health in later life" by the Mental Health Foundation: 2016),* helpful approaches to mental and emotional wellbeing included:

- Being prepared for changes
- Talking about problems and concerns
- Asking for help
- Thinking ahead and having a plan
- Caring for others
- Keeping in touch
- Being active and sleeping well
- Eating and drinking sensibly
- Doing things that you enjoy
- Relaxing and have a break

'Connecting' was seen as the fundamental and principle antidote to loneliness, isolation, and mental health issues. This included connecting with

the self, connecting with others, and connecting with support.

Connecting with self:

Issues	Recommended Action
• feeling of low esteem and worthlessness • loss of family or social role • disappointments and disillusionment • loss and bereavement • physical ill-health • addictions	• reminiscence work • dealing with loss and bereavement • working through positive and negative experiences and feelings • replacing shame and assumptions of guilt with compassionate acceptance • counselling and talking therapies • volunteering

Connecting with others:

Issues	Recommended Action
• social isolation and emotional isolation • isolation through rejection • self-isolation as distraction • feeling of inadequacy or low self-esteem • ill-health, disability, abuse addictions, low self-esteem	• keeping in touch or reconnecting • social clubs, recreational activities, learning activities • befriending • social media – Facebook, Skype • volunteering

Connecting with support:

Issues	Recommended Action
• Independence • not acknowledging need for support • not knowing where to go for support • not being physically or	• motivational work • planning for later life • drawing upon social capital and community networks.

emotionally able to engage	

When people with mental health issues were asked where they went for support, feedback showed that the most valued support received was from family members, neighbours, friends, colleagues, local community associations, college classes, libraries, and faith communities. It was important to recognise that whilst there were appropriate medical responses to clinical conditions; most of the issues of loneliness and isolation were not clinical.

People say they wanted the following support:

- how to maintain good integrated health and well-being
- support at the right time – the earlier the better
- where to go for the right support
- how to get support quickly
- how to self-manage their health and well-being
- how to address social isolation and its causes
- peer support from other people with “lived experience”
- challenge stigma and discrimination

Hillingdon MIND offered the following:

- groups and social clubs
- culturally specific support
- (South Asian, Somali, Afghan, Nepalese, Tamil, LGBT)
- befriending
- counselling and psychotherapy
- information and sign-posting
- mental health awareness
- anger management
- volunteering
- peer-support
- (women’s and men’s groups, Creative Minds, “Hearing Voices”, Creative Writing, walking)
- substance misuse and addictions
- carers

Suggested Priorities and recommendations for Hillingdon Council included:

	• public awareness of the relationship between loneliness and isolation, and mental health • amplify the voice and engagement of older people in co-production • attention to diverse culturally specific needs (BME, LGBT) • investment of businesses and employers to help people prepare for life beyond employment • development of social capital • promotion of befriending and volunteering **RESOLVED:** **1. That the witness testimony be noted;** **2. That the figures for library membership of over 60's be circulated to Members.**
28.	**CABINET FORWARD PLAN** *(Agenda Item 7)* **RESOLVED: That the Cabinet Forward Plan be noted.**
29.	**WORK PROGRAMME 2017-18** *(Agenda Item 8)* It was confirmed that, following the Committee's request for a further meeting to be added to the calendar of meetings, the date of 7 December 2017 had been reserved. **RESOLVED: That the Work Programme 2017-18 be noted.**
	The meeting, which commenced at 7.00 pm, closed at 9.35 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Neil Fraser - Democratic Services Officer on 01895 250692. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

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SOCIAL SERVICES, HOUSING AND PUBLIC HEALTH POLICY OVERVIEW COMMITTEE - 2017/19 BETTER CARE FUND PLAN

REASON FOR ITEM

To make the Committee aware of the content of the 2017/19 Better Care Plan and the implications for residents.

OPTIONS OPEN TO THE COMMITTEE

a) To question officers about the content of the plan.

b) To make suggestions or recommendations to inform the development of the plan from 2018/19.

c) To instruct officers about frequency of further updates required by the Committee.

INFORMATION

Introduction

1. The Better Care Fund (BCF) is a Government initiative introduced in 2014/15 that is intended to improve efficiency and effectiveness in the provision of health and care through closer integration between health and social care. The first BCF plan was for 2015/16.

2. The *2017/19 Integration and Better Care Fund Policy Framework* published in March 2017, required Hillingdon to develop a Better Care Fund Plan (BCF) for the 2017/19 period. This is Hillingdon's third BCF plan and, as with the two previous iterations, the focus of the 2017/19 plan will continue to be the 65 and over population.

3. Hillingdon's 2017/19 BCF plan was formally submitted on the 27 September. The formal submission comprised of the following documents:

- Supporting narrative plan
- Delayed transfers of care (DTOC) action plan (General and Mental Health)
- NHSE planning template.

4. These documents are available on the Council's website by using the following link http://www.hillingdon.gov.uk/28647. The updated Equality Impact and Health Impact Assessments can also be accessed by following this link.

Progress to Date

5. The eight schemes in the 2016/17 plan expanded on the activity undertaken in 2015/16 whilst maintaining a cautious approach to integrated working and the pooling of budgets. This approach minimised the risk to both the Council and HCCG. The key developments on the 2015/16 plan included:

- Extending the 2015/16 schemes where benefits could be achieved for other adult client groups, e.g. development and management of the supported living market that included all adults and extending the scheme on supporting Carers to all unpaid Carers;
- Extending the scope of the pooled budget where this would have demonstrable benefits for residents/patients, e.g. specialist palliative personal care service for people at end of life;
- Extending the scope of the plan to include new types of activities, e.g. dementia;

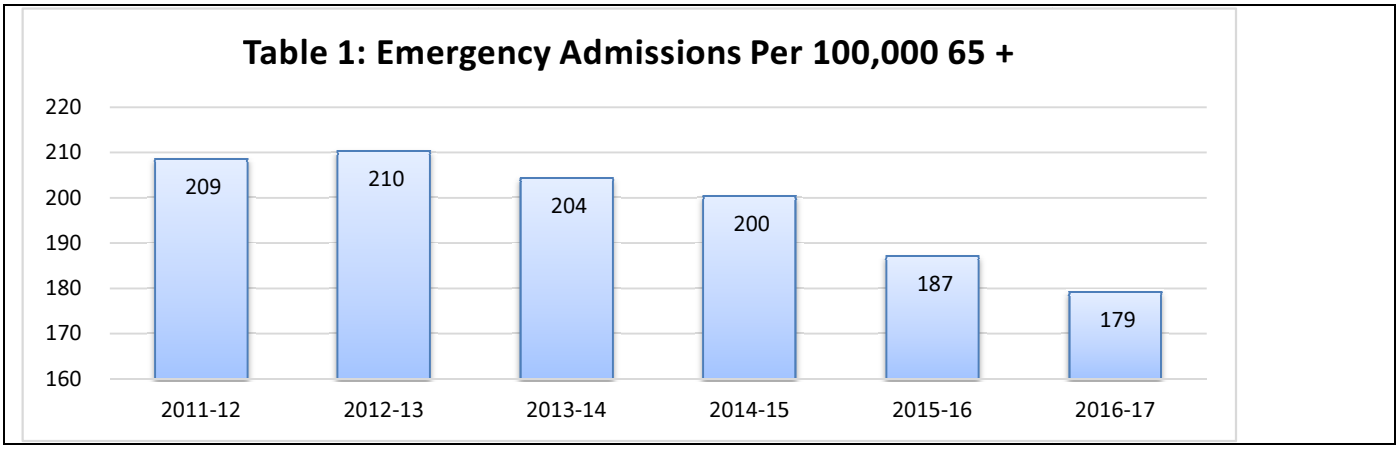
- Accelerating benefits through a greater ambition to integrate services across health and social care, building on progress made in 15/16, e.g. intermediate care; and
- Correcting anomalies from the 2015/16 plan, e.g. bringing the Council's budget for the community equipment contract into the pooled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

6. The eight schemes in the 2016/17 plan were:

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

7. **Measuring Success: Performance against National Metrics** - The following shows the 2016/17 outturn against the national metrics, including the locally determined user/patient experience indicators that we were required to report on:

- *Emergency admissions - Target missed*: During 2016/17 there were 10,252 emergency admissions (also known as non-elective admissions) of people aged 65 and over which exceeded the ceiling for the year of 9,700. However, the performance was similar to the outturn for 2015/16, which was 10,210 emergency admissions. As illustrated in table 1 there has been a steady decline in the number of emergency admissions per 100,000 of people aged 65 and over since 2014/15, i.e. demand has been managed and growth consumed within the context of an increasing older people population.



- *Delayed transfers of care (DTOC) - Target missed*: There were 8,364 delayed days during 2016/17 against a ceiling of 4,117 delayed days. 66% of the delayed days were attributed to the NHS, 22% to social care and 12% to both. Table 2 below shows that Hillingdon's performance was above the average for London but below that for England.

Table 2: Number of Delayed Days Per 100,000 18 + Population, 2016/17 Compared			
	England	**London**	**Hillingdon**
NHS	2,990	1,611	2,402
Social Care	1,791	1,058	810
Both	405	148	417
Total	**5,186**	**2,818**	**3,630**

- *Permanent admissions to care homes - Target missed*: There were 161 permanent admissions to care homes in 2016/17 against a ceiling of 150 permanent admissions. Table 3 shows that Hillingdon performed better than both London and England in 2016/17 in respect of the number of long-term admissions per 100,000 people aged 65 and over.

Table 3: Long-term Admissions to Care Homes per 100,000 65 + Population 2016/17 Compared		
England	**London**	**Hillingdon**
610.7	438.1	398.9

- *Still at home 91 days after discharge from hospital to reablement - Target missed*: The 2016/17 outturn was 86.1% against a target of 93.5%. The 2016/17 target was imposed by NHS England (NHSE). The factors that impact on target delivery are people who pass away during the 91 day period, as well as people who are readmitted to hospital or who have an updated care plan, e.g. due to escalated needs. Table 4 below shows that Hillingdon's performance was better than the average for both London and England.

Table 4: Percentage of People Still at Home 91 Days After Discharge 2016/17 Compared		
England	**London**	**Hillingdon**
82.47%	85.49%	86.1%

- *User experience metric: Social care-related quality of life - Target exceeded:* This metric was tested through the Adult Social Care Survey undertaken each year in Q4. The results are scored out of 24 and the higher the number the better. The target for 2016/17 was 18.6 and the outturn was 19. Table 5 below shows that Hillingdon's performance was higher than that of London and equal to the average for England.

Table 5: Adult Social Care Survey: Social Care-related Quality of Life 2016/17 Compared		
England	**London**	**Hillingdon**
19	18.6	19

- *User experience metric: People who have found it easy to access information and advice - Target missed*: This metric is also tested through the Adult Social Care Survey. The target for 2016/17 was 75.5% and the outturn was 73.3%. Table 6 below shows that Hillingdon performed better than the average for both London and England.

Table 6: Adult Social Care Survey: Proportion of people who find it easy to find information 2016/17 Compared		
England	**London**	**Hillingdon**
70.3%	68.4%	73.3%

8. **Key Successes** - Despite missing a number of centrally given metrics, the plan has delivered a number of successful improvements:

- *Joint working across services, e.g. Homesafe, Rapid Response and Reablement* - This has had a significant impact on reducing the number of hospital admissions during a period that has seen a considerable rise in the number of attendances. It has also been possible to achieve shared benefits through more efficient management of the community equipment service;

- *H4All Wellbeing Service* - This innovative service, delivered by a local third sector consortium, is intended to prevent the needs of older people living with long-term conditions escalating which may otherwise result in a loss of independence and lead to an increased demand on health and care services. The service became operational in 2016/17 and is showing 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. 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 intended to help ensure a more consistent discharge process across wards;

- *Step-down arrangements* - Partners worked together to establish bed-based step-down to assess arrangements in local care homes in order to relieve pressure on Hillingdon Hospital;

- *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.

9. **Conclusions from 2016/17 plan** - 2016/17 has been a positional year that has enabled relationships to develop to create the opportunity for greater integration to deliver the objectives within the Sustainability and Transformation Plan (STP), secure better outcomes for residents from 2017/18 and address challenges across the health and care system.

10. Complexities of the local landscape and capacity within the health and care system meant that it was not possible to deliver some of the key actions within the 2016/17 plan in year. However, much of the developmental work has taken place that will facilitate delivery from 2017/18, e.g. integrated brokerage and integrated homecare.

