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# External Services Scrutiny Committee

**Councillors on the Committee**

Councillor John Riley (Chairman)
Councillor Ian Edwards (Vice-Chairman)
Councillor Teji Barnes
Councillor Mohinder Birah
Councillor Tony Burles
Councillor Brian Crowe
Councillor Phoday Jarjussey
Councillor Michael White

**Date:** **WEDNESDAY, 11 OCTOBER 2017**

**Time:** **6.00 PM**

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

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

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# Terms of Reference

1. To scrutinise local NHS organisations in line with the health powers conferred by the Health and Social Care Act 2001, including:

   (a) scrutiny of local NHS organisations by calling the relevant Chief Executive(s) to account for the work of their organisation(s) and undertaking a review into issues of concern;

   (b) consider NHS service reconfigurations which the Committee agree to be substantial, establishing a joint committee if the proposals affect more than one Overview and Scrutiny Committee area; and to refer contested major service configurations to the Independent Reconfiguration Panel (in accordance with the Health and Social Care Act); and

   (c) respond to any relevant NHS consultations.

2. To act as a Crime and Disorder Committee as defined in the Crime and Disorder (Overview and Scrutiny) Regulations 2009 and carry out the bi-annual scrutiny of decisions made, or other action taken, in connection with the discharge by the responsible authorities of their crime and disorder functions.

3. To scrutinise the work of non-Hillingdon Council agencies whose actions affect residents of the London Borough of Hillingdon.

4. To identify areas of concern to the community within their remit and instigate an appropriate review process.

# Agenda

## Chairman's Announcements

## PART I - MEMBERS, PUBLIC AND PRESS

**1** Apologies for absence and to report the presence of any substitute Members

**2** Declarations of Interest in matters coming before this meeting

**3** Exclusion of Press and Public

To confirm that all items marked Part I will be considered in public and that any items marked Part II will be considered in private


| | | |
|---|---|---|
| **4** | Minutes of the meeting on 6 September 2017 | 1 - 6 |
| **5** | Minutes of the meeting on 14 September 2017 | 7 - 14 |
| **6** | Population Growth Planning by Utility Companies | 15 - 22 |
| **7** | 2017/2019 Better Care Fund Plan | 23 - 50 |
| **8** | Work Programme 2017/2018 | 51 - 56 |


## PART II - PRIVATE, MEMBERS ONLY

**9** Any Business transferred from Part I

# Minutes

**EXTERNAL SERVICES SCRUTINY COMMITTEE**

**6 September 2017**

**Meeting held at Committee Room 5 - Civic Centre, High Street, Uxbridge UB8 1UW**

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| | **Committee Members Present**:<br>Councillors John Riley (Chairman), Ian Edwards (Vice-Chairman), Teji Barnes, Mohinder Birah, Tony Burles, Brian Crowe, Phoday Jarjussey and Michael White<br><br>**Also Present**:<br>Claire McDonald, Communications and Engagement Adviser, NHS England<br>Hazel Fisher, Head of Delivery for NWL, Specialised Commissioning London, NHS England (London)<br><br>**LBH Officers Present**:<br>Dr Steve Hajioff (Director of Public Health) and Nikki O'Halloran (Democratic Services Manager)<br><br>**Press and Public: 2** |
| 15. | **EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 3)*<br><br>**RESOLVED: That all items of business be considered in public.** |
| 16. | **MINUTES OF THE PREVIOUS MEETING - 11 JULY 2017** *(Agenda Item 4)*<br><br>**RESOLVED: That the minutes of the meeting held on 11 July 2017 be agreed as a correct record.** |
| 17. | **PROPOSALS TO IMPLEMENT STANDARDS FOR CHD SERVICES FOR CHILDREN AND ADULTS IN ENGLAND** *(Agenda Item 5)*<br><br>The Chairman welcomed those present to the meeting. He noted that the Committee had already heard from representatives from the Royal Brompton and Harefield NHS Foundation Trust and were now looking to gain an understanding of NHS England's position in relation to the proposals regarding congenital heart disease services in England. Members had previously expressed concerns about the impact of the proposals on, and perception of, residents in Hillingdon. As this issue was close to residents' hearts, it would be important to ensure that expectations were managed.<br><br>Ms Claire McDonald, Communications and Engagement Adviser at NHS England (NHSE), advised that the congenital heart disease services being reviewed were those that cared for people who were born with the disease. Over the last 16-18 years, there had been a range of national and local service delivery changes with the most recent proposals being a standards-based solution rather than numbers-based solution. As a result of significant and lengthy consultation, 200 standards had been agreed in 2015 for each of the three levels of care (1: surgical and interventional; 2: ongoing care and minor interventional; 3: ongoing care closer to home) in children's and adults services. Since then, NHSE had assessed each of the centres and worked with providers to |

determine how they were going to be able to meet all of the standards. Once the majority of patients had undergone surgery in a Level 1 centre (hub), they would then receive ongoing regular monitoring from a more local Level 3 hospital (spoke). Receiving this care closer to home enabled patients to live a more regular life.

Ms McDonald advised Members that the standards had not been developed on a cost basis and that parents and children had been encouraged to identify those elements that made their stay in hospital more comfortable (for example, the availability of onsite accommodation for parents, wifi, etc). NHSE had worked with providers to identify where capital investment would be needed and these providers had assured NHSE that this investment to meet the standards had already been provided for within their budgets so there would be no need for additional funding. It was thought that providers had already anticipated the increasing demand / projected growth and had put plans in place to address this. Great Ormond Street Hospital (GOSH) had advised that it would bring forward its expansion plans and Evelina had stated that it would be able to accommodate the growth. Members found it difficult to accept that the implementation of the proposals would not need additional funding from NHSE.

Congenital heart disease covered a huge range of conditions of varying severity. Members were advised that, to ensure that skills were maintained, the standards included positive volume outcomes where each surgeon needed to complete at least 125 surgeries per year and work in a team of four surgeons. This would ensure that each surgeon was performing a number of the same operation on the same type of congenital heart issue each year. It was thought that there were about 38 surgeons in the country (who shared their expertise) and about 5,000 surgeries performed each year. Members were advised that the more surgeries undertaken by each surgeon, the better the patient outcomes. The collocation of services standard would ensure that patients with comorbidities had specialist staff on hand at the same site to deal with those conditions.

Members were assured that the congenital heart disease services being reviewed were not performed at Harefield Hospital so the impact on that centre was likely to be minimal and the expertise there would be retained. With regard to resources, it was suggested that the financial impact mentioned in the consultation document would be largely offset by the savings made through a reduction in overhead costs. It was thought that the £7m annual 'stranded costs' mentioned in the report related to those costs at Royal Brompton relating to the congenital heart disease service that would not be able to be transferred or scaled back. As such, Royal Brompton would need to look at its longer term financial planning.

It was noted that adult cardiology and respiratory services would continue at Harefield Hospital. The expectation was that there would be strong relationships between the centres providing all three levels of care. To this end, there would be a Level 3 provision included in network meetings.

The consultation document proposed the withdrawal of children's congenital heart disease services from Central Manchester, Leicester and Royal Brompton. The consultation ran from February 2017 to 17 July 2017 and prompted around 7,500 responses. NHSE was currently reviewing these responses and looking at the suggested impact and alternative methodology put forward by some of the providers.

An article had appeared in the HSJ on 18 July 2017 about Royal Brompton investigating the relocation of its congenital heart disease services to St Thomas' Hospital to achieve world class standards. Although NHSE would now need to assess

this proposal from Royal Brompton, it was anticipated that this development would meet the collocation standard.

Ms Hazel Fisher, Head of Delivery for North West London, Specialised Commissioning at NHSE, advised that NHSE had received no concerns from Royal Brompton about the wider sustainability of the Trust. Any joint arrangements with Guy's and St Thomas' would need to go through three stages: training and staff rotation across the sites to build a cohesive unit; children's services were already provided from the Evelina so services were collocated; adult services would move over and research capacity could be built. Although it was not mentioned in any detail in the consultation document, ideally, children would receive surgery in a hospital specifically for children rather than adults. The new proposal from Royal Brompton would go some way to meeting some of the standards.