Sustainability and Transformation Plans (STPs) Explained

STPs are plans developed over footprints defined by the Government and including a range of clinical commissioning groups and local authorities with the intention of showing how a sustainable health and care system can be delivered by 2021. The footprint for Hillingdon is the North West London (NWL) CCGs and local authorities, e.g. Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster.

The Hillingdon aspect of the NWL STP is the local Health and Wellbeing Strategy, which we are required to have by law. This was approved by the Health and Wellbeing Board for public consultation on 26th September 2017.

2017/19 BCF Plan

11. The primary purpose of the 2017/19 plan is to deliver those aspects of the STP that require integration between health and social care and/or closer working between health and the Council for delivery.

12. The agreed BCF pooled fund for 2016/17 was £22,531k The HWB and HCCG Governing Body have agreed the total value of the 2017/18 expenditure plan as being £36,814k. The agreed expenditure plan for 2018/19 is £54,049k. Table 7 below provides the detailed total planned expenditure by organisation. The scheme descriptions attached as **Appendix 1** provide a detailed financial investment breakdown by scheme, but this is summarised in table 8 below.

Table 7: Council and HCCG Financial Contributions Summary

Organisation	2016/17 *£,000s*	2017/18 *£,000s*	2018/19 *£,000s*
HCCG	11,965	17,158	26,770
LBH	10,566	19,656	27,279
TOTAL	**22,531**	**36,814**	**54,049**

Table 8 Council and HCCG Financial Contribution by Scheme Summary

	SCHEME	Funder 2017/18		Funder 2018/19	
		LBH £000's	HCCG £000's	LBH £000's	HCCG £000's
1	Early intervention and prevention	5,060	2,353	5,426	2,353
2	An integrated approach to supporting Carers	862	18	878	18
3	Better care at end of life	50	992	51	992
4	Integrated hospital discharge	4,607	11,406	4,643	11,406
5	Improving care market management and development	8,695	2,389	15,893	12,001

6	Living well with dementia	300	0	306	0
	Programme Management	82	0	82	0
	Total Partner Contributions	**19,656**	**17,158**	**27,279**	**26,770**
	TOTAL ANNUAL VALUE	**36,814**		**54,049**	

13. The key developments under the 2017/19 plan are:

- ***Joint market management and development approach*** - This is the area that represents step-change for Hillingdon. It includes:
    - Development of an all-age joint brokerage service. This service will arrange homecare packages, short and long-term nursing home placements and Direct Payments and Personal Health Budgets on behalf of the Council and the CCG;
    - Commissioning of integrated, all-age homecare provision in 2017/18 on behalf of the Council and the CCG;
    - Commissioning of integrated end of life care at home provision in 2017/18 on behalf of the Council and the CCG;
    - Development of an integrated commissioning model for nursing home placements from 2019/20;
    - Supporting care homes - This is a combination of preventing emergency admissions that are avoidable and using different approaches to ensure sufficient supply of residential care homes and nursing care homes for people living with dementia as well as general nursing homes.

- ***Getting hospital discharge right*** - The plan is proposing to bring together the various services involved in facilitating discharge from hospital into the community into a more integrated model.

- ***Developing the Accountable Care Partnership (ACP)*** - The Council will consider joining the ACP if the case for change demonstrates that this will result in better outcomes for residents.

Accountable Care Partnership (ACP) Explained

An ACP is a partnership of organisations which:

- Is commissioned to jointly deliver an agreed set of outcomes.
- Is accountable for end to end care of the population so that the resident receives a seamless offering across organisational boundaries.
- Is built around an identified registered population e.g. older people.
- Functions at a scale sufficient to hold clinical and financial accountability for this population group.
- Makes decisions on organisation and delivery of care within the partnership, sharing financial risks and benefits.

- Embeds service users/residents in decision making and governance.

The ACP in Hillingdon, known as the Hillingdon Health and Care Partners (HHCP), comprises of The Hillingdon Hospitals, CNWL, the Hillingdon GP Confederation and the H4All third sector consortium, i.e. Age UK, Disablement Association Hillingdon (DASH), Harlington Hospice, Hillingdon Carers and Hillingdon Mind.

- **Developing Care Connection Teams (CCTs) and care planning** - The development of CCTs will support anticipatory care planning in GP surgeries to prevent hospital attendances and admissions that are avoidable. Adult Social Care will work closely with the emerging CCTs and will identify specific staffing resources where extra care housing schemes are located.

Care Connection Teams Explained

The 15 CCTs being established in the borough are intended to take a more proactive approach to identifying the needs of Hillingdon's older residents who may be at risk of their needs escalating resulting in a loss of independence and increased demand on the local health and care system. Each CCT is comprised of:

a) *Practice GP lead* – They have oversight over the whole care pathway within primary care, with additional time spent with those patients at most risk of becoming unstable;

b) *Guided Care Matron (GCM)* – They are responsible for case management, daily monitoring of patients and referring to other services; in-reach support to care homes and supported housing and linking with Rapid Response for out of hours care.
c) *Care Coordinator (CC)* – They assist the Guided Care Matron in proactive care of patients, pulling practice and system intelligence on patients and updating care plans and communicating with other providers.

- ***Developing a single point of access for older people*** - The scope for developing a single point of access into third sector provided services for older people linked with the H4All Wellbeing Service will be explored.

- ***Exploring use of Disabled Facilities Grant flexibilities*** - A business case for using flexibilities to address anticipated needs and support hospital discharge, e.g. home/garden clearance, home deep cleaning, home fumigation, furniture removals to set up micro-environment, etc, will be developed;

- ***An integrated approach to supporting Carers*** - The intention is to consolidate the work that has taken place so far in supporting Carers to ensure a shared commitment across partners to the identification and referral of people who are Carers so that they can access timely support.

14. The integrated homecare and integrated care at home service for people at end of life are the two main areas where direct benefits for residents will be realised through the BCF pooled budget. The purpose of a pooled budget is to ensure that need is addressed irrespective of funding responsibility and this should be demonstrated in these two service areas. It should expedite access to services and prevent the need for residents to change service provider if their needs escalate, unless their service provider is no longer qualified to meet their needs.

Measuring Success

15. The success of the 2017/19 plan will be measured against a combination of nationally determined and some scheme specific metrics.

16. **Performance against national metrics** - The number of reportable national metrics has reduced from six in 2016/17 to four for the duration of the 2017/19 plan and these are:

a) ***Emergency (also known as non-elective) admissions*** - Hillingdon will be reporting on the component of the CCG's emergency admissions target associated with patients aged 65 and over. For 2017/18 a reduction target of 975 emergency admissions is proposed with scheme contributions as shown below:

- Intermediate care (see scheme 4: *Integrated hospital discharge*) - 49 (5%)
- Care of the Elderly Consultant (see scheme 1: *Early intervention and prevention*) - 78 (8%)
- Wellbeing Gateway (see scheme 1: *Early intervention and prevention*) - 127 (13%)
- Care Connection Teams (see scheme 1: *Early intervention and prevention)* - 517 (53%)
- Homesafe (see scheme 4: *Integrated hospital discharge*) - 205 (21%)

b) ***Permanent admissions to care homes*** - This applies to permanent admissions to care homes by the Council of people aged 65 and over. The proposed target is 150 for 2017/18 and reducing to 145 in 2018/19 to reflect the opening of Grassy Meadow Court and Park View Court extra care sheltered housing in June and September 2018 respectively. The proposed target for 2018/19 reflects a reduction in permanent placements into residential care homes but recognises that permanent admissions to residential dementia, nursing and nursing dementia care homes will continue.

c) ***Delayed Transfers of Care 2017/18*** - In July 2017 NHSE issued Health and Wellbeing Board area targets for the NHS and for social care. Final clarification of NHSE requirements was received on 8th September and table 9 below shows the target for 2017/18 and its apportionment across the NHS, Social Care and both.

Table 9: 2017/19 DTOC Targets

Attributed Responsibility	Number of Delayed Days		
	2016/17	2017/18	2018/19
NHS	5,536	6,005	6,095
Social Care	1,866	2,271	2,305
Both	962	1,062	1,078
TOTAL	**8,364**	**9,337**	**9,478**

17. A straightline projection based on activity from April to August 2017 would suggest an outturn for 2017/18 of 9,000 delayed days against a ceiling of 9,337, which means that this would appear to be achievable. However, it is susceptible to changes in local circumstances, e.g. a bad winter increasing demand at the Hospital and/or capacity issues within the local care market.

18. The range of key initiatives included within the Urgent and Emergency Care Plan and the DTOC action plan that will support the reduction of DTOCs at Hillingdon Hospital include:

- Stronger processes in the Hospital to ensure that delays being reported reflect the correct definition;
- Improved information available for patients and family members to help manage expectations and address the main cause of delays for the Hospital;
- Implementation of the SAFER patient flow bundle;
- Implementation of discharge to assess (D2A);
- Support to care homes, including the action by Adult Social Care to increase capacity by converting spot placements into block arrangements.

19. The key initiatives that will contribute to the reduction in the number of DTOCs attributed to patients of CNWL with mental health needs include:

- Stronger processes to ensure that delays being reported reflect the correct definition;
- Implementation of a discharge planning tool;
- Reviewing the training and guidance provided to staff presenting cases to the joint funding panel for mental health patients that includes membership from Adult Social Care, the CCG and Mental Health; and
- Establishing regular meetings with the Council's Housing Team to address accommodation issues at an early stage.

d) ***Delayed Transfers of Care 2018/19*** **-** The expectation is that a target for 2018/19 will be mandated and the target shown in table 3 above applies a 1.5% increase to the 2017/18 baseline to reflect demographic growth. The DTOC total and apportionment across NHS, Social Care and both is also shown in table 3 above.

e) ***Effectiveness of reablement*** - This is seeking to identify the proportion of people aged 65 and over who have been discharged home from hospital into reablement who are still at home 91 days after the discharge. The agreed target for 2017/18 is 88% with the provisional target for 2018/19 is also set at 88%, although this will be subject to the outcome of discussions about Hillingdon's intermediate care service model going forward.

20. **Performance against scheme specific metrics** - The schemes detailed in **Appendix 1** contain a further range of metrics that will not be reported to NHSE but will be reported to the HWB and HCCG's Governing Body as part of the quarterly performance reports. These additional metrics will give a broader understanding of the successful implementation of the plan than the national metrics and will also be supported by specific testing of the service user experience by services. The following are examples of the additional metrics that will be reported:

- Utilisation rates for Connect to Support, i.e. the Council's online information portal.
- Utilisation of self-assessment facilities on Connect to Support.
- % of users of Adult Social Care who have found it easy or difficult to access information and advice about services (tested through annual Adult Social Care Survey).
- Improvement in quality of life score for users of Adult Social Care services (tested through annual Adult Social Care Survey).
- Number of falls-related emergency admissions.
- Number of emergency admissions from care homes.
- Number of emergency admissions from extra sheltered housing schemes.
- Number of emergency admissions with a length of stay of between 0 and 1 days.
- Number of admissions a day avoided following a referral to Rapid Response by Hillingdon Hospital's Emergency Department.
- Number of referrals to Reablement per month.
- % of new users of the Reablement Service where there is no request for long-term support.

- Number of readmissions during a period of reablement.
- % of hospital discharges taking place before midday.
- % of Continuing Healthcare assessments taking place in an acute hospital trust setting
- Number of readmissions within 30 days.
- Number of Disabled Facilities Grants provided and value.
- Number of Carers' assessments completed.
- Number of Carers receiving respite or another Carer's service following an assessment.

Improved Better Care Fund Grant 2017/19

21. On 9 March, the Department of Communities and Local Government (DCLG) published funding allocations for the additional Improved Better Care Fund (IBCF); the Council's share of this increased funding is £4.1m available in 2017/18. The Council has committed the IBCF funding to stabilising the local social care provider market, e.g. care homes and homecare, which will have a direct impact on the health and care system's ability to support admission avoidance.

22. The Council is required to report quarterly to the DCLG on the use and impact of this funding in addition to the current requirement for quarterly updates on the progress of the BCF plan to NHSE.

Governance

23. The delivery of the BCF schemes is overseen by the Transformation Group, which comprises of officers from the Council and the CCG, as well as representatives from the GP Confederation. This group has broader project management responsibilities for the delivery of STP programmes and is chaired by the chairman of the CCG's Governing Body.

24. The Core Officer Group comprising of the Council's Corporate Director of Finance , the CCG's Deputy Chief Finance Officer, the Corporate Director of Adults and Children and Young People's Services (a statutory member of the HWB), the CCG's Chief Operating Officer and the Council's Head of Health Integration and Voluntary Sector Partnerships that has overseen the delivery of plans over the last two years, will continue to have oversight and will also consider opportunities for integrated working and/or joint commissioning for recommendation to the HWB. Any decisions about the use of resources will have to be referred to the Council's Cabinet and the CCG Governing Body in accordance with constitutional arrangements and agreed delegations.

25. An equality impact assessment of the plan was undertaken that did not identify any inequalities arising from the proposed schemes. However, it was recognised that particular attention will need to be given to how schemes develop to address the greater diversity in the south of the borough and during the lifetime of the plan there are areas for development that may require specific assessments to support decisions made by the Health and Wellbeing Board and either the Council's Cabinet and/or HCCG's Governing Body.

Post-April 2019 Position

26. It is as yet unclear what the Government's intentions are in respect of the integration agenda at the end of the current plan. Officers will advise the Committee in due course once further information is known. In the meantime it is proposed that officers provide an update on progress in Q4 2017/18, including details of any revisions to the plan for 2018/19.

2017/19 BCF Plan Scheme Descriptions

Scheme 1: Early Intervention and Prevention

a) Strategic Objectives

This scheme seeks to manage demand arising from demographic pressures by reducing the movement of Hillingdon residents/patients from lower tiers of risk into higher tiers of risk through proactive early identification and facilitating access to preventative pathways, that includes a focus on promoting self-care. It builds on the work undertaken under Hillingdon's 2015/16 and 2016/17 BCF plans and also the broader programme of integration to taking forward the anticipatory model of care and apply a more preventative approach to addressing health and social care need.

b) Scheme Overview

As with previous iterations of the Hillingdon's BCF plan, the focus of this scheme will be people living with dementia, people susceptible to falls and/or who are socially isolated and also people at risk of stroke as these long-term conditions are disproportionately represented in our non-elective admissions and admissions to long term residential care.

Initiatives under this scheme include:

- *Access to information and advice* - Access to good information and advice is fundamental to people being able to self-manage their own health and wellbeing. Over the last two years the Council has developed and promoted the online resident portal called Connect to Support. In 2017/18 platform supplier arrangements will be subject to competitive tender and service specification development will include accessibility through portable technology options. Partners will work on the links between the resident portal and the development of a directory of services to support the hospital discharge process referred to further in scheme 4: *Integrated Hospital Discharge*. A key objective here is to reflect synergies and avoid unnecessary duplication.

- *Risk stratification* - Much work has taken place over the last two years in applying risk stratification tools within primary care, e.g. Qadmissions, PAR30, the Electronic Frailty Index (EFI) and the Patient Activation Measure (PAM), as a means of early identification of people at risk of escalated needs. The development of fifteen Care Connection Teams (CCTs) across the borough comprising of a guided care matron and care coordinator working alongside GPs, will support more proactive interventions to prevent or delay what might otherwise be an inevitable trajectory towards escalated need. Proactive work between social care and, initially, CCTs in the north of the borough to identify people receiving both social care and health support and explore opportunities for a more efficient and effective means of addressing need will be explored. Involvement of Adult Social Care in multi-disciplinary team (MDT) meetings: the weekly *'huddles'*, where appropriate will ensure a multi-agency approach to addressing the needs of people on the cusp of escalated needs. The allocation of social care resources to support CCTs that have extra care schemes and a concentration of care homes within their catchment area will be explored. See scheme: 5: *Improving care market management and development.*

- *Developing the preventative role of third sector* - 2016/17 has seen the successful implementation of the Wellbeing Service provided by the third sector consortium H4All. People referred to this service have benefitted from an assessment using the Patient Activation Measures (PAM). This assessment is intended to identify people needing support to engage more actively in the management of their own condition(s). During 2017/18 the model of investment in the third sector by both the Council and CCG will be reviewed with voluntary and community sector partners to see how the successes of the H4All Wellbeing Service can be built on to most effectively support Hillingdon's older residents, e.g. by improving access to information, addressing social isolation and keeping people active, through the creation of a single point of access for older people. Any enhancements to the model will be implemented in 2018/19, subject to approval through governance processes.

- *Keeping older people physically active* - Keeping people active is a contributory factor in preventing stroke and preventing or delaying the onset of dementia. During 2017/18 the Council and ACP partners will work together to develop a physical activity strategy, ensuring integration with existing services and the Council's new Sport and Physical Activity Team will continue to deliver a range of activities to keep older people physically active and also prevent social isolation, e.g. tea dances, chair exercise classes and healthy walks.

- *Stroke prevention*: As set out in the 2016/17 plan, the key components of a stroke prevention strategy are: increasing physical activity, addressing excess weight issues and early detection. During 2017/19 the following initiatives will be undertaken:

  - *Increasing physical activity* - Alluded to above, an existing physical activity programme targeted at people aged 55 and over carrying excess weight will continue due to the beneficial outcomes for this group of people.

  - *Early detection* - Atrial fibrillation (AF), a disturbance of heart rhythm, is a major cause of stroke and is not tested as part of the health check programme. In late 2016/17 a pilot started using detection equipment in six community pharmacies in the borough. The results from this will be used to inform possible expansion of screening programmes in 2017/18.

  - *Stroke risk and stroke prevention campaign* - During 2017/18 the Council's Communications Team will develop a proposal for a campaign intended to promote the uptake of the health checks programme for people most at risk of stroke and also signpost residents to physical activities and groups, social engagement activities, and facilities such as leisure centres, green spaces, and libraries.

- *Making best use of assistive technology* - The work of the CCTs referred to above, as well as the integrated approach to hospital discharge described in scheme 4: *Integrated Hospital Discharge,* provide opportunities to identify people who may benefit from assistive technology, e.g. telecare and telehealth, and to make referrals. This technology can help to provide the residents/patients and their families with greater confidence about them remaining in their own home.

- *Flexible use of Disabled Facilities Grants* - A business case will be developed for a six month early intervention pilot to provide a non-means-tested grant to people aged 75 and over for installation of a level-access shower where they have disability/medical condition that significantly restricts their mobility; they have reported difficulty with getting in and out of the bath; and they have no intention of leaving the property for at least 5 years. This is about proactively anticipating needs.

c) Intended Outcomes/Success Measures

This scheme will contribute to the following key BCF metric:
- Reduction in non-elective admissions.

The following measures that link to the Hillingdon outcomes framework for older people will also be used to identify whether the scheme is working:

- Increase in utilisation rates for Connect to Support (new and repeat users);
- Contributing towards a 5% reduction in falls-related non-elective admissions on 2016/17 outturn;

- % of users of Adult Social Care who have found it easy or difficult to access information and advice about services and/or benefits (test through the Adult Social Care Survey);

- Proportion of patients (among all those with a PAM score) whose PAM score has improved in the last 12 months.

- % of people aged 55 and over participating in screening programmes.

d) Scheme Investment Requirements

Service	Provider	Funder 2017/18			Funder 2018/19			
		LBH £000's	HCCG £000's	Total £000's	LBH £000's	HCCG £000's	Total £000's	Total 2017/19 £000's
a) Connect to Support	Shop-4-Support	45	-	45	46	-	46	91
b) Online Service Co-ordinator	LBH	49	-	49	50	-	50	99
c) Wellbeing Service	H4All	543	334	877	543	334	877	1,754
d) Information Advice Welfare and Benefits Service	Age UK	150	-	150	150	-	150	300
e)Social Wellbeing Service	Age UK	100	-	100	100	-	100	200
f) Practical Support Service	Age UK	76	-	76	76	-	76	152
g) Falls Prevention Service	Age UK	-	143	143	-	143	143	285
h) Older People Wellbeing Initiatives	LBH	20	-	20	20	-	20	40
i) Telecare	LBH	262	-	262	267	-	267	529
j) Disabled Facilities Grant	LBH	3,815	-	3,815	4,174	-	4,174	7,989

k) Integrated Care Programme	CCG	-	1,062	1,062	-	1,062	1,062	2,124
l) Care Connection Team	CCG	-	759	759	-	759	759	1,518
j) Primary Care		-	56	56	-	56	56	112
	Total	**5,060**	**2,353**	**7,413**	**5,426**	**2,353**	**7,779**	**15,193**

Scheme 2: An integrated approach to supporting Carers.

a) Strategic Objectives

The strategic objective of this scheme is to maximise the amount of time that Carers are willing and able to undertake a caring role. This will be contributed to by Carers being able to say:
• "*I am physically and mentally well and treated with dignity*"
• "*I am not forced into financial hardship by my caring role*"
• "*I enjoy a life outside of caring*"
• "*I am recognised, supported and listened to as an experienced carer*"

b) Scheme Overview

This scheme continues the priority given in 2016/17 to support Carers and reflects the implementation of legal duties on local authorities under the Care Act, 2014 and the Children and Familes Act, 2014 respectively to support Adult and Young Carers. It also reflects policy directives on NHS bodies as directed by NHSE. The health and wellbeing of Carers will be supported through the following actions:

- *Maintaining capacity to deliver Carer's assessments through the Carers in Hillingdon contract that provides a single point of access for Carers in the borough* - Under this contract a triage assessment will continue to be promoted so that Carers can make informed decisions about whether to go through the full assessment process. In addition the online self-assessment facility through Connect to Support will be promoted and supported by Hillingdon Carers.

- *Implementation of NHS England's integrated approach to assessing Carer health and wellbeing* - This will entail the development of a Memorandum of Understanding (MoU) between the Council and Health partners, which will set out how partners will work together to support Carers.

- *Identifying "hidden" and "young" Carers* - This will entail using existing networks and materials e.g. Hillingdon People, social media, local press, street champions newsletter, Public Health initiatives and voluntary sector promotional event, etc, to identify people who do not necessarily consider themselves to be Carers. It will also entail the development of a consistent mechanism for identifying and recording Carers in primary care.

- *Developing the remit of the Young Carers Strategy Group* - This group was launched in 2016/17 to embed Young Carer initiatives at a strategic level, e.g. Healthy Schools Strategy; developing an early intervention and prevention strategy. A key role for the group in 2017/18 will be to develop a Young Carers Plus programme for Young Carers affected by parental drug, alcohol or mental health issues;

- *Health checks and flu prevention* - GP Health Checks and Flu Jab programmes for Carers will be promoted;

- *Hospital admissions and discharge* - Partners will work together to ensure that Carers are supported throughout the hospital admission and discharge care planning processes;

- *Personalisation for Carers* - Awareness of and access to Carer Personal Budgets and the individual's Personal Health Budgets will be maximised;

- *Social activities for Young Carers* - A range of social activities for Young Carers will be developed;

- *Extending availability of services for Adult Carers* - Options to extend services for Adult Carers, particularly working Carers who cannot access weekday provision, will be explored;

- *Social Worker drop-in sessions* - Social Worker drop-in sessions at the Hillingdon Carers Partnership Carers' Centre will be delivered.

c) Intended Outcomes/Success Measures

This scheme will contribute to the following BCF national metrics:
- Reduction in non-elective admissions.
- Reduction in permanent admissions to care homes of 65 + population.