Members were advised that it was hoped that the consultation responses and the new alternative proposals suggested by providers (including the proposal from Royal Brompton) would be considered by NHSE Board on 28 September 2017. If this was not possible (as there was a significant amount of work involved in getting this information processed ready to be presented), it was thought that an additional Board meeting would be scheduled as soon after this date as was practicable. It would be important to progress any agreed changes as soon as possible to relieve the uncertainty currently experienced by staff and patients. However, NHSE would need to look at the feasibility of the alternative proposals (likely to be in December 2017) which would be followed by a significant amount of investigation.

Ms Fisher advised that, if children's congenital heart disease services were withdrawn from Royal Brompton, GOSH and Guy's and St Thomas' had indicated that they had planned additional capacity that would be able to absorb the additional activity that the change would create.

It was noted that the number of surgeries undertaken each year was increasing and survival rates were also increasing which meant that children were living much longer lives than previously experienced. Furthermore, congenital heart disease was more prevalent in the Asian community who tended to live in concentrated areas, of which West London was one. Ms Fisher advised that these national and local growth rates and geographical locations had been taken into account as well as the number of surgeons required.

With regard to monitoring centres' adherence to the standards, a dashboard was being developed to focus on a number of key standards to enable NHSE to monitor issues such as patient experience. Three patient representatives had been involved in the development of this dashboard. If the dashboard highlighted any failings, NHSE would be able to take swift action to address the issues.

Ms McDonald stated that patient outcomes in the UK were very good. National Institute for Cardiovascular Outcomes Research (NICOR) collected clinical information from UK hospitals into secure registries established by the cardiovascular specialist societies. This helped to improve quality of care by checking that the care received by heart disease patients met good practice standards. This was done by conducting clinical audit and by comparing patient outcomes, such as readmission rates.

It was noted that there had previously been significant changes to the provision of services in Oxford. The adjustment process during this period of change had been refined and could now act as a blueprint for future significant service changes. Ms

McDonald advised that an unplanned collapse of services would have more of an impact than a planned change and, as such, implementation plans would need to be worked through with staff to maximise success.

Ms McDonald noted that the paediatric intensive care unit (PICU) at Royal Brompton would be at risk (reduced demand) if congenital heart disease services were no longer provided from the site as only patients with respiratory problems would be supported there. Members were advised that a PICU / ECMO review was currently underway and was being expedited to align with the congenital heart disease review to ensure that all requirements were met. NHSE was mindful of the impact of one service on another as well as the need to move swiftly but thoroughly to avoid any possible judicial reviews.

It was noted that if the PICU at Royal Brompton were to close, there was already sufficient capacity in the GOSH PICU to meet the demand. The national PICU review was likely to identify the optimal number of beds needed to ensure that the capacity was available to meet demand.

Concern was expressed that the review of congenital heart disease services had been ongoing in one form or another for a long time which had exacerbated uncertainty amongst patients and staff. Ms McDonald stated that NHSE had spent a lot of time rebuilding relationships and that it had been the community that had identified the need for standards to be in place.

Recruitment and retention had been an ongoing challenge in the NHS for some time and it was recognised that there was currently a degree of anxiety at Royal Brompton. It was noted that there was an opportunity with the alternative proposition to meet the collocation standard and that this proposition identified the need to rotate and build a single body of staff. Although surgeons would often move from one area in the country to another, this was not the case with nursing staff. Most of the nurses at Royal Brompton lived in London and it would be important that the support of staff be a key component in any changes implemented.

Although there was no empirical evidence available to suggest that collocation had better outcomes for children, the Royal Society of Paediatrics and Child Health had asserted that children did better as a whole if they were in a child specific environment. This meant that different teams worked together regularly in a child centred environment and therefore patients did not need to visit multiple centres for multiple conditions. The Clinical Advisory Panel had also emphasised the need for collocation despite there not currently being any empirical evidence to support better patient outcomes.

Members noted that Newcastle had been given special dispensation with regard to not meeting the standards and that this would raise the issue of fairness. Ms McDonald noted that Newcastle was currently in the process of developing plans for collocation. The centre dealt with advanced heart failure and provided the one of two paediatric heart transplant services in the country. However, there were no clear timescales for when the centre was expected to meet the standards. Members queried whether this leniency had been borne of geographical requirements but were advised that it was difficult to move a transplant service to another centre. It was anticipated that Newcastle would meet the collocation and volume standards but the logistics of how this would be achieved had not yet been established. It was suggested that a mobile transplant team might be the way forward.

It was noted that NHSE's proposals should not result in a worse situation. Ms

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| | McDonald advised that the provision of a service in only one location was not advisable. As such, the decommissioning of a service that was only available in one centre could not be undertaken until the service had been established elsewhere.<br><br>With regard to the hub and spoke model, it was noted that travel and accommodation could be an issue for some patients and their families. As such, the provision of multiple services in a particular centre (that was possibly a long way from the patient's home) with ongoing care located in a spoke that was closer to the patients home was seen as a good thing.<br><br>Members were advised that the transition from children's services to adult services mentioned in the consultation document referred to ensuring that the handover from one centre to another and the communication between them was seamless. This would be particularly important where a patient had moved from one city to another. It was noted that St Bartholomew's and GOSH had advised NHSE of their transition arrangements which were already in place.<br><br>**RESOLVED: That the discussion be noted.** |
| 18. | **WORK PROGRAMME 2017/2018** *(Agenda Item 6)*<br><br>Consideration was given to the Committee's Work Programme. Members were advised that the Community Sentencing Working Group would be meeting on 21 September 2017 and that there were still challenges in getting a representative from the Community Rehabilitation Company to attend a meeting.<br><br>The GP Pressures Working Group witness sessions had taken place in 2015/2016. Although the final report had been drafted, there had since been significant changes within the health sector. As such, the Chairman had requested that two additional witness sessions be organised to refresh the information that had already been received and to enable Members to speak to a representative from the Royal College of GPs.<br><br>At its meeting on 14 September 2017, the Committee would be hearing from the Borough Commander in relation to the MOPAC & MPS Public Access and Engagement Strategy consultation and would also consider a report on LAC offending. The Cabinet Member for Community Commerce and Regeneration would be responding to the consultation on behalf of the Council and any comments made by Members would be forwarded to him. It was noted that the Council's Chief Executive had expressed an interest in this matter and would be attending the meeting to watch proceedings from the public gallery.<br><br>**RESOLVED: That the Work Programme be noted.** |
| | The meeting, which commenced at 6.00 pm, closed at 7.47 pm. |

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

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**Minutes**

**EXTERNAL SERVICES SCRUTINY COMMITTEE**

**14 September 2017**

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

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| | **Committee Members Present**:<br>Councillors John Riley (Chairman), Teji Barnes, Mohinder Birah, Tony Burles, Alan Chapman (In place of Ian Edwards), Brian Crowe, Phoday Jarjussey and Michael White<br><br>**Also Present**:<br>Steve Ashley, Chairman, Local Safeguarding Children Board / Safeguarding Adults Partnership Board<br>Dan Kennedy, Deputy Director Housing, Environment, Education, Health and Wellbeing<br>Tom Murphy, Assistant Director of Early Intervention Prevention & SEND<br>Jacqui Robertson, Service Manager for Community Safety<br>Colin Wingrove, Borough Commander, Hillingdon Metropolitan Police Service<br><br>**LBH Officers Present**:<br>Nikki O'Halloran (Democratic Services Manager)<br><br>**Press and Public: 2** |
| 19. | **APOLOGIES FOR ABSENCE AND TO REPORT THE PRESENCE OF ANY SUBSTITUTE MEMBERS** *(Agenda Item 1)*<br><br>Apologies for absence had been received from Councillor Ian Edwards (Councillor Alan Chapman was present as his substitute). |
| 20. | **EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 3)*<br><br>**RESOLVED: That all items of business be considered in public.** |
| 21. | **MAYOR'S OFFICE FOR POLICING AND CRIME AND METROPOLITAN POLICE SERVICE: PUBLIC ACCESS AND ENGAGEMENT STRATEGY** *(Agenda Item 4)*<br><br>The Chairman thanked the Borough Commander, Mr Colin Wingrove, for attending, particularly as he had also been presenting at an event about the same issue in the Council Chamber the previous evening. Mr Wingrove had been pleased with the attendance at that event which gave members of the public the opportunity to comment on the proposals. It was noted that the deadline for consultation responses was 5.30pm on 6 October 2017.<br><br>The MPS had been engaging with members of the public and encouraging responses to the consultation through Facebook, Twitter and, more locally, in Hillingdon People. However, it had still been challenging to get residents to attend the consultation events.<br><br>Members were advised that the strategy had been worked up by the Mayor's Office for |

Policing and Crime (MOPAC) and not by the Borough. It covered all 32 London boroughs and had been brought about by the need to save £400m on top of the £600m already saved. The first round of savings had resulted in the outsourcing of some back office functions and a reduction in the number of PCSOs. It was anticipated that the proposals would result in revenue and capital savings and would include an additional 800 new police officers.