The following measures that link to the Hillingdon outcomes framework for older people will also be used to identify whether the scheme is working:

- Number of Carers' assessments completed.
- Number of Carers' self-assessment completed.
- Number of Carers receiving respite or a carer specific service following an assessment.
- Through the National Carers' survey in 2018/19:
  Proportion of Carers who have found it easy or difficult to find information and advice about support services or benefits
  Carer quality of life questions about:
  - Getting enough sleep and eating well
  - Having sufficient social contact
  - Receiving encouragement and support.
- Increasing the number of Carers identified and registered on the Hillingdon Carers' Carers' Register.
- Number of Carers in receipt of a Direct Payment or an individual with Personal Health Budget to contribute to the local trajectory by 2021 (303 to 607).

d) Scheme Investment Requirements

Service	Provider	Funder 2017/18			Funder 2018/19			TOTAL 2017/19 £,000
		LBH £,000	HCCG £,000	TOTAL £,000	LBH £,000	CCG £,000	TOTAL £,000	
a) Carers' hub, assessments and review	Hillingdon Carers (lead)	649	0	*649*	661	0	*661*	*1,310*
b) Services to Carers (inc respite)	Various P & V	213	0	*213*	217	0	*217*	*430*
c) Carer Support Worker		0	18	*18*	0	18	*18*	*36*
TOTAL		**862**	**18**	***880***	**878**	**18**	***896***	***1,776***

Scheme 3: Better care at end of life

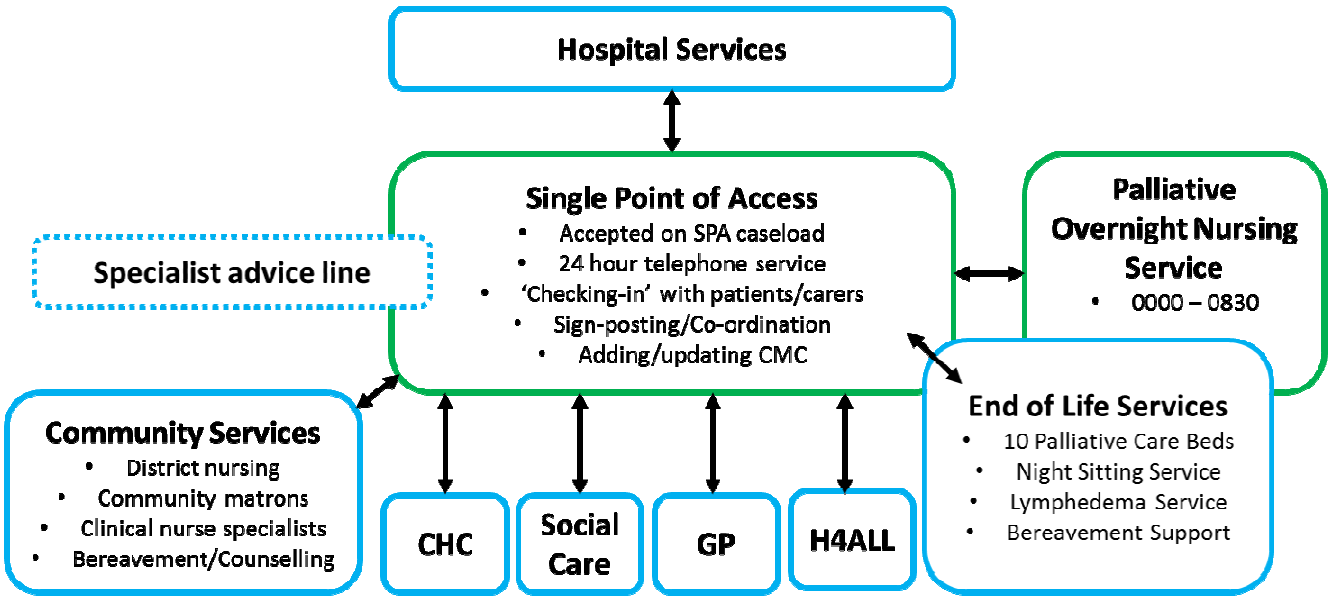
a) Strategic Objectives

This scheme seeks to realign and better integrate the services provided to support people towards the end of their life in order to deliver the ethos of a 'good death.' The main goals of the scheme are to:

- Ensure that people at end of life are able to be cared for and die in their preferred place of care; and
- To ensure that people at end of life are only admitted to hospital where this is clinically necessary or where a hospital is their preferred place of care or death.

b) <u>Scheme Overview</u>

Building on work undertaken during 2016/17, activity under this scheme will be aligned to the development of a new single point of access for people diagnosed as being within their last year of life. The SPA will act as a central information and advice hub for end of life/palliative care patients and services, whilst providing a co-ordination on behalf of patients, Carers and staff and giving the wider generalist workforce 24/7 access to specialist palliative advice. This will be supported by the palliative overnight nursing function (PONS) which, in addition to telephone advice will be able to assess and provide hands on care and support at the patient's place of residence if required. The intended model is shown below.



The key initiatives under this scheme intended to deliver better outcomes for people at end of life are:

- <u>*Facilitating seamless care provision between health and social care*</u> - The specialist homecare needs of people at end of life will be reflected in the integrated homecare service model tender referred to in scheme 5: *Improving care market management and development.* The intention behind this and a clear benefit of having the BCF pooled budget in place is to remove the possibility of disruption in care being caused by a transition in funding responsibility between health and social care, except in cases where the existing provider is unable to meet the escalating needs of the person at end of life.

- <u>*Reviewing charges for Council funded services*</u> - The Council will also explore the feasibility of removing the potential charge for people diagnosed as likely to have only six months to live and whose needs are primarily social care. This would help to avoid the complexities and potential disputes that can arise when trying to determine at what point a person's care should be health funded.

- *Utilisation of multi-disciplinary care and support planning* - In 2016/17 Adult Social Care gained read and write access to Coordinate My Care (CMC), an advanced care planning tool used in London primarily to support people at end of life. The intention and expectation is that there will be increased use of this tool by social care staff in line with the expected increase in use by other professionals and service providers across the borough.

- *Reviewing hospice bed provision requirements* - This is linked into the bed-based services requirements review action contained outlined in scheme 5: *Improving care market management and development.* The intention would be to identify future requirements and provision options.

c) Intended Outcomes/Success Measures

This scheme will contribute to the following key BCF metric:
- Reduction in non-elective admissions.

The following measure that links to the Hillingdon outcomes framework for older people will also be used to identify whether the scheme is working:
- Proportion of people on an end of life pathway on CMC who achieved their preferred place of death.

d) Scheme Investment Requirements

Service	Provider	Funder 2017/18			Funder 2018/19			TOTAL 2017/19 £,000
		LBH £,000	HCCG £,000	TOTAL £,000	LBH £,000	CCG £,000	TOTAL £,000	
a) Palliative home care.	Various P & V	50	884	*934*	51	884	*935*	*1,869*
b) Community Palliative Team.	CNWL	0	108	*108*	0	108	*108*	*216*
TOTAL		**50**	**992**	***1,042***	**51**	**992**	***1,043***	***2,085***

Scheme 4: Integrated hospital discharge

a) Strategic Objectives

This scheme seeks to prevent admission and readmission to acute care following an event or a health exacerbation and enabling recovery through intermediate care interventions with the aim of maximising the person's independence, ability to self-care and remain in their usual place of residence for as long as possible.

A further objective of this scheme is to support discharge from mental health community beds in recognition of the impact of these delays on patient flow through Hillingdon Hospital.

b) Scheme Overview

This scheme seeks to consolidate the move to a discharge home to assess model that expedites the flow out of hospital of people whose medical needs no longer require them to be there. This assumes that most people will recover more quickly from the cause of their admission in their usual home environment. The scheme is also seeking to establish an integrated hospital discharge service with a single point of referral to eliminate the existing fragmentation that exists between services and organisations.

Under Hillingdon's Discharge to Assess model there are three pathways:

- *Pathway 0 (Simple Discharges)* - This is for people whose needs can safely be met at home and

need no additional assessment. The patient is functionally fit or at functional baseline when they are declared medically optimised. The patient can go directly home either without care or with a care package restart. The patients for this pathway are identified and their discharges managed by ward staff. It is envisaged that the majority of patients will be discharged on this pathway.

- *Pathway 1 (Home to Assess)* - This is for people who are not at their functional baseline when they are declared medically optimised. Following a risk assessment, their needs can be safely met at home (including a residential or nursing care home), where an assessment will be undertaken. Any care, equipment or rehabilitation will be provided at home, including a Continuing Healthcare assessment where appropriate. The discharge will be managed by the Discharge Coordinators or the Integrated Discharge Team (IDT) when required. At present needs are met either by the Council's Reablement Service for up to six weeks or Community Homesafe provided by CNWL for up to 10 days for people who have had a Comprehensive Geriatric Assessment (CGA). The intention is to get to a point where there is a community-based single point of referral and discharge coordinated by community-based staff, including arranging transport and community equipment. The assessment to determine ongoing care needs would then take place in the person's usual place of residence.

- *Pathway 2 (Cannot return home)* - This is for people who are unable to return home as they require a period of further rehabilitation, their care needs are not able to be safely met in their usual place of residence or their home needs preparation or adaptation. It is intended that people will be identified by ward staff and the discharge managed by the Discharge Coordinators or the IDT. The onward route from hospital will either be to the 22 bed Hawthorne Intermediate Care Unit (HICU) for people who require rehabilitation, the 5 step-down beds in a private nursing home commissioned by the CCG for people who require a bed based service on discharge and will be non-weight-bearing for more than 3 weeks or require a full continuing healthcare (CHC) assessment. The Council also has a step-down flat available in an extra care scheme where a person's home is unsuitable to meet their immediate needs.

Improvements to hospital discharge processes, including early identification of people with complex needs likely to impact on timely discharge and transport and medication issues are captured within the Urgent and Emergency Care Work Plan and the Delayed Transfers of Care (DTOC) action plan.

Other actions that will be taking place under this scheme include:

- *Reviewing the Integrated Discharge Team (IDT)* - Within the context of the Discharge to Assess model, the role and function of a multi-agency IDT will be undertaken by the Leadership Centre, an independent organisation that supports the public sector to address complex issues.

- *Emergency Care Improvement Programme (ECIP) undertaking a review of mental health discharges processes and causes of delay* - Delayed discharges of people with mental health needs represent the largest proportion of delayed transfers of care in Hillingdon.

- *Establishing regular liaison meetings between Mental Health and Housing* - Housing-related issues present one of key causes of delays in supporting the discharge from hospital of people with mental health needs. The Council and the community mental health provider, CNWL, will establish more structured referral routes and escalation pathways to ensure early identification of people with complex needs.

- *Developing a business case for establishing a Hospital Discharge Grant* - A business case will be developed to use flexibilities in the use of the Disabled Facilities Grant permitted under the Regulatory Reform Orders to establish a non-means tested grant of up to £4k to pay for the following in order to expedite a resident's discharge from hospital:
  - Home/garden clearance.
  - Home deep cleaning.
  - Home fumigation.
  - Furniture removals to establish a micro-environment.

- Heating repairs, e.g. repairing or replacing boilers.
- Repairs to, or replacement of, essential appliances, e.g. cooker, refrigerator/freezer.

c) Intended Outcomes/Success Measures

This scheme will impact on the following BCF metrics:

- Reduction in the number of non-elective admissions.
- Reduction in permanent admissions of older people aged 65 years and over to residential and nursing care homes, per 100,000 population.
- 88% of older people aged 65 years and over who are still at home 91 days after discharge from hospital into reablement
- % reduction in delayed transfers of care (delayed days), including:
  - % reduction in delays attributed to the NHS
  - % reduction in delays attributed to Adult Social Care

The following measure will also be used:

- 85% of new clients who received reablement where no further request was made for ongoing long term support;
- Less than 15% of Continuing Healthcare assessments completed in a hospital.

d) Scheme Investment Requirements

Service	Provider	Funder 2017/18			Funder 2018/19			
		LBH £000's	HCCG £000's	Total £000's	LBH £000's	HCCG £000's	Total £000's	Total 2017/19 £000's
a) Rapid Response	CNWL	-	1,669	1,669	-	1,669	1,669	3,338
b) Hawthorn Intermediate care Unit	CNWL	-	1,603	1,603	-	1,603	1,603	3,206
c) Community Rehab	CNWL	-	1,198	1,198	-	1,198	1,198	2,396
d) Prevention of Admissions and Readmission (PATH)	Age UK	29	74	103	29	74	103	206
e) Take Home and Settle	Age UK	-	63	63	-	63	63	126
f) Reablement and Hospital Assessments	LBH	2,638	-	2,638	2,689	-	2,689	5,327
g) Reablement Physio	CNWL	51	-	51	51	-	51	102
h) Community Equipment	Medequip	756	715	1,471	761	715	1,476	2,947

i) Community Homesafe	CNWL	0	688	688	0	688	688	1,376
j) Packages of care	Various P&V	1,044	0	1,044	1,064	0	1,064	2,108
k) Step Down beds (Franklin House)	Care UK	0	198	198	0	198	198	396
l) Pressure Mattresses	CCG	0	206	206	0	206	206	412
m) Continence Service	CNWL	0	582	582	0	582	582	1,164
n) Community Matrons	CNWL	0	599	599	0	599	599	1,198
o) District Nursing	CNWL	0	3,346	3,346	0	3,346	3,346	6,692
p)Twilight Service	CNWL	0	124	124	0	124	124	248
q) Tissue Viability	CNWL	0	288	288	0	288	288	576
r) Support to step down Beds	CNWL	0	53	53	0	53	53	106
s) Cottesmore Reablement Flat	Paradigm Housing group	49	0	49	50	0	50	99
t) Mental Health Nurse in rapid response	CNWL	40	0	40	0	0	-0	40
	Total	**4,607**	**11,406**	**16,013**	**4,643**	**11,406**	**16,049**	**32,062**

Scheme 5: Improving care market management and development

a) **Strategic Objectives**

This scheme is intended to contribute to the STP 2020/21 outcomes of achieving:

- A market capable of meeting the health and care needs of the local population within financial constraints; and
- A diverse market of quality providers maximising choice for local people.

b) **Scheme Overview**

The focus of this scheme is the following areas:

- Pilot of an integrated brokerage;
- Integrated homecare for adults and young people;
- Care home market development; and
- Support for extra care sheltered housing.