The Metropolitan Police Service (MPS) currently occupied more than 400 buildings across London and it was anticipated that the proposals would reduce this number to around 100. Each borough would have one police station which was open 24/7 - the proposal was that, in Hillingdon, this control centre would be on the current Hayes site. The stations in Uxbridge and Ruislip would be sold off and the Northwood station would be returned as per the building's covenant. Mr Wingrove noted that the Uxbridge site would sell for more money than the Hayes site and cost more to maintain. The proposals would include the refurbishment and modernisation of Hayes police station to accommodate the additional 200 officers that would need to be decanted from Uxbridge. The detail of this work had not yet been determined. It was suggested that the projected value of the Hayes site would increase with the advent of Crossrail so that it was more in line with (or exceeded) the value of the Uxbridge site.

Members queried whether an adequate cost benefit analysis of the proposals had been undertaken (which included the impact on services and operational ability) and whether the value of the sale of Uxbridge and the refurbishment of Hayes would cancel each other out. Concern was expressed about whether Hayes, even after development, would have sufficient capacity for staff and whether consideration had been given to developing a brand new purpose built station in the Borough. It was noted that there were operational advantages and disadvantages to both sites, for example, demand was greater in Hayes, Yiewsley and West Drayton but Uxbridge would be more visible and was closer to Brunel, the London Underground and major road networks.

Each of the 32 London boroughs previously had their own Borough Command. Pilots had been undertaken to group some boroughs together into single command structures/Basic Command Units (BCUs) in order to deliver a better and more efficient service. Although the performance of / learning from these pilots had not yet been evaluated / analysed, if BCUs were to be rolled out across London, Hillingdon would be partnered with Ealing and Hounslow and consideration would be given to the structure of specialist teams.

Concern was expressed about the restructuring of specialist services and how they would communicate with Borough officers. This communication was critical with regard to child protection conference and strategy meetings so it would be essential that social workers were able to contact the relevant officers out of hours. Mr Wingrove advised that Islington/Camden had created a safeguarding umbrella for a number specialist units where officers worked shifts to cover 24/7. He also assured Members that many local arrangements, such as MASH, would remain in place but that other additional arrangements would also be put in place.

Hillingdon was a large borough bordered multiple counties and which was impacted by issues such as HS2. As such, it would be important to ensure that consideration was given to locating patrol cars in Ruislip and Hayes as part of the new arrangements. It was noted that Ealing was a smaller and more compact borough but that it would experience similar patrol car coverage issues as its police station was likely to be in Acton.

Members were advised that the number of Dedicated Ward Officers (DWOs) in each Hillingdon ward had increased from 1 to 2 in 2016 and had resulted in very positive feedback. Public confidence had increased over the last year from 56% to 64%.

It was thought that police officers' use of mobile technology would be helpful and would enable them to be more responsive. Tablets would be rolled out to all front line officers in mid-October and, unlike the rest of their equipment, they would be allowed to take them home. Officers would be given power packs to ensure the batteries for their tablets lasted for the duration of their shifts. A trial of mobile technology in Hammersmith and Fulham had freed officers up for at least one hour each day and had proved very popular.

Investigations were currently underway to identify partner locations around the Borough that could be used as hubs for DWOs. The Council and other partners had been supportive of this concept. It was anticipated that hubs would be based near to DWOs' patrol areas and would be accessible. Mobile technology would be key and would help to improve efficiency through the increased use of Skype and the collection of CCTV footage (an application was being developed for businesses to be able to transfer encrypted files to the MPS). As the DWOs would be able to access information remotely, they would be able to update reports on vulnerable adults and children, which would assist with safeguarding.

It was recognised that an increased police presence was an important part of effective policing which provided a visible deterrent.

Hillingdon's major custody suite was based at Polar Park which would be affected by the third runway at Heathrow if it went ahead. Individuals arrested by police officers in Hillingdon would generally be transported to Polar Park to be held in custody.

Concern was expressed that the location of DWOs in hubs around the Borough, rather than working from a central base, would reduce contact between police officers and potentially have a negative impact on team working and camaraderie. Mr Wingrove noted that Hillingdon was currently a people-centric Borough with police officers being able to access support services such as counselling, the wellbeing forum and professional development days. Consideration would need to be given to how this approach to staff would be maintained with regard to remote working, particularly from a supervisor perspective. To this end, where possible, Mr Wingrove tried to contact every officer in Hillingdon that was injured in the line of duty to ensure that they were looked after. Plans had been put in place to monitor staff wellbeing and the leadership would need to ensure that remote workers were adequately supported.

Mr Wingrove advised that the proposals also included an increase in the number of Safer Schools Officers (SSOs) to ensure that every school had access to one. Concern was expressed that if there were fewer police stations, the schools would become a substitute station. Members were assured that SSOs were associated with specific schools.

The consultation had already prompted a significant number of detailed questions about the logistics of the proposed changes. However, as the proposals were still in the early stages, this level of detail had not yet been worked out.

Mr Wingrove noted that there had been a soft launch of the new online service. Despite not advertising the facility, there had been an increase in its usage. The soft launch had enabled the MPS to smooth out any wrinkles in the system. Users were only able to report less serious crimes through the online service and the website would force the user to call the police if the crime were more serious.

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| | It was anticipated that online and telephone investigations would evolve over time. The MPS was aiming to increase the number of telephone investigations from 34% to 40%. It was noted that 101 operators assessed calls as they came in and passed them on to the relevant team to progress. This process freed up officers from having to visit every victim or scene of crime so that they could concentrate on more urgent issues. Clearly, there were some crimes where it would be important for officers to visit and speak to victims face to face.<br><br>It was recognised that the introduction of web contact could ease the pressure on the 101 service. As demand had already increased by 12%, plans were in place to improve the way that this contact was dealt with as well as how to reduce the demand on the service in conjunction with partners (for example, monitoring repeat callers who were known to multiple organisations). Demand varied and an algorithm was used to determine the right number of officers and put them in the right place at the right time. Members were assured that any hate crime reported through Twitter was dealt with quickly.<br><br>The service would need to ensure that plans were in place with regard to how these proposals would actually work on the ground: consideration would need to be given to how an officer's day would actually look like; where their equipment would be stored; and where they would park their personal vehicles. Mr Wingrove acknowledged that staff engagement would be a very important part of the process and that a team was in place to work on the fine detail through a sophisticated change programme.<br><br>If they were interested, Mr Wingrove invited Members of the Committee to ride along with a member of his team to experience their working day first hand.<br><br>**RESOLVED: That:**<br>**1. the Committee's comments be forwarded to the Cabinet Member for Community, Commerce and Regeneration; and**<br>**2. the presentation be noted.** |
| 22. | **THE CRIMINALISATION OF LOOKED AFTER CHILDREN (LAC)** *(Agenda Item 5)*<br><br>As the criminalisation of looked after children (LAC) fell within the remit of more than one Policy Overview and Scrutiny Committee, the Chairman and Labour Lead of the Children, Young People and Learning Policy Overview Committee had been invited to participate in this item.<br><br>Mr Tom Murphy, the Council's Assistant Director of Early Intervention Prevention & SEND, advised that the Strategy and Protocol attached to the report set out the activity between the police, social care and youth offending, primarily around placements. The effectiveness of the Strategy and Protocol would be regularly monitored by the Corporate Parenting Board.<br><br>Where a LAC had committed a crime, staff in children's homes would be more likely to call the police than foster carers who tended to deal with the situation as they would with their own child. As such, consideration needed to be given to how the police were equipped to make a judgement about an individual child (culturally and professionally) in a care home.<br><br>It was noted that Children in Care (CiC) were disproportionately represented within the criminal justice system. As the corporate parent, the Council had a responsibility to work with the police to put local arrangements in place to ensure that |

proportionate/balanced action was taken to deliver justice.