The scheme represents both a logical progression from work undertaken in 2016/17 and also step-change in the integration between health and social care, which can be seen with the establishing of lead organisation/commissioner arrangements in respect to tendering of homecare and the potential to develop this further for nursing care home provision. By taking the step on the road to integration between health and social care this scheme seeks to address private provider market capacity and service quality issues that have a significant impact on Hillingdon's health and care system. This scheme is therefore also critical to the delivery of the objectives of several other schemes within the BCF plan, e.g. scheme 3: *Better care at end of life*, scheme 4: *Integrated hospital discharge* and scheme 6: *Living well with dementia*.

The key objectives of this scheme will be achieved through the following initiatives:

Integrated Brokerage

- Expanding utilisation of e-brokerage facility in Connect to Support to include nursing care home and homecare placements for Continuing Healthcare patients.

- Trial of co-locating both Council and CCG brokerage teams from September 2017.

- Developing affordable options for Council and CCG approval to expand scope of joint brokerage to include self-funders.

- Expanding take-up of Personal Health Budgets (PHBs) and integrated budgets, e.g. combination of Direct Payments (DPs) and PHBs in order to achieve the defined trajectory by 2021.

- Reviewing the impact of the brokerage pilot and consequent closer alignment of teams to inform a decision about any structural integration in 2018/19.

Integrated homecare for adults, children and young people

- The Council will lead for itself and the CCG in the tendering for an integrated, tiered service model of homecare through a Dynamic Purchasing System (DPS), e.g. a type of framework agreement that allows new providers to the market place to enter at any time if certain specified criteria are met. The DPS will become operational in October 2017 for two years. For the Council the tender will provide coverage for a part of the borough where a contract is currently not in place; it will also provide additional capacity in other parts of the borough. The model is intended to address NHS capacity requirements in all parts of the borough.

- Homecare placements will be made through the piloted integrated brokerage team through an electronic process.

- The integrated homecare model will include specialist palliative provision for people whose final preferred place of care is at home. The investment element for this provision is reflected in scheme 3: *Better care at end of life*, although delivery will be through work undertaken as part of this scheme 5.

- A review of the impact of the model in 2018/19 will inform the approach taken by both the Council and the CCG to respond to the expiry of the Council's other homecare contracts at the end of 2019.

Care home market development

- Developing and launching a market position statement following a joint health and social care bed based services demand exercise to advise the market of Council and NHS supply requirements over the next 10 years.
- Exploring with providers increasing local capacity for residential dementia and nursing (inc dementia) care home capacity through conversion of spot purchases to block arrangements and seeking approval for other affordable options to meet supply needs.

- Developing an integrated nursing care home specification, e.g. to meet social care and CHC requirements.

- Determining the agreed procurement route for delivery in 2019/20, including the possibility of the Council being included within the NHS Any Qualified Provider (AQP) contract.

- Expanding the existing weekend GP advice and visiting service across the Borough and establish a Monday to Friday GP with specialist interest pilot to provide an emergency response, e.g. advice and/or visits as appropriate, for a defined number of care homes from October 2017 to March 2018.

- Based on the outcomes of the pilot, commission a GP advice and visiting service in an integrated way with existing and planned services in community/primary care through the ACP to support care homes.

- Developing a range of training opportunities for care home staff supported through the ACP and Council, e.g. falls prevention, deprivation of liberty and mental capacity assessments, prevention of pressure ulcers, continence care, palliative care and respiratory conditions.

- Developing a business case for additional community dietician to specifically work with care homes.

- Exploring the development of a career pathway for nursing care home staff through the ACP to contribute to addressing shortage of qualified nurses in this setting.

- Developing a '*Red Bag'* scheme pilot scheme with local care homes. The '*Red Bag*' keeps important information about a care home resident's health in one place, easily accessible to ambulance and hospital staff. contains standardised information about the resident's general health, any existing medical conditions they have, medication they are taking, as well as highlighting the current health concern. This means that ambulance and hospital staff can determine the treatment a resident needs more effectively.

- Developing a care home dashboard to be shared with care home managers that shows the number of hospital attendances and admissions from care homes and also London Ambulance call outs to care homes and conveyances to hospital.

Support for extra care sheltered housing schemes

- Developing a model of in-reach health and social care support for extra care schemes linked to Care Connection Teams. This will include dedicated social work support and it is proposed will entail the reallocation of Protecting Adult Social funding from contributing to the mental health nurse in Rapid Response to resourcing a dedicated social work post to support extra care.

- Delivering a new care and wellbeing service at Cottesmore House and Triscott House in 2017/18 and at two new schemes called Grassy Meadow Court and Park View Court in 2018.

- Delivering a model of primary care, e.g. GP, support for extra care schemes. This links into the proposed service for care homes referred to above.

c) **Intended Outcomes/Success Measures**

This scheme will contribute to the following national BCF metrics:

- Reduction in non-elective admissions
- Reduction in permanent admissions to care homes of 65 + population.
- Reduction in delayed transfers of care and specifically for those attributed to the lack of care home placement or package of care reasons.

The following measures that link to the Hillingdon outcomes framework for older people will also be used to identify whether the scheme is working:

- Reduction in non-elective admissions from care homes.
- Reduction in inappropriate non-elective admissions from extra care sheltered housing schemes.
- Proportion of people on an end of life pathway on CMC who achieved their preferred place of death.

The following targets will be set for people in receipt of a combination of PHBs, integrated health and social care budgets, e.g. a combination of PHBs and Direct Payments, and people with a managed Personal Health Budget, which is where the actual sum of money allocated is identified but it is managed on behalf of the individual by the CCG:

PHB Target by Quarter 2017/19 (Cumulative)				
	Q1	**Q2**	**Q3**	**Q4**
2017/18	38	58	83	113
2018/19	148	183	223	263

d) **Scheme Investment Requirements**

Service	**Provider**	**Funder 2017/18**			**Funder 2018/19**			**Total 2017/19 £000's**
		LBH £000's	**HCCG £000's**	**Total £000's**	**LBH £000's**	**HCCG £000's**	**Total £000's**	
a) Quality Assurance team	LBH	168	-	168	171	-	171	339
b) Adult Safeguarding	LBH	260	-	260	265	-	265	525
c) Brokerage Team	LBH	315	62	377	315	62	377	754
d) Home Care	Various P&V	7,952	251	8,203	7,952	251	8,203	16,406
e) Care Home Prescriber	HCCG	0	32	32	0	32	32	64
f) Older peoples care Home	Various P&V	0	1,968	1,968	7,149	1,968	9,117	11,085
g) EMI over 65	Various	0	0		0	2,913		2,913

Residential	P&V			-			2,913	
h) EMI over 65 Domicillary	Various P&V	0	0	-	0	199	199	199
i) Physical Disability (Under65)	Various P&V	0	0	-	0	2,370	2,370	2,370
j) Pallative Care - Residential	Various P&V	0	0	-	0	509	509	509
k) Pallative Care - Domicilliary	Various P&V	0	0	-	0	596	596	596
l)Funded Nursing Care	Various P&V	0	0	-	0	3,025	3,025	3,025
m) Extra Care Social Work Post	LBH	0	0	-	41	0	41	41
n) Medication Admin	HCCG	0	24	24	0	24	24	48
o) Community Matron	CNWL	0	52	52	0	52	52	103
	Total	**8,695**	**2,389**	**11,084**	**15,893**	**12,001**	**27,893**	**38,977**

Scheme 6: Living well with dementia

a) **Strategic Objective**

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

- *I was diagnosed in a timely way.*
- *I know what I can do to help myself and who else can help me.*
- *Those around me and looking after me are well supported.*
- *I get the treatment and support, best for my dementia, and for my life.*
- *I feel included as part of society.*
- *I understand so I am able to make decisions.*
- *I am treated with dignity and respect.*
- *I am confident my end of life wishes will be respected. I can expect a good death.*

b) **Scheme Overview**

Dementia is primarily a condition associated with old age and as Hillingdon's population ages the numbers of people living with this condition is likely to increase significantly, with a consequential impact on the local health and social care economy. This scheme represents a continuation of work undertaken in 2016/17 and many of the key actions required to support people living with dementia and their families are addressed within other schemes in the plan. These include the following actions:

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

- *Securing care home provision for people living with dementia with challenging behaviours* – The current limited availability of this provision is the cause of people with dementia staying in inappropriate care settings for longer than is desirable and can contribute to delayed transfers of care. The work being undertaken under scheme 5: *Improving care market management and development is* intended to address this gap in provision.

- *Securing care provision for people living with dementia at end of life* – The work being undertaken under scheme 5: *Improving care market management and development* will ensure that appropriate service provision is available to address need at this particularly sensitive time.

- *Developing dementia-friendly alternatives to care home settings* - Linked to scheme 5: *Improving care market management and development,* two extra care sheltered housing schemes that have been built to the University of Stirling's Gold Standard, an internationally renowned design standard for dementia-friendly environments, will open in 2018. These are Grassy Meadow Court with 88 self-contained flats and Park View Court with 60 flats. Both schemes are intended as a realistic alternative to residential care for older residents and tenants will have access to 24/7 on site care and support provision.

The following action is specific to this scheme:

- *Developing a local dementia resource centre model* - A dementia resource centre will be included in the Grassy Meadow Court extra care scheme referred to above that is due to open in early 2018. This resource is primarily intended to meet the social care needs of people living with dementia in the community with family carers, but during 2017/18 health and social care partners will work together to identify how the maximum benefit can be obtained from this facility.

c) **Intended Outcomes/Success Measures**

This scheme will impact on the following BCF metrics:
- Reduction in permanent admissions to care homes.

d) **Scheme Investment Requirements**

Service	Provider	Funder 2017/18			Funder 2018/19			TOTAL 2017/19 £,000
		LBH £,000	HCCG £,000	TOTAL £,000	LBH £,000	CCG £,000	TOTAL £,000	
Wren Centre (dementia resource centre)	LBH	300	0	300	306	0	306	606
TOTAL		**300**	**0**	**300**	**306**	**0**	**306**	**606**

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HILLINGDON
LONDON

Policy and Overview Committee Update Report
TeleCareLine October 2017

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1. Background and overview of the LBH TeleCareLine (TCL) Service

The TeleCareLine service as grown from the original "button and box" alarm type service provided to sheltered housing tenants. Since 2010 there has been a strong focus in the council of promoting TCL as a key preventative service widely available to all residents of the borough. From 2011 the service has been offered free to over 85's, this was extended in 2015 to a free service to all residents over 80. There have been a number of campaigns to actively target these residents for telecare as part of supporting residents to live safely and independently in their own homes for as long as they wish.

The current number of TeleCareLine users as at 30th September 2017 is 4,949, this figure includes residents living in sheltered accommodation. Within this figure the total number of TeleCareLine users aged 80+ as 30th September 2017 is 3,768.

There are a number of service levels available to residents which are outlined below:

> **Standard** - Level 1 this service includes standard unit, pendant, bogus caller button and monitored smoke detector with the resident having their own nominated responders in the event of an emergency, Level 2 is the same equipment but with LBH mobile response service
>
> **Enhanced** - Level 3, this would include the equipment in level 1 plus additional sensors to meet the needs of the client following an assessment eg falls detector, movement sensors, door sensors again with the residents own nominated responders or Level 4 with LBH mobile response service.

The TCL system is monitored 24/7 by the councils TCL team who provide the first line response to all alerts raised, details of how this element of the service is being developed is detailed in Section 3 of this report.

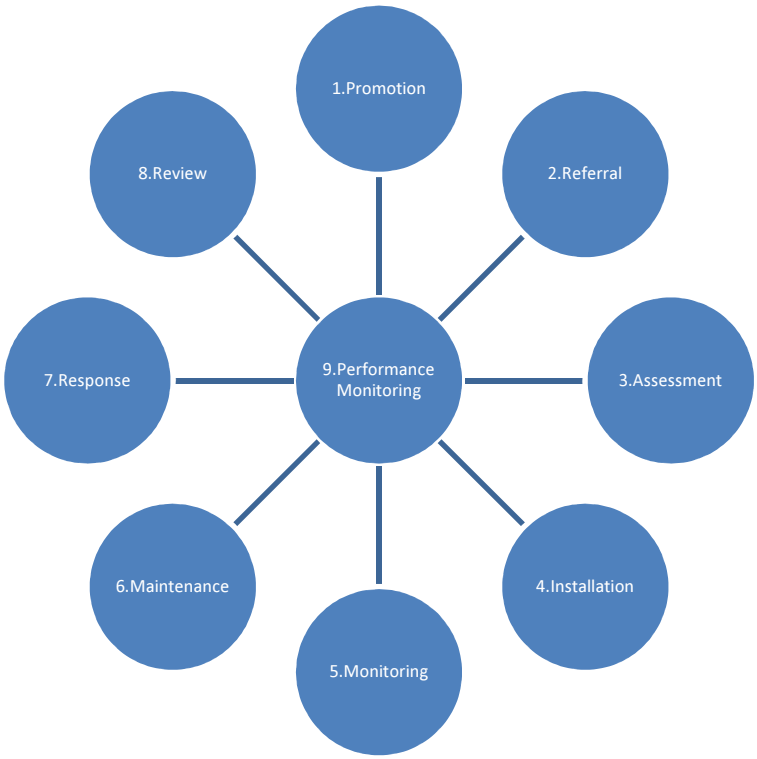
For residents who have their own nominated responder, the TCL monitoring team will make contact with them in an emergency. Where emergency services are required these will be instructed by the monitoring team.

Residents who do not have a family or friends who live close enough to act as an emergency responder they can still benefit from TCL with the councils mobile response service. This support is provided by the Senior Reablement Carers between 8am and 10pm and the dedicated night response officer who respond to call outs as required.

Case studies demonstrating impact the telecare service has had on older people in the borough and on individuals with a learning disability in supported living are included in **Appendix 1**.

2. How the telecare service operates in London Borough of Hillingdon

Good practice suggests that a successful telecare service has nine key elements, these are set out in the diagram below.



A description of each element and how it is currently delivered in the council is outlined in the table below:

TCL Cycle	Description	LBH approach to delivery
1.Promotion/ marketing and initial enquiry	Benefits of TCL are widely promoted through the Connect to Support and published material as a key part of the councils preventative services offer, it is widely available to all residents.	• All handled by LBH, material produced in house, awareness raising internally and externally and staff training all completed by TCL Officer. • Initial enquiries are taken through Hillingdon Social Care Direct or by social work staff during assessments. Residents can apply directly via an online form.
2.Referral	Basic service (Level 1 or 2) can be installed without assessment,	• Regardless of the point of entry

TCL Cycle	Description	LBH approach to delivery
	charges apply to residents under 80 years old in accordance with LBH charging policy.	all referrals for basic service are processed through to the TCL team who check the documentation, organise the installation and set up the charging where relevant. • Circa 112 new referrals per month.
3.Assessment	Enhanced service level 3 or 4 requires a social care assessment to ensure additional sensors are meeting the needs of the individual, clients at this level are likely to be known to social care and the provision of TCL equipment will have a direct impact on their package of support.	• Assessments are carried out by social work teams who make a referral to the TCL team for installation.
4.Installation	Home visit to install relevant equipment	• Appointments are booked for the in house installation team. The contract for equipment is currently with Tunstall, the value of this contract is circa £420k per annum.
5.Monitoring	24 hour /365 days a year support provided to all residents with TCL installed. This team will respond to alerts for support and maintenance issues such as low battery alerts. This function also carries out periodic system checks to equipment to ensure its working as expected. The team managed in excess of 110,000 per annum.	• Following a recent review this function is being transitioned from an in house service to Anchorcall. More details about this change are detailed in Section 3 of this report.
6.Maintenance	Includes resolving faults, upgrades to equipment, replacing old equipment and testing.	• In house service provided by the installation team.
7.Response	Residents can either provide their own responder in case of emergency, a nominated key	• Provided by in house teams - Senior/Reablement Carers attend between 8am and 10pm,

TCL Cycle	Description	LBH approach to delivery
	holder who is able to enter the property in an emergency. Alternatively the resident can request the LBH response service.	with the dedicated Responder Service operating out of the Civic Centre throughout the night.
8.Review	Review of clients needs is completed by social work teams for those in receipt of social care support, residents not known to social care have their equipment monitored and reviewed from a maintenance perspective. Any issues identified by the monitoring team based on usage patterns will be referred to social care.	• Provided in house by social work teams for clients in receipt of social care, by the monitoring team if they are only known to TCL service. As part of normal periodic social care reviews.
9.Service Performance Monitoring and KPI's	Good practice in telecare is set by the Telecare Services Association (TSA) which sets out a code of practice and KPI's.	The service utilises the Jontec system for client management and monitoring. Additional information will be held on the social care system IAS for clients known to social care.

3. Developments to the operating model.

Following a transformation review of the Older People's Housing Service (OPHS) and the Out of Hours call handling service, a recommendation was put forward to cabinet on the 28th September 2017. Cabinet approved the recommendation and awarding of the contract to AnchorCall is underway with a go-live date of 27th November.

Anchorcall is a subsidiary of Anchor Trust and it is provides Telecare Monitoring Service for all Anchor Trust properties & tenants. Anchorcall has been established for over 25 years and has been a member of the regulated industry's body: Telecare Services Association (TSA) since 1994. TSA is the industry's regulated body for technology enabled care (TEC) services, representing over 350 organisations including health and social care commissioners, digital health businesses, telecare and telehealth providers, housing associations, emergency services, academics, charities and government bodies.

The Council will still retain in -house all front facing functions of the telecare service in particular the processing of referrals, product support for both staff & users, scheduling of new installations, booking maintenance/repair calls of the TeleCare equipment and being the first responders where applicable for alarm alerts.

Preliminary discussions begun with Anchor Call on the 17th October and a project team was been set-up. The project formally commenced as of 23rd October and workshops around processes, data migrations, systems set-up etc have also commenced.

4. Impact of TeleCareLine on Residents - Safer Walking Programme

A key priority for the council was to provide solutions that could support individuals living at home with dementia to be effectively supported to lead an active lifestyle yet be easily located should they become confused or lost away from home. For many carers of individuals with dementia, the fear of them getting lost causes tension at home, as they take steps to keep them in doors to avoid the risk of them getting lost. Continuing with daily routines such as visiting the shops or going for a walk are important parts of an individuals day to day life and if these can be safely maintained it supports both peace of mind for the carer and helps support the risk for the vulnerable person. This issue led to the implementation of the **Safer Walking Program.**

Background

LBH invested in the Everon Vega watch which is a purpose built system to aid safer walking for those with Dementia or other cognitive disorders. The Vega allows wearers to walk freely and if appropriate, in a predetermined safe zone, but raises an automatic alarm should the wearer walk outside of this zone. Vega also features a radio frequency home base that will recognise when the Vega wearer is at home. The watch also has an emergency button which allows the wearer to call for help if they became distressed outside the home. This will put them in contact with the response centre as the Vega has a two-way speech capability, allowing them to speak to the person if appropriate until help arrives.

This equipment is not suitable for everyone who has been identified as having a history of going out and becoming disorientated and “lost”, there are limitations to the support it can provide specifically:

- This technology is not designed to keep the person locked up in doors but to help manage the associated risks of walking freely,
- The purpose of Safer walking technology is to increase a person’s independence and allow the individual to walk more freely which in turn provides physical and psychological benefits
- The person's current routines/patterns in respect of going out and about are understood so that a judgement on the level of risk can be made; and the device effectively set up to support the individual?
- The person has sufficient insight to consent to and engage with the device
- There is sufficient support from carers/family to ensure effective battery management and that the individual is wearing/carrying the device
- Monitoring must be provided by family/carers known to the individual who can make a judgement on how best to respond to individual circumstances, where this support is not available GPS technology may not be suitable for the individual.
- It is unlikely this technology will be suitable for an individual living alone without a local support network.

The safer walking program started mid May 2013 and at 25th October 2017

- 101 clients have been supported using the GPS technology
- 26 remain active
    - 20 older people living with Dementia
    - 6 Adults with learning disability

- The average length of time a service user used the Vega watch before returning it = 383 days
- Agreement was reached in all cases from the Service user to wear the watch
- All service users have close support from family, and agreed in principle to use the watch.

Impact on of the Safer Walking Programme

In the majority of the cases, the GPS technology primarily provided peace of mind to the service users family / carer. This enabled the service user to continue to access the community without hindrance in the knowledge that if they did not return home, the family member is able to locate the service user and take any necessary action to support their safe return home. The case studies in **Appendix 2** provide more detail of the impact of this service.

5. **Priority areas for further development of telecare support**

In recent years, there have been significant developments in how technology can be used to support individuals with a wide range of needs to maintain or increase their independence. The range of reliable technology solutions in this space is continually growing and consideration is being given to how the Council can make the most of these new opportunities.

From social care perspective there are a number of priority areas where initial research is underway to consider how technology can play a role in order to:

- managing the risks associated with epilepsy both inside and outside the home
- improve communication and reduce social isolation
- locate individuals who are thought to be lost - new GPS technology that may be able to be used when a watch is not appropriate.

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Telecare provided free to over 80s

The challenge

The UK population is ageing, and in the London Borough of Hillingdon the number of people over 80 is 10,625, projected to increase by 13% over the next five years (ONS). In response to this, Hillingdon Council Adult Social Care has worked in partnership with NHS Hillingdon to develop a new model of care which effectively mainstreams telecare and reablement services, reducing reliance on residential care. The service aimed to create a fundamental shift in service provision away from institutionalised care, towards home-based support, risk prevention and early intervention.

What we did

Hillingdon has offered a community alarm service to residents for some years, and following a review of the evidence from other areas in the UK, took the decision to extend this service by offering a telecare support service free of charge to residents over the age of 85 in April 2011, extended to over 80 in 2014. Similar telecare packages are offered free for the first six weeks as part of a re-ablement service and for those individuals who meet FACs (Fair Access to Care) criteria subject to a financial assessment. In addition, all residents of the borough may choose to self-fund.

Hillingdon's TeleCareLine service provides varying levels of support, with eligible residents provided with a Lifeline Connect+ personal alarm, a MyAmie+ pendant, bogus caller alarm and a smoke detector as standard, and additional sensors provided based on the residents' individual needs.

The new model of care aimed to support 3,000 people by the end of 2014/15 and to reduce/delay entry into residential care, prevent people needing ongoing care and support confidence during the re-ablement process.

A comprehensive financial model has been created to monitor efficiency, ensuring that resources are used in the most effective way and that residents are able to remain in their own homes for as long as possible, enjoying a better quality of life than may otherwise be the case.

Result highlights

As a result of the telecare and reablement service:

- £4.95m savings were generated (April 2011 - March 2014)
- Residential/nursing care placements reduced from 8.08 per week, to 2.13 per week
- Homecare hours purchased reduced by 10%
- Over 3,300 people are currently benefitting from telecare

Technology like TeleCareLine can play a vital role in helping care for an ageing population and that's why in Hillingdon are offering it to those aged over 80 for free. By enabling residents to stay in their own homes we can increase people's independence and reduce dependency on traditional social care services such as residential or nursing care, which can in turn result in significant savings for the council.

Tony Zaman, Director for Adult Social Care

HILLINGDON LONDON

Results

More than 3,300 people are currently benefitting from telecare. Of these installations, more than 1,163 have been self-referrals from Hillingdon residents as a result of the council's efforts to raise awareness of the telecare service at user level.

The telecare and reablement service has achieved the financial savings target of £4.95m (from April 2011 to March 2014.) Detailed analysis has revealed that the service has resulted in:

- Long-term residential/nursing care placements reducing from 8.08 per week in 2010 to 3.57 per week by end February 2012
- Reduction in homecare hours purchased of 10% from April 2011 to April 2012, forecast continued year-on-year reduction of 7.8%.
- From January 2013 to February 2014 the percentage of residents not requiring further services after the initial six week reablement programme was 46.44%, and the number of residents who only required a reduced service after their reablement period was 16.83%.

Not only has the telecare and re-ablement service delivered significant financial savings, it also supports LB Hillingdon's mission to enable residents to live healthy, safe lives in the home of their choice.

> Like most people, our older residents and those with disabilities have told us they want to be, and remain, independent. Hillingdon's TeleCareLine service allows them to do just that, safe in the knowledge that assistance is on hand should they need it.

Cabinet Member for Social Care, Health and Housing, Councillor Philip Corthorne

Case study

Fire prevention

Claire is 88 years old, and has mild confusion and short term memory issues. She has the TeleCareLine standard package installed and was recently admitted to hospital.