It was suggested that the police formed a wider part of the community parenting community and recognised that the relationship between the Council and the police was good. Mr Murphy noted that the protocol had helped the Council to assist the police in their duties and raise awareness of people in care that had issues which made their transition from child to adult more challenging.

One of the three children's homes in the Borough had had 51 police attendances in the last quarter (37 of which were in relation to one child). Mr Murphy advised that the majority of police attendances had been curfew related.

Members were advised that there were currently 12 children currently deemed to be missing from care. However, 7 of these were thought to be immigration absconders. Mr Murphy would forward further details regarding absconders to Democratic Services for circulation to Members.

It was suggested that children in foster care were less likely to have a lot of other children at home and therefore proportionately less likely to be exposed to negative influences. Furthermore, children admitted to care homes were likely to be older so it was more challenging to correct poor behaviour. It was noted that children could become LAC because they had a criminal episode or could have a criminal episode because they were LAC.

Concern was expressed that children in foster care experienced breakdowns in communication with their carers because of the child's criminal behaviour. Furthermore, appearances in court were seen by some of these children as a badge of honour and they needed to be educated about the impact of the behaviour in terms of their future. As the application of principles and approach in the Strategy and Protocol applied to children foster care and care homes, Mr Murphy would ensure that the documents were updated to be more explicit. It was suggested that this education be delivered by the care homes and that consideration be given to addressing the emotional root causes of the behaviour before it became an issue. Programmes such as Unique Swagga offered young people a diversionary opportunity to turn their lives around.

It was queried whether it needed to be the police that dealt with all calls from care homes as this could result in the badge of honour or the start of a stigma. Furthermore, it was suggested that there would be benefit to postponing police action in some cases and clear guidelines on when to charge children. As such, Members requested that the wording in paragraph 2.3 be updated to state that there would be a *presumption* that the police would not necessarily arrest. Mr Murphy would revisit this wording to ensure that the best solution was derived from the given circumstances.

With regard to out of borough placements, the Council was still the corporate parent to these children. It was suggested that consideration be given to putting children in placements outside of Hillingdon where they were taken away from local negative influences and potentially minimising the risk of further offending. It was also queried as to the extent that CiC were given opportunities that were normal to other children, such as membership of uniformed groups (Air Cadets, Police Cadets, Scouts, Guides, St John's Ambulance, etc), sports clubs and creative activities, and whether they took up these opportunities. The Hillingdon Virtual School provided activities for LAC at certain times of the year but these were not clubs where the children could be part of a group of children that regularly met. Mr Murphy would establish whether there was any

data available on memberships and, if there was, forward it to Democratic Services for circulation to the Committee.

Members requested that the services provided by the Council (and perhaps other organisations) be linked to the Strategy and Protocol. Mr Murphy noted that paragraph 2.6 of the Protocol mentioned signposting to other services/partners. However, consideration would need to be given to how the wider offer could be plugged in.

It was noted that one of the Corporate Parenting Sub Groups had been investigating the possibility of a leisure card for LAC. This type of scheme had been implemented in other parts of the country with the possibility of reciprocal arrangements with other local authorities where their LAC had been placed out of borough. Progress was being made in Hillingdon.

Concern was expressed that, if the police attended, it was a judgement call as to whether or not the young person was arrested which could then result in a criminal record. LAC taken to a police station were likely to have to wait up to eight hours before someone arrived to represent them who they may never have met before (it was important to get a social worker there as soon as possible to support the child in the same way that other parents would). These children would be given different advice and treated differently to non-LAC. It was noted that if every parent phoned the police every time their child missed their curfew, the police would be very very busy.

CiC were often labelled as being trouble. There were some school staff who had complained about the number of LAC that they had to take in. These staff should be reminded that LAC were children and should not be labelled in this way.

It was suggested that the Strategy and Protocol needed to be forwarded to the LSCB and other bodies to ensure that there was buy in and the expectations of other agencies needed to be clear. Mr Murphy advised that the content of these documents had been coproduced by the police, Council and other partners.

Concern was expressed about the possible closure of Mulberry Parade Children's Home. Mr Murphy would speak to colleagues in Social Care to establish what was happening. It was suggested that the future care of these children needed to be considered by the Corporate Parenting Board.

The Committee wanted to stress that crime was not an inevitability for LAC. It would be important to ensure that all agencies signed up to the approach being proffered and that the police identified alternative action to arrest.

**RESOLVED: That:**

1. **Mr Murphy forward further details regarding absconders to Democratic Services for circulation to Members;**
2. **Mr Murphy ensure that the Strategy and Protocol documents were more explicit about the inclusion of foster care;**
3. **Mr Murphy establish whether any data was available on memberships and, if there was, forward it to Democratic Services for circulation to the Committee,**
4. **Mr Murphy speak to colleagues in Social Care to establish what was happening with Mulberry Parade Children's Home; and**
5. **the presentation be noted.**

| | |
|---|---|
| 23. | **WORK PROGRAMME 2017/2018** *(Agenda Item 6)*<br><br>Consideration was given to the Committee's Work Programme.<br><br>**RESOLVED: That the Work Programme be noted.** |
| | The meeting, which commenced at 6.00 pm, closed at 8.32 pm. |

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

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# EXTERNAL SERVICES SCRUTINY COMMITTEE - POPULATION GROWTH PLANNING BY UTILITY COMPANIES

**Contact Officer:** Nikki O'Halloran
**Telephone:** 01895 250472

## REASON FOR ITEM

To enable the Committee to receive updated on the action being taken to ensure that the growing demand for utility services in Hillingdon has been planned for and will be met.

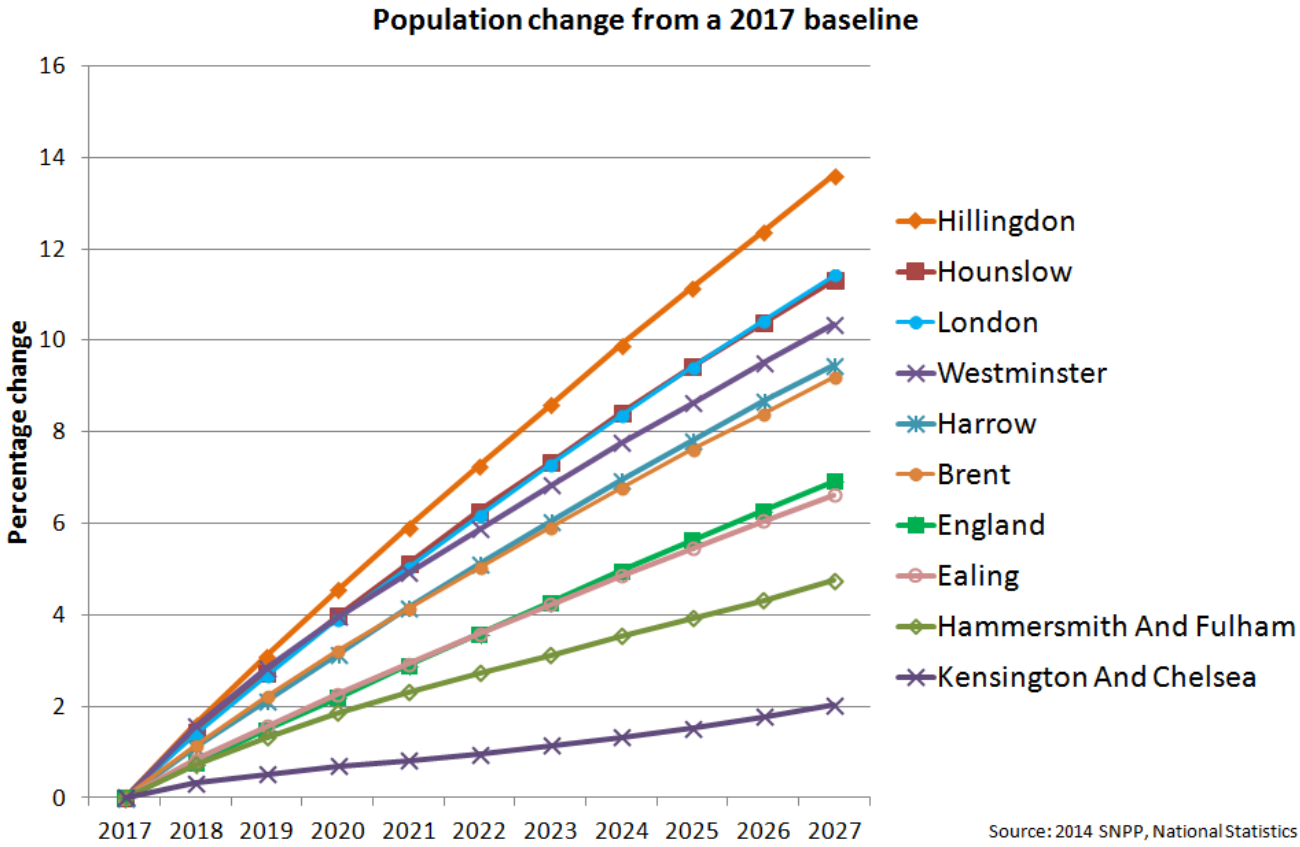
## OPTIONS AVAILABLE TO THE COMMITTEE

- Ask the witnesses questions as required.
- Make recommendations to address issues arising from discussions at the meeting.

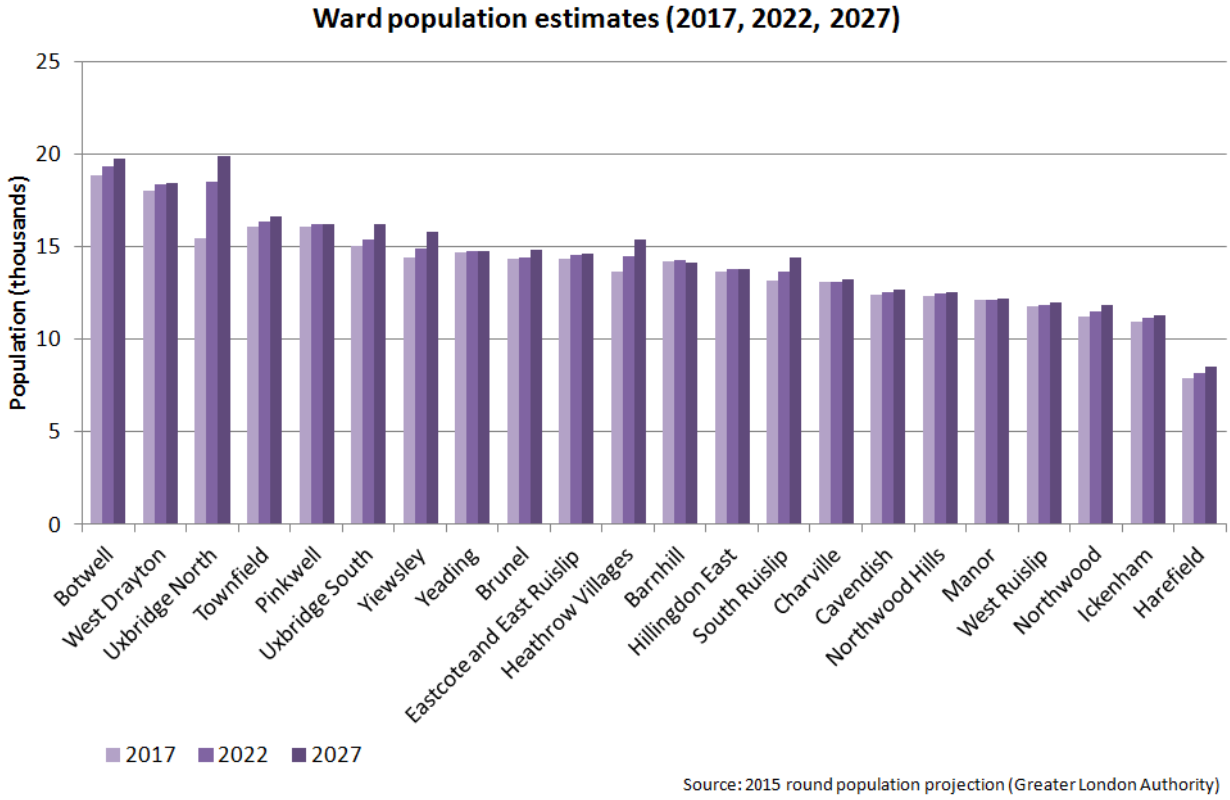
## INFORMATION

### Population Growth

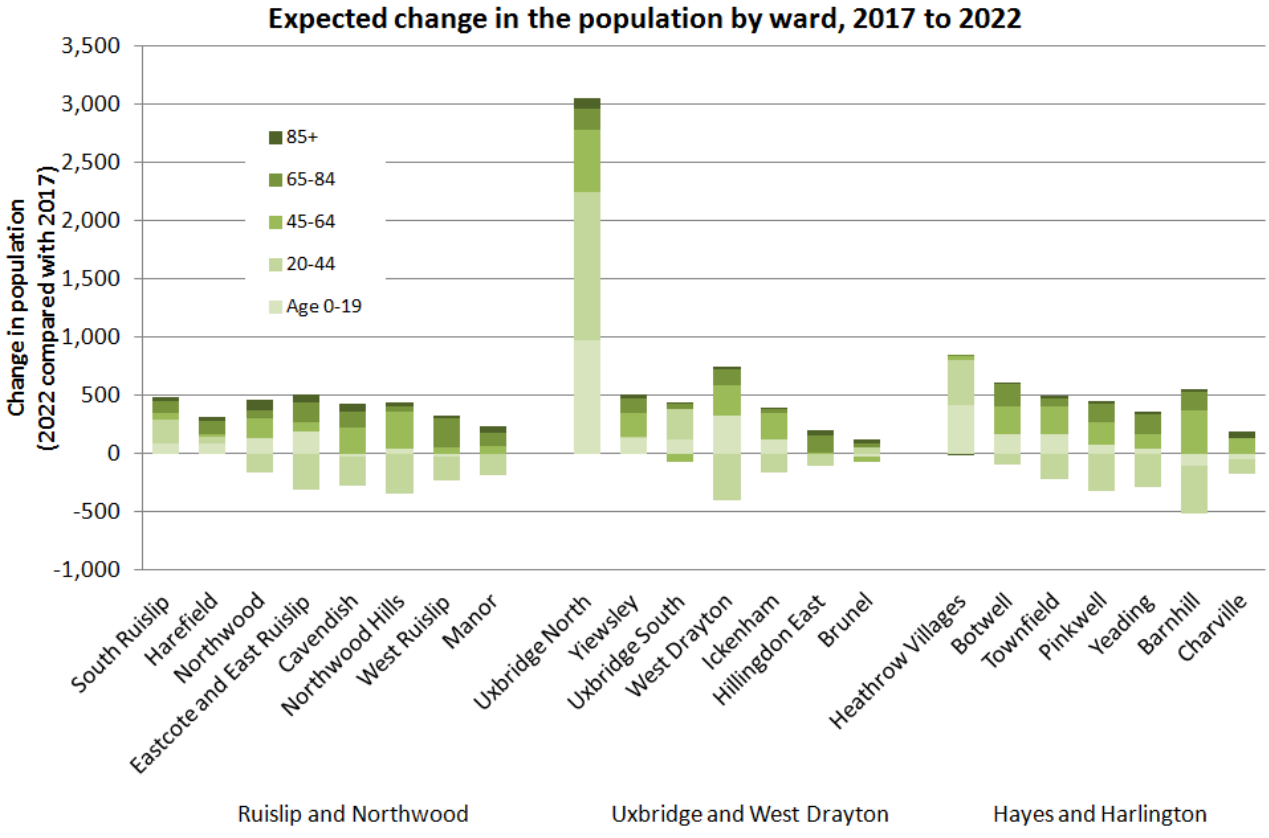
The Office for National Statistics Sub-national population projections estimate that there are 309,300 people currently living in Hillingdon. This figure is expected to increase, with the percentage change in Hillingdon expected to be higher than other boroughs in North West London, London and England.



This anticipated population increase can be broken down to Ward level and the following two charts show where the greatest increases are expected.




Source: 2015 round population projection (Greater London Authority)



A meeting of the Greater London Authority (GLA) Planning Committee on 17 October 2016 noted that demand on energy supplies in the capital was set to increase by 20%. Furthermore, Thames Water projects that demand for water will exceed supply by 10% by 2025, rising to 21% in 2040. It is anticipated that London's growth will require infrastructure investment of around £1.3 trillion from now until 2050.

Whilst London faces a number of complex infrastructure challenges arising from population growth, 60% of London's current infrastructure assets sit in private hands. Concern has been expressed by the GLA that some utility companies only forecast three years ahead.