While Claire was in hospital her daughter visited the property with some shopping and left some bags on the electric hob, without noticing that one of the rings had been left turned on.

Claire's daughter left the property, but the smoke detector subsequently raised the alarm at the monitoring centre. The monitoring officer was able to instantly view Claire's notes on screen and see she was in hospital, and so contacted Claire's daughter who was then able to quicky return to the property, and remove the smouldering bags from the cooker before more serious consequences occurred.

Without a monitored smoke alarm as part of the TeleCareLine service there was likely to have been serious damage to Claire's property. However, because of telecare, Claire was able to return home and recuperate in familiar surroundings, with the reassurance that the system would continue to raise an alert at the monitoring centre if it detected a potential problem.

For more information about Hillingdon TeleCareLine visit www.hillingdon.gov.uk or call 01885 556633

Tunstall Healthcare (UK) Ltd is a member of the Tunstall Group.
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London Borough of Hillingdon – using telecare to support people with learning disabilities

Hatton Grove aims to promote and enhance the lives of all our service users through privacy, dignity, independence, choice and protection of rights.

The challenge

Hillingdon is London's second largest borough, and is home to around 278,000 people. The council's vision for 'putting our residents first' is driven by taking a forward-thinking and innovative approach to a range of initiatives, including the delivery of social care.

Hillingdon Council's Adult Social Care, working in partnership with the NHS in Hillingdon, has recently developed a new model of care incorporating telecare and reablement services, reducing reliance on residential care. The aim is to create a fundamental shift in service provision away from institutionalised care, towards home-based support, risk prevention and early intervention. This transformational approach to social care has already delivered significant financial and quality-of-life benefits, by supporting people in their own homes.

However, there will always be a need for provision of care for those people who cannot be supported at home, including people with adults learning disabilities and more complex needs.

How can telecare contribute to making residential care settings places that enhance the lives of the people who live and work there?

Highlights

- Privacy and independence of service users enhanced
- Staff feel better able to offer individualised support
- Service users' safety protected
- Staff have more time to interact with service users
- Telecare can be easily adapted to changing needs

> "Whilst recognising that the preferred housing options for people should be personalised, it is also necessary to offer a range of accommodation that meets the needs of Hillingdon's residents, including residential care.
>
> In Hillingdon, the services offered in a care home include the latest technology to enhance quality of life for residents and ensure safe and individualised service delivery.
>
> Hillingdon continues to work towards greater independence, where appropriate, for its residential care users and telecare forms part of the support package that enables people to lead full and independent lives."

Sandra Taylor, Service Manager, Resources for Adults and Older People

HILLINGDON
LONDON

Background

Hatton Grove is a Care Quality Commission (CQC) registered residential care home in Middlesex, supporting adults with a range of learning and physical disabilities. The home is divided into four units, and can support up to 20 adults, each benefiting from their own personal space. Hatton Grove also contains a small flat to support a service user to live independently.

At Hatton Grove, all service users need 24 hour care and support. All have complex health needs and physical disabilities and half need two members of staff to assist with all transfers.

As none of the service users can access the community on their own, due to their complex disabilities, a range of support is offered by the in-house teams ranging from aromatherapy and speech therapy to help accessing online education. Hatton Grove provides a warm, caring and stimulating environment in which the people who live there are able to develop skills and achieve maximum quality of life. Staff aim to encourage the intellectual, emotional and social development of service users through guidance, support, counselling and by providing positive role models.

How has telecare been used at Hatton Grove?

Each of the four flats at Hatton Grove is staffed separately, with eight staff on shift at any one time covering all the flats during the day. During the night, two waking night staff are onsite along with a duty senior. Occupancy levels vary from flat to flat, with six people living in two of the flats, five in another and three in the last.

> To me, supporting the people that live here is as much about encouraging their passions and developing their abilities as it is about ensuring their personal care needs are met.
>
> Telecare has been fantastic for us. Not only does it help to manage risk and preserve dignity, it also frees up staff, enabling them to spend more personal time with the people they work with.
>
> **Jenna Cowling, Registered Care Manager, Hatton Grove**

Despite the high level of care provided, staff continually seek to improve the lives of people living at Hatton Grove and night staff in particular sought a means of ensuring they would still be aware of any seizures, falls or incidents but without the need to make impersonal and undignified half-hourly checks, disturbing service users.

In 2010-11, Hatton Grove completed the Dignity Challenge, a 10 step process designed to ascertain how people's dignity is respected. As a result, small changes were made, including staff using small torches rather than turning main lights on during night time checks. However, further changes were required, and it was decided to evaluate the advantages of using telecare.

Telecare was introduced gradually to Hatton Grove - initially, with a small number of sensors being used for a week - to assess the benefits to service users. The aim was to maintain privacy and dignity whilst keeping service users safe.

What solutions were employed?

Sensors have been put in place to support the night staff team, with sensors active from 9pm until 6am.

Epilepsy sensors have been used to support service users who have a diagnosis of epilepsy but are largely seizure free. Staff no longer need to make checks on these service users every half an hour during the night, helping to maintain their dignity and privacy.

A door sensor has been used for one service user whose mobility means she is at a greater risk of falling if she leaves her room, and as she becomes distressed when other service users enter her room. Staff are now immediately alerted if the door opens during the night, indicating one of these events. See Helen's case study on page 4.

A bed occupancy sensor has been fitted for an older service user who leaves his bed at night to visit the bathroom and is at risk of falling. Previously, he would often wake when staff checked on his safety in the night and he would get out of bed and follow them. Now he remains undisturbed, but staff will be alerted if he leaves his bed and can assist him to the bathroom.

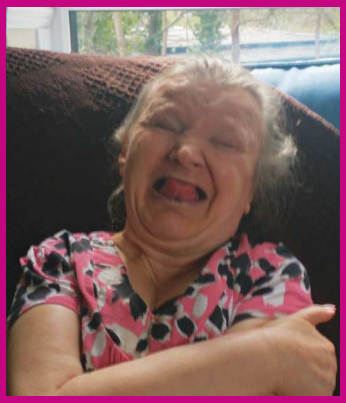
A PIR (movement sensor) has been used to support a service user prone to leaving her bed at night, but for whom a bed occupancy sensor wasn't appropriate due to her sleeping positions. Previously staff inadvertently woke her on occasions when making their checks, but they are now immediately alerted if the PIR senses her leaving her bed. See Emma's case study on page 4.

The CareAssist pager receives alerts from all of the other sensors, and indicates to staff which device has been activated so they are able to offer swift support to the correct service user.

Case study - Helen and Emma have lived together for 60 years, latterly at Hatton Grove.

Helen's story

Challenge



Helen is 68 and has a dual diagnosis of severe learning disabilities and mental health issues. Although she is unable to communicate verbally, Helen makes it very clear she does not want any night staff in her room. Helen also has arthritis in both knees and whilst quite safe in her room, she is at risk of falling in communal areas. Other service users at Hatton Grove sometimes enter Helen's room at night, which she finds upsetting and on occasion their boisterous behaviour has been of concern to staff regarding Helen's safety. Items have also been taken from Helen's room, and sometimes thrown from her window.

Solution

A door sensor has been fitted to the main door of Helen's flat, which immediately alerts care staff via the CareAssist pager so they are able to offer her assistance.

Outcome

Since the door sensor has been fitted, staff no longer need to make frequent checks to ensure Helen's wellbeing as they will be alerted if she leaves the safety of her flat, thus complying with her desire for privacy. The system also means staff can be on hand if Helen ventures into the corridor at night, helping to mitigate the risk of her falling.

Helen's flatmates are now aware that staff will be immediately on hand should one of them enter her room, which has considerably reduced the instances of night-time disturbance. The use of telecare at Hatton Grove has reduced the number of night time checks staff need to make, increasing the time they have to spend with service users. Now, if Helen chooses to leave her room during the night, staff are able to sit with her, spending social time with her interacting and looking at books.

Emma's story

Challenge

Emma is 69, and has severe learning disabilities, along with Crohn's disease and has periods of hyper-mania. She walks and spins in circles constantly and can be awake for 24-36 hours at a time. When she does go to bed, she may get up three or four times during the night. Staff were checking on Emma regularly when she was asleep to ensure her safety, but this often woke her and was having a detrimental effect on her mental health.

Solution

Because Emma often sleeps curled up in different parts of her bed, a bed occupancy sensor was not appropriate. Instead, a bed level PIR (movement sensor) was fitted in Emma's room and configured to alert staff if she leaves her bed. An override switch was fitted to enable the PIR to be turned on and off during the hours the telecare system is usually operational (9pm to 6am) to accommodate Emma's irregular sleeping patterns. Should Emma leave her bed during this time period, staff can switch off the PIR and switch it on again when she returns to bed.

Outcome

Emma is no longer woken up by care staff checking on her wellbeing whilst she is asleep, and seems more content. She enjoys company and because telecare has freed staff time, Emma is able to enjoy more one-to-one social interaction, improving her quality of life.

Results

A before and after survey showed staff saw a significant improvement in how well they were able to respect service users' privacy and automony.

Staff no longer feel they are invading people's privacy by making regular checks, or disturbing their sleep, yet still feel reassured that the people they are caring for are safe. Despite some initial scepticism about the technology, care workers at Hatton Grove now trust telecare, and find it a great support to them in their jobs. Care workers can also spend more quality time with the people living at Hatton Grove, and can accommodate individual needs and interests more easily.

Prior to telecare being used, staff spent much of their time, particularly at night, walking from room to room to check on the welfare of the people they support. Now they have been able to significantly reduce these regular checks, which has freed their time to undertake more meaningful activities, such as e-learning, to aid their professional development. Staff also have the time to write night reports in a much greater level of detail than was previously possible. This in itself has brought numerous benefits including enabling all stakeholders to gain a more holistic and detailed picture of a service user's health and wellbeing over a period of time and revealing any decline at an earlier stage than may otherwise be the case.

> "The epilepsy sensors are fantastic because we now don't disturb anyone through the night. We now only make one check to make sure service users are safe and comfortable."
>
> **Support worker at Hatton Grove**

Service users have not found the technology intrusive. Many of the sensors are largely invisible when in place, and those that aren't have not proven to be of interest to service users. The introduction of telecare has also helped family and friends to feel reassured that their loved-ones are safely supported.

Next steps

The staff at Hatton Grove remain committed to providing appropriate, personalised care and support, adapting plans according to the changing needs of the people who live there. The telecare solutions employed will evolve as part of these changing requirements. Over time, new service users will be welcomed to Hatton Grove, and their needs will be reviewed to assess how telecare may provide beneficial support.

Telecare has made significant improvements to the level of privacy and personalised care provided at Hatton Grove, and whilst it remains a residential care home, it is in no way an institution.

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"Safer Walking" Pilot Case Studies

Case study 1

Background

Mr P is an active 92 year old man who has been recently widowed. Prior to his wife's death, Mr P regularly visited his wife in a local care home and was known by the carers working in the home. Following his wife's death, Mr P continued to visit the home and the carers felt that he was becoming increasingly confused, forgetting that his wife had passed away.

Mr P's daughter, Jo, moved in with him to provide support with daily activities. She was not happy for her father to go out and often tried to keep him at home, which led to arguments.

Issue

On one occasion Mr P took it upon himself to reminisce and go to a place he used to live with his wife many years ago. When he arrived in the area he found it had changed and he was found by a resident "wandering" the street muttering to himself. When the resident approached him, Mr P repeatedly said "it has all changed, I don't recognise it". The resident was concerned that Mr P may be lost and called the Police. The police called an ambulance, and after checking him physically, the paramedic found an issue with Mr P's heart and took him to hospital. During this time Jo was becoming increasingly alarmed because her father had not returned home and began to search for him. Eventually she was informed he had been taken to hospital.

Solution

With his agreement, Mr P was issued with the Vega watch. The Vega watch is a purpose built system to aid safer walking for those with Alzheimer's disease or other cognitive disorders. The Vega watch allows wearers to walk freely in a predetermined safe zone but raises an automatic alarm should the wearer walk outside of this zone. The emergency button was deactivated as it was felt that Mr P would become distressed if he was contacted. Jo contacts her husband when she becomes concerned if her father is late home. Her husband looks on the secure website and passes on Mr P's location. Jo then makes a decision to leave him to make his own way home or goes to meet him.

Outcome

It appears Mr P has a regular route he walks in the local area. Although Mr P's daughter admits that she would prefer her father to stay at home, she is reassured knowing where he is and that he is safe, the number of arguments they have has reduced. Mr P continues to enjoy going out daily.