It is important that London has a programme of infrastructure investment that is coordinated between sectors, responds to change and can be delivered in good time, at a reasonable cost. This issue has been explored in the GLA's *London Strategic Infrastructure Requirements* report which looks at where infrastructure should be built and improved to respond to growing demands. The report:

- examines the capital's infrastructure requirements to the early 2030's across the following sectors: rail, road, electricity and heat, waste, water supply, water management and flood risk, digital connectivity and green infrastructure.
- assesses the planning and funding status of each project.
- analyses needs by location to highlight where investment would 'unlock' housing and economic growth.
- investigates the obstacles to improving infrastructure and opportunities to innovate in each area.

**Electricity and Heat**

There is a significant challenge related to whether the existing grid will be able to cope with new electricity demand and what reinforcement and mitigation strategies will be needed in the network. London is currently heavily reliant upon the national grid for electricity and for gas, and its supply is inextricably linked to national energy infrastructure and national energy policy. Therefore costs and security of supply challenges at the national level will directly affect London's resilience and its customers, potentially exposing them to risks that are beyond the direct control of London's authorities.

In general, the London Infrastructure Plan 2050 estimated that London will require a 20% increase in energy supply to 2050 unless significant demand reduction is realised through retrofit and/or user behaviour.

There is no clear direction from the GLA on which should be the energy supply matrix to generate 25% of London energy requirements. The Solar action plan will support this, but this is still a small proportion of the supply. Increase in District Heating Networks will provide most of the decentralised resources but identifying, and then delivering, networks remains a challenge.

Electric heat pumps are being prioritised to replace gas boilers in order to deliver zero carbon heat. However, they may not be the most efficient technology and a wholesale switch will put a significant amount of pressure on the grid capacity.

Mayoral priorities, challenges and opportunities for innovation in relation to electricity and heat include:

- the use of a DevCo model to provide and manage investment in electricity distribution infrastructure which would reduce developer and investor risk in investing ahead of need.
- a Licence Lite model which involves the GLA obtaining a junior electricity supply licence whereby it can purchase output from low and zero carbon electricity generators and supply the electricity produced to public and commercial electricity users in London.
- the development of a framework and the implementation of integrated energy strategies in all new developments and major refurbishment projects in order to reduce demand on the grid and create a more sustainable and self-sufficient system.
- a move towards a zero carbon and 'smart' electricity grid able to accommodate decentralised electricity generation at all scales and in coordination with national energy policy (intermittent wind generation at the national scale, and manage demand associated with electric vehicles, heating, and energy hungry locations at vulnerable points on the network).
- district heating to connect buildings in dense areas and areas not suited to building-scale heat pumps.
- agglomeration of schemes and infrastructure solutions could be an important way for Distribution Network Operators (DNOs) and suppliers to efficiently reinforce an area, rather than following a development-by-development approach.
- within developments, there is the example of Nine Elms which has a linear park along which major utilities are provided and has supported a "dig once" approach.

**Water Supply**

Currently all water companies in London (Thames Water supplies 76% of London's water, Affinity Water supplies 14%, Essex and Suffolk supplies 7% and Sutton and East Surrey supplies 4%) are rated "serious" in terms of water stress and are designated "areas of serious water stress" by the Environment Agency. Thames Water projects a 6% capacity deficit by 2020 (this could be up to 30% by 2050).

Population growth and a reduction in average household sizes means that a growth in water supply will be required unless demand management activity is significantly increased. Other challenges for the delivery of growth include:

- the aged infrastructure whereby a large proportion of the pipe network is over 100 years old and there is a high leakage rate.
- the retrofitting of meters faces major challenges for implementation, particularly in flats.
- interaction with boroughs immediately outside the GLA boundaries is very important to understand demand and management issues.
- water companies concentrate their expenditures on a 5 year cycle which can create issues in delivering supply for the long term based on a short cycle.
- water companies have constraints on what they can charge customers.
- most of water companies' funding comes through asset management plans.

In terms of opportunities for innovation, it has been suggested that:

- Integrated Water Management Strategy (IWMS) for major developments could be a way of ensuring the water supply and management is planned in an integrated way. It is

likely to be a more viable solution if it has a compound effect for a number of developments across a growth corridor.

- actively promote demand management measures to reduce leakages and improve efficiency across London, e.g., smart meters, recycling wastewater for non-potable supply (certain issues around reusing - provenance and future use of recycled water).
- after demand management and leakages are maximised, all water companies in the south east must coordinate to guarantee an efficient utilisation of resources and agree the most suitable supply source for the future.
- increase supply within regulatory framework specified by OFWAT which prescribes resilience as a priority, allowing more innovative solutions.
- from 2017, non residential water users will be allowed to sell water surpluses and become small providers.
- potential for multi-utility companies that could add competition and innovation to the market.
- opportunities around cross-sector utilities coordination to increase cost-efficiency and reduce road disruptions.

**Water Management - Stormwater, Foul Water and Flood Risk**

London's projected population growth to 2050 will challenge the capacity of drainage and sewerage network. Based on Thames Water's model of flow capacity utilisation, several growth corridors across the city will not have sufficient capacity to manage the expected flows. The Thames Tideway Tunnel project will address current problems of combined sewer overflows into the Thames but will not increase capacity of the network. Treatment capacity (five main treatment works) will need upgrading during the next 20 years and there are challenges around securing funding for fluvial and surface water. For example, SuDS programme is funded until 2021 and its extension is subject to evaluation.

Consideration needs to be given to the potential of partnership contributions as a funding mechanism, cross boundary water management plans to extend catchment and include boroughs outside the GLA boundary. It should be noted that the Environment Agency and the GLA are working together in relation to water management, flood risk interventions and land/sites safeguarding.

In terms of opportunities for water management, the following have been suggested:

- natural flood management which can provide multiple societal benefits alongside reducing flood risk. Assessment of opportunities at a river basin/catchment scale is required.
- opportunity to develop long-term (25 year) flooding plans looking at challenges, solutions and high-level costs of flood infrastructure across London, e.g., Lea Valley pilot plan.
- identifying synergies between sectors that will help to optimise investments and improve capacity and performance, e.g., coordinated solutions that make use of existing and planned green infrastructure.

**Digital**

The digital sector is perhaps the most challenging sector to plan infrastructure in the medium term due to the fast pace of its development. At present, planning has started for

"5G" or fifth-generation mobile communication technologies, but with an average five year length of "generations", there could be another two or more by the mid 2030's. The UK Government recently published a strategy for "Next Generation Mobile Technologies: A 5G strategy for the UK" in March 2017, but definitive standards for 5G are not set to be agreed until 2019.

5G is proposed to support a number of different "use cases" which could transform the form and functions of London's infrastructure including: connected vehicles; the usage of drones for logistics and maintenance; and smart cities applications like traffic management, street lighting controls, smart grids and waste management.

The "London's strategic infrastructure requirements - an evidence base for the London Plan" has focused on two main priorities which are primarily related to the infrastructure itself, i.e., the provision of connectivity, rather than focusing on particular use cases of 5G, for example:

1. Getting the "basics" right for households and businesses, i.e., ensuring that there is close to 100% coverage of 4G across London (indoor and outdoor) and close to 100% coverage of superfast broadband (over 24 Mbps). It is acknowledged that some categories of business (particularly large companies) have very different needs to SMEs or home users. Therefore, the general principle that the GLA is likely to adopt is that all households and businesses should be able to access the connectivity service that best fits their needs wherever they are in London.
2. Supporting future access by households and businesses by considering key opportunities and challenges to the delivery of infrastructure, i.e., access to ultrafast broadband (UFBB) of at least 100Mbps (whether by Fibre to the Property (FTTP) or other means), next generation "5G" mobile access to the internet from close to 100% of London (indoor and outdoor).

There are currently no major strategic projects that are dedicated to improving London's connectivity. The digital projects that are currently being facilitated by the GLA and Transport for London include: the 5G Innovation Gateway with 5G Innovation Centres; the public building Wi-Fi scheme; London Underground's 4G network (in planning); and TfL's connectivity plan (in planning). However, these are not considered to be major strategic projects. The major strategic projects that are planned to support digital infrastructure across London include:

- Virgin Media's ultrafast broadband network (£3 billion across the UK).
- BT's ultrafast broadband network (£6 billion across UK).
- 4G upgrades likely due to emergency services usage (moving off airwaves) and Home Office usage for public safety.

It is likely that the coverage of 4G will improve in London due to the emergency services moving off airwaves and Home Office usage to monitor public safety. However, the GLA could help to facilitate improvement of London's digital connectivity through:

- working with boroughs to facilitate the use of street furniture as nodes for improving mobile connectivity.
- including policy guidance in the London Plan on digital infrastructure particularly enabling better use of public buildings to enable connectivity and avoiding new developments blocking digital signals.
- encouraging the use of shared ducts in new developments.

There will be challenges for the delivery of digital growth which include:

- London currently ranks poorly on the European Digital City Index 2016 - 42nd out of 60 cities and below many of its competitors including Paris, Barcelona, Amsterdam and Stockholm. It ranks particularly poorly for internet download/upload speed (44/60), mobile internet download/upload speed (45/60) and ranks last in terms of availability of fibre internet (60/60).
- main tools to support infrastructure rollout are at national government level such as UK Government's support of Virgin's Ultra-fast Broadband scheme through the UK Guarantees scheme, and at the regulatory (OFCOM) level. Supra-national issues such as European State aid regulation affects how much fiscal support UK Government can give to this sector (even post-Brexit is likely that the UK will need to retain a lot of the constraints to maintain a level-playing field).
- due to industry investment cycles, digital infrastructure is not "future-proofed", i.e., providers do not invest ahead of demand.
- improving 4G coverage across London, particularly central London.
- many of the future "use cases" identified for 5G will involve a significant amount of street-furniture including sensors, charging points, etc. In general, a much greater densification of nodes is necessary. The main issue is how to cope with and facilitate densification of infrastructure including mobile base stations, small cells and fibre.
- there are significant challenges involved in installing small cell sensors which include fragmented ownership of street furniture (street lights, advertising billboards, etc) and difficulties in securing planning permission for new street furniture including sensors.
- there is a challenge involved in the data that is available from OFCOM to understand broadband provision across London. At present, OFCOM only presents data based on BT and Virgin provision and does not include a number of the other fibre providers that are currently providing FTTP connections across London such as Hyperoptic and Venus Fibre. Other providers such as Optimity provide access to an ultra-fast network using wireless technology (fixed wireless access). This means that the ultra-fast broadband availability data from OFCOM is not an accurate portrayal and therefore it is challenging to understand the true picture of availability across London.

The opportunities for digital innovation include:

- making it as transparent as possible for the private sector to invest in London, such as having information on which assets are available for the private sector to install their infrastructure
- tackling information failures about alternatives to standard FTTP fibre connections such as point-to-point fixed access wireless. These technologies are very quick to set up and can provide an equivalent service to UFBB. They can be used as "last mile" technologies to facilitate connections to businesses in areas which have poor FTTP provision or where it is more challenging to implement FTTP.
- Innovative approaches to planning for street works and street furniture. GLA could support by mapping out small cell planning availability which will support the private sector in their investment programmes. At present, many local authorities do not have this information.
- the GLA could use the London Plan to provide an overarching view of what should be enabled in terms of the densification of nodes.

- the GLA could support fibre provision by ensuring that every time there are development works, there is a duct installed which enables fibre to be installed by various providers at a later date. The GLA could then keep mapping information of duct locations and enter into arrangements with providers whereby they can provide fibre to an entire network using the available ducts. An example of where this has been done previously is in the Olympic Park whereby ducting was installed across the area so that any provider could use it to run their cabling.

**Conclusion**

There is currently significant housing development underway in the Borough to accommodate the increasing population and therefore an increase in demand on utility services. Members of the External Services Scrutiny Committee are keen to hear how the developments and plans set out in the report will be borne out in Hillingdon and what action is being taken to mitigate the challenges faced by the utility companies.

**Witnesses**

Representatives from a range of utility and service organisations have been invited to attend the meeting. Additional witnesses may be invited to attend the meeting.

**SUGGESTED SCRUTINY ACTIVITY**

Members to question representatives from the organisations on the utility services provided within the Borough and decide whether to take any further action.

# EXTERNAL SERVICES SCRUTINY COMMITTEE - 2017/19 BETTER CARE FUND PLAN

**Contact Officer:** Gary Collier
**Telephone:** 01895 250730

**Appendix 1: 2017/19 BCF Plan Scheme Descriptions**

## 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

1. To question officers about the content of the plan.
2. To make suggestions or recommendations to inform the development of the plan from 2018/19.
3. 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 27 September 2017. 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 also minimised the risk to both the Council and HCCG. They 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.

- *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.

- *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.

- *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.

- *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.

- *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%.

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.

**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 1 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 2 below.

**Table 1: 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 2 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 |

| Table 2 Council and HCCG Financial Contribution by Scheme Summary | | | | | |
|---|---|---|---|---|---|
| | | Funder 2017/18 | | Funder 2018/19 | |
| | SCHEME | LBH £000's | HCCG £000's | LBH £000's | HCCG £000's |
| 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 can be made that this will result in better outcomes for residents.

- **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.

**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.

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 3 below shows the target for 2017/18 and its apportionment across the NHS, Social Care and both.

| Table 3: 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 July 2017 would suggest an outturn for 2017/18 of 9,366 delayed days and the difference between this figure and the NHSE set target shown above (9,337 delayed days) is 29 delayed days, which means that the target is achievable but 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.

**Post-April 2019 Position**

25. 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) <u>Scheme Investment Requirements</u>**

| 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 | - | | | - | | 529 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | 262 | 267 | | 267 | |
| 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**

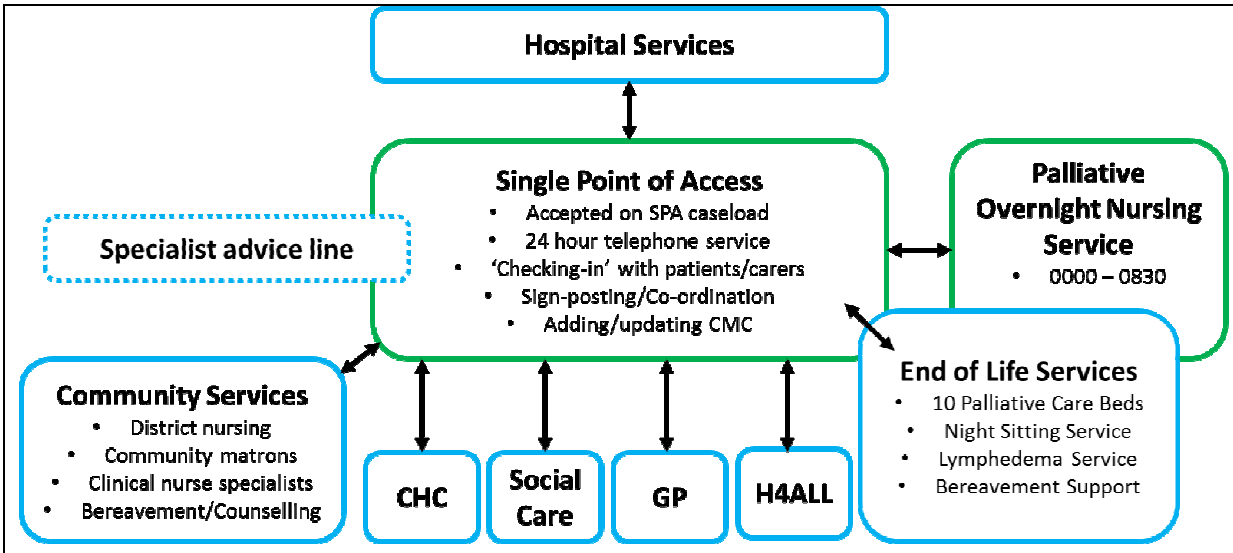
**a) Strategic Objectives**

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:

- *Facilitating seamless care provision between health and social care* - 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.

- *Reviewing charges for Council funded services* - 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**<br><br>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 Residential | Various P&V | 0 | 0 | - | 0 | 2,913 | 2,913 | 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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# EXTERNAL SERVICES SCRUTINY COMMITTEE - WORK PROGRAMME 2017/2018

**Contact Officer:** Nikki O'Halloran
**Telephone:** 01895 250472

**Appendix A:** Work Programme 2017/2018

## REASON FOR ITEM

To enable the Committee to track the progress of its work in 2017/2018 and forward plan its work for the current municipal year.