Case study 2

Background

Mr H is an 86 year old man who is diagnosed with dementia. He lives with his wife, Daphne, who provides support by prompting him to carry out personal activities of daily living. Mr and Mrs H's son and daughter have noticed that their father is becoming forgetful.

Issue

Mr H went out one day un-noticed by Daphne. When it was discovered that he had gone, Daphne become upset and called her family to help look for him. Not knowing which direction Mr H took, the police were called and a search of the area was started. Mr H was eventually found, seemingly making his way to work. Mr H used to work in central London and an underground station is close by.

Solution

Although Mr H does not recall the incident and does not recognise there is an issue with him going out, he acknowledges that his family worry if he goes out and agreed to use the Vega watch to help reassure them. The Vega watch has been set up to trigger an alarm to the monitoring centre if Mr H goes out beyond the Safe Zone. The monitoring centre contact his son and daughter giving directions to his location. His family are then able to supervise his safe return home. The emergency button has been de-activated as it was felt Mr H would become distressed if he was contacted.

Mr H's son and daughter visit weekly ensuring the battery is charged fully. As Mr H does not feel comfortable wearing the Vega watch he has consented to the family placing it in his jacket pocket.

Outcome

It appears that Mr H does not go out on a regular basis, however the Vega watch has reduced family stress by providing reassurance that Mr H can be safely located should he walk away from home. The family are confident enough in the support of the equipment to continue caring for Mr H at home.

Case study 3

Background
Mr B is an active 77 year old man who is diagnosed with dementia and lives with his wife, Catherine, who provides support with daily activities. Mr B goes out for a walk around the neighbourhood several times a day, taking a varied route each time and depending on how far he has walked, he would sometimes take a bus back home.

Mr B usually carries a mobile phone which his wife rings to check on his whereabouts, however he has recently began to ignore the phone ringing, or if he does answer it, he does not talk to his wife, leaving her very stressed and anxious.

Mr B has on occasions taken the wrong bus home and has been known to travel out of the borough. On one particular occasion Mr B did not return home and his wife was unable to raise him on the mobile phone. Frantic with worry, she called her family who all tried to contact him. After several hours Mr B eventually answered the phone and following his wife's instruction passed the phone to a nearby person who informed Catherine that they were travelling on a bus heading to High Wycombe. The passenger was able to direct Mr B to the correct bus to take him on a return journey. Mr B's family met him at the station. On another occasion Mr B travelled to Isleworth.

Issue
Mr B is increasingly getting on the wrong bus home, taking him out of his normal surroundings. It is becoming increasingly difficult for Catherine to maintain contact with her husband when he goes out and she is becoming increasingly stressed and anxious about his safety. This is having an impact on her social activities because she is reluctant to leave him on his own. Catherine is also restricting the number of times Mr B goes out alone.

Solution
The Vega watch was shown to Mr B and he agreed to use it to help support his wife and give her reassurance on his whereabouts. A geo-fence was set up incorporating the known routes Mr B walks. If he goes outside this safe zone an alert is triggered to the monitoring centre, who informs Catherine of his location. Catherine is then able to monitor his route and intervene if necessary.

Outcome
Initially, Catherine was receiving a high number of alerts indicating that Mr B often walks further than she realised. The Geo-fence was expanded to cover most of the routes he takes while ensuring an alert is triggered if he enters a high risk area where he can take a number of buses to various locations away from home.

Each time Mr B goes out Catherine is able to contact the monitoring centre who is able to give his location reassuring Catherine that he is safe and whether he is making a homeward journey. Mr B has entered a bus to Gerrards Cross and the police were called to help intervene, however before they could meet him he returned home of his own accord. After this episode Catherine now leaves him to travel for a number of hours, knowing that she can monitor his journey.

Catherine is able to continue with her voluntary work, and social activities. Mr B is able to continue to maintain his independence and enjoy walking. Catherine has recently purchased a new phone which has internet connection and is now able to monitor her husband's journeys.

Catherine stated that she is "more relaxed when her husband goes out on his travels reassured that she can monitor his journey". On the occasions that he has deviated from his normal route the "experience in finding him has been easier and better".

Catherine has been able to attend functions with her grandchildren that she would previously have had to miss as she would not have left her husband on his own.

OLDER PERSONS SERVICE AT BELL FARM CHRISTIAN CENTRE

REASON FOR ITEM

Below is a brief information item provided by Jane Cook, Director of Projects at Bell Farm Christian Centre, following the Member visit held on Tuesday 17 October 2017.

OPTIONS OPEN TO THE COMMITTEE

To consider the report as part of the ongoing review into loneliness and social isolation in older residents.

Older Persons

Aims and Objectives

- To provide a lunch and social club on one day per week.
- To provide outreach to the isolated older people in the community.
- To provide other activities to the older people in the community.
- To provide or obtain services for the older people in response to need.
- To share the Gospel with and provide pastoral care to the older people.
- Where appropriate, to provide support to the families and carers of older persons.

In the past year the Older Persons Lunch and Social club has continued to be a great success providing a healthy two course meal, the opportunity and socialise and an activity on a weekly basis. There are currently 96 regular members who have attended the luncheon club with three mini buses having been in operation each Tuesday to pick members up and take them back home. There are an additional 29 individuals who have come on trips and holidays. There is also a waiting list of people wanting to attend the luncheon club.

There are lots of different activities or entertainment that takes place each week for the club members to enjoy. Over the past year these have included:

Arts and craft classes
Weekly raffle
Green Fingers
Reminiscence classes
Musical sing-along
Live entertainment
Cinema afternoon

The Queens 90th birthday celebrations
Valentines party
Easter party
Christmas party
Mobile clothes shop

Day trips away have also been provided including additional trips for disabled older persons to Eastbourne, Worthing Margate, a pantomime, Windsor boat trip, Christmas lunch and a trip to see the Christmas lights in central London. A holiday took place to Folkestone.

Holidays are organised twice a year which have proved very popular. This is arranged through a holiday company to ensure the holiday is well organised and costs kept to a minimum. Places that have been visited have been the Isle of Wight and Devon. People attending the holiday club have valued the companionship, being on holiday and having fun.

Partnership work with the Doorway Advice Centre which is one of the projects at B.F.C.C. ensures that if people need help with their benefits then that is available. Following a referral to the luncheon club the manager of older person's service assesses people at home which includes an assessment of their financial situation. If a person is unable to attend the luncheon club or trips due to financial hardship then the fees for this would be waived and paid for by Bell Farm Christian Centre. Also any older person in financial need can also access the foodbank run by BFCC which is open on Tuesdays and Thursdays.

The club has continued to reduce loneliness and isolation among the older population.

A trip to Margate

Outreach Work

Over the past year the Older Persons' Manager has been visiting the isolated older persons in the community. These will have been referred by Age UK, Social Services or families. The Manager also visited Club members who have at times needed support or

even if they have just felt lonely and wanted someone to talk to – as often happens. The Manager also has supported older persons who have been at risk in the community and alongside other agencies has successfully moved clients into safer sheltered housing where there has been a consequential improvement in the quality of their lives. The Manager carried out 82 home visits, 20 hospital visits, has attended 3 funerals and is available by phone for those members who have emergencies and need support, especially where they have no family or their family lives a considerable distance away.

Volunteers

The Older Persons' Lunch and Social Club relies heavily on the hard work of the dedicated team of volunteers. There are currently 10 volunteers who help out each week and do a fantastic job.

Comments from Service Users

"So *far it's wonderful, good work"*

"It is fantastic and does a lot for Drayton Village Care Centre, they love it."

"The lunch club serves a much needed facility, something to look forward to, the benefits are indescribable"

"I think the club is great. I like everything about it"

"People are always friendly"

The main hall prepared for the older persons' Christmas lunch

Total Service Users	Disabled	Male	Female	LBH Residents
125	36%	26%	74%	98%

Ethnicity

White British	Black British	Asian	Eastern European	European	Other White	Black Caribbean
89.6%	0	1.6%	0%	0%	0.8%	1.6%
Black African	**Indian**	**Pakistani**	**Mixed Race**	**Irish**	**Any other ethnic background**	**Not recorded**
0%	1.6%	0%	0%	3.2%	1.6%	0%

Support at Christmas

On Christmas Day a lunch and other activities were provided for individuals who otherwise would have been alone on Christmas Day. The day included a full Christmas lunch, games, other activities and gifts for all. The event was provided by volunteers and funded by personal donations. 40 people attended the event, 15 of whom were over 65 years of age and one of whom was disabled.

Factors affecting the achievement of the objectives of the organisation are as follows:

1. The position of the organisation within the wider community. BFCC has a very good relationship with the local community, including good working relationships with the local Members of Parliament, Ward Councillors and other agencies working in the area. This provides a good platform for partnership working.

2. BFCC has a very good relationship with members of the local community and many members of the local community are very happy to be able to attend the activities and services that are provided at the Centre. This is particularly good for the sections of the community that are particularly marginalised and vulnerable. The Organisation is pleased that some of these groups such as the Travellers and migrants feel able to attend the activities.

3. BFCC has a good relationship with funders. Agencies and funders have often approached BFCC to see if they would deliver services on their behalf if funding was provided, or to work in partnership with them to deliver services.

4. BFCC has a good, hardworking and loyal work force and all its members of staff are highly motivated and committed to the work that they do.

5. BFCC has a hard working and loyal group of volunteers who help deliver the services to the local community.

JE.Cook Director of Projects
17th October 2017

CABINET FORWARD PLAN

Contact Officer: Neil Fraser
Telephone:01895 250692

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 - 16 November 2017									
200	**2017/19 Better Care Fund Plan Section 75 Agreement**	Cabinet will be asked to approve the agreement with Hillingdon Clinical Commissioning Group, that will give legal effect to the financial arrangements in the 2017/19 Better Care Fund plan approved by the Health and Wellbeing Board.	All		Cllr Philip Corthorne	SC - Gary Collier	Health and Wellbeing Board, CCG		Public
210	**Older People's Plan Update**	Cabinet will receive its twice yearly update on progress on the Older People's Plan (May and November annually).	All		Cllr Ray Puddifoot MBE / Cllr Philip Corthorne	CEO - Kevin Byrne	Older People, Leader's Initiative	**NEW**	Public

214	**Hillingdon Homelessness Prevention Strategy 2017 to 2022**	Following Member approval to consult, Cabinet will consider the outcome of the consultation proves and comments received before formally approving the Hillingdon Homelessness Strategy 2017 to 2022.	All		Cllr Philip Corthorne	RS - Dan Kennedy / Debby Weller		**NEW**	Public

WORK PROGRAMME 2017/18

Contact Officer: Neil Fraser
Telephone: 01895 250692

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 note dates for meetings 2017/18

2. To make suggestions for future working practices and/or reviews for the year 2017/18.

INFORMATION

All meetings to start at 7.00pm

Meetings	Room
28 June 2017 - CANCELLED	**CR 6**
20 July 2017	**CR 6**
5 September 2017	**CR 6**
2 October 2017	**CR 6**
6 November 2017	**CR 5**
7 December 2017	**CR 6**
23 January 2018	**CR 6**
27 February 2018	**CR 6**
22 March 2018	**CR 6**

Social Services, Housing and Public Health Policy Overview Committee

Work of the Committee 2016/17

20 July 2017	Budget Planning Report for SS,Hsg&PH
	Final Major Review Witness Session - Benefit Reforms
	Scoping Report for next Major Review
	Work Programme 2017/18
	Cabinet Forward Plan

5 September 2017	Major Review - Benefits Final Report
	Major Review Witness Session - Loneliness and Isolation in Older Residents
	Annual Complaints Report
	Cabinet Forward Plan
	Work Programme

2 October 2017	Major Review Second Witness Session - Loneliness and Isolation in Older Residents
	Annual Report: Adult Safeguarding Board
	Cabinet Forward Plan
	Work Programme

6 November 2017	Update on the Use of Assistive Technology/Telecare Line
	2017/19 BCF Plan
	Cabinet Forward Plan
	Work Programme

7 December 2017	Adult Safeguarding Board - Report

Part I - Members, Public and Press

Social Services, Housing, and Public Health Policy Overview Scrutiny Committee - 6 November 2017

(reserve meeting)	Major review Draft Final Report: Loneliness and Isolation

23 January 2018	Council Budget 2018/19
	Cabinet Forward Plan
	Work Programme

27 February 2018	Presentation/Information Item - TBC
	Cabinet Forward Plan
	Work Programme

22 March 2018	Stroke Review - Update Report
	Cabinet Forward Plan
	Work Programme

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