## OPTIONS OPEN TO THE COMMITTEE

Members may add, delete or amend future items included on the Work Programme. The Committee may also make suggestions about future issues for consideration at its meetings.

## INFORMATION

1. The Committee's meetings tend to start at either 5pm or 6pm and the witnesses attending each of the meetings are generally representatives from external organisations, some of whom travel from outside of the Borough. The meeting dates for this municipal year are as follows:

| Meetings | Room |
|---|---|
| Wednesday 14 June 2017, 6pm | CR6 |
| Tuesday 11 July 2017, 6pm | CR6 |
| Wednesday 6 September 2017, 6pm | CR5 |
| Thursday 14 September 2017, 6pm | CR6 |
| Wednesday 11 October 2017, 6pm | CR6 |
| Tuesday 14 November 2017, 6pm | CR5 |
| Thursday 11 January 2018, 6pm | CR6 |
| Tuesday 13 February 2018, 6pm | CR6 |
| Wednesday 14 March 2018, 6pm | CR6 |

2. It has previously been agreed by Members that consideration will be given to revising the start time of each meeting on an ad hoc basis should the need arise. Further details of the issues to be discussed at each meeting can be found at Appendix A.

### Scrutiny Reviews

3. Members have been asked to suggest possible future review topics for consideration by the External Services Scrutiny Committee during this municipal year. It was proposed that the Committee identify one/two topics it would like to scrutinise as single meeting reviews during 2017/2018:
    a) At the meeting on 11 July 2017, it was agreed that a single meeting review be undertaken on 11 January 2018 to look at the provision of GP services in Heathrow Villages.

## BACKGROUND DOCUMENTS

None.

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**APPENDIX A**

**EXTERNAL SERVICES SCRUTINY COMMITTEE**

**2017/2018 WORK PROGRAMME**

*NB – all meetings start at 6pm in the Civic Centre unless otherwise indicated.*

*Shading indicates completed meetings*

| Meeting Date | Agenda Item |
|---|---|
| 14 June 2017<br><br>***Report Deadline**:*<br>*3pm Friday 2 June 2017* | **Update on the implementation of recommendations from previous scrutiny reviews:**<br>• Alcohol Related Admissions Amongst Under 18s<br><br>**Major Review (2017/2018):** Consideration of scoping report. |
| 11 July 2017<br><br>***Report Deadline**:*<br>*3pm Friday 30 June 2017* | **Health**<br>Performance updates and updates on significant issues:<br>1. The Hillingdon Hospitals NHS Foundation Trust<br>2. Royal Brompton & Harefield NHS Foundation Trust<br>3. Central & North West London NHS Foundation Trust<br>4. The London Ambulance Service NHS Trust<br>5. Public Health<br>6. Hillingdon Clinical Commissioning Group<br>7. Healthwatch Hillingdon<br><br>**NHS England Consultation on the Future of Congenital Heart Disease Services**<br><br>**CQC Consultation Response** |
| 6 September 2017<br><br>***Report Deadline**:*<br>*3pm Friday 25 August 2017* | **NHS England - Proposals to Implement Standards for Congenital Heart Disease (CHD) Services for Children and Adults in England**<br>To provide Members with an opportunity to speak to representatives from NHS England about the proposals for children's congenital heart disease services in England. |
| 14 September 2017<br><br>***Report Deadline**:*<br>*3pm Monday 4 September 2017* | **Crime & Disorder**<br><br>MOPAC - Public Access and Engagement Strategy: To review the consultation document and provide comment.<br><br>LAC offenders: To scrutinise the issue of crime and disorder in the Borough:<br>1. Community Safety<br>2. Youth Offending Service<br>3. Corporate Parenting<br>4. Public Health |

| Meeting Date | Agenda Item |
|---|---|
| | How many LAC offend as a result of substance misuse?<br>What proportion of young offenders are LAC?<br>What proportion of LAC offenders go on to reoffend? |
| 11 October 2017<br><br>***Report Deadline**:*<br>*3pm Friday 29 September 2017* | **Update from Utility Companies on Plans to Accommodate Increasing Demand on Services**<br>To receive an update on plans to accommodate the increasing demand on services that has resulted from increased housing development in the Borough.<br><br>**Better Care Fund Update**<br>To receive an update on the Better Care Fund (BCF). |
| 14 November 2017<br><br>***Report Deadline**:*<br>*3pm Thursday 2 November 2017* | **Health**<br>Performance updates and updates on significant issues:<br>1. The Hillingdon Hospitals NHS Foundation Trust<br>2. Royal Brompton & Harefield NHS Foundation Trust<br>3. Central & North West London NHS Foundation Trust<br>4. The London Ambulance Service NHS Trust<br>5. Public Health<br>6. Hillingdon Clinical Commissioning Group<br>7. Healthwatch Hillingdon<br><br>**Major Review (2017/2018) - Community Sentencing:**<br>Consideration of final report from the Community Sentencing Working Group |
| 11 January 2018<br><br>***Report Deadline**:*<br>*3pm Tuesday 2 January 2018* | **GP Service Provision in Heathrow Villages**<br>To scrutinise the issue of GP service provision in Heathrow Villages:<br>1. Hillingdon Clinical Commissioning Group (CCG)<br>2. Public Health<br>3. Local Medical Committee<br>4. Healthwatch Hillingdon<br>5. Service Users |
| 13 February 2018<br><br>***Report Deadline**:*<br>*3pm Thursday 1 February 2017* | **Crime & Disorder**<br>To scrutinise the issue of crime and disorder in the Borough:<br>1. London Borough of Hillingdon<br>2. Metropolitan Police Service (MPS)<br>3. Safer Neighbourhoods Team (SNT)<br>4. London Fire Brigade<br>5. London Probation Area<br>6. British Transport Police<br>7. Hillingdon Clinical Commissioning Group (CCG)<br>8. Public Health |

| Meeting Date | Agenda Item |
|---|---|
| 14 March 2018<br><br>***Report Deadline**:*<br>*3pm Thursday 1 March 2018* | **Update on the implementation of recommendations from previous scrutiny reviews:**<br>• Hospital Discharges (SSH&PH POC) |
| **Possible future single meeting or major review topics and update reports** | |
| | |

## PROPOSED MAJOR SCRUTINY REVIEW (WORKING GROUP)

**Members of the Working Group:**

- Councillors Edwards (Chairman), Allen, Dann, Higgins, Khatra and Palmer

**Topic:** Community Sentencing

| Meeting | Action | Purpose / Outcome |
|---|---|---|
| **ESSC:**<br>14 June 2017 | Agree Scoping Report | Information and analysis |
| **Working Group:**<br>**1st Meeting -**<br>5pm 28 June 2017 | Introductory Report / Witness Session 1 | Evidence and enquiry:<br>• Community Rehabilitation Company<br>• National Probation Service<br>  ○ How does the management split work in practice? |
| **Working Group:**<br>**2nd Meeting -**<br>CANCELLED<br>5pm 20 July 2017 | Witness Session 2 (Management) | Evidence and enquiry:<br>• Magistrates<br>  ○ How many community sentences given? For what duration?<br>  ○ How many repeat offenders?<br>  ○ Magistrates' expectations of community sentences?<br>  ○ Standards expected from offenders (e.g., behaviour, attendance)?<br>  ○ Do Magistrates think community sentencing works well? How could it be improved? |
| **Working Group:**<br>**3rd Meeting -**<br>CANCELLED<br>5pm 1 August 2017 | Witness Session 3 (Operational) | Evidence and enquiry:<br>• Community Rehabilitation Company<br>  ○ What community sentence work is done in LBH and how often?<br>• Community Safety Team |
| **Working Group:**<br>**4th Meeting -**<br>5pm 21 September 2017 | Witness Session 2 | Evidence and enquiry:<br>• National Probation Service<br>• West London Local Justice Area<br>• Community Safety Team |
| **Working Group:**<br>**5th Meeting -**<br>TBA | Consider Draft Final Report | Proposals – agree recommendations and final draft report |
| **ESSC:**<br>11 January 2018 | Consider Draft Final Report | Agree recommendations and final draft report |
| **Cabinet:**<br>15 February 2018<br>*(Agenda published 7 February 2018)* | Consider Final Report | Agree recommendations and final report |

*Additional stakeholder events, one-to-one meetings and site visits can also be set up to gather further evidence.*