Appendix 3

2015/16 Better Care Fund Plan Evaluation

A. BCF Evaluation Matrix

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

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

B. Scheme Specific Identified Gaps/Suggestions

Scheme 1: Early identification

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

Scheme 2: End of life

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

Scheme 3: Rapid response and Joined up intermediate care

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

Scheme 4: Seven day working

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

Scheme 6: Care home initiative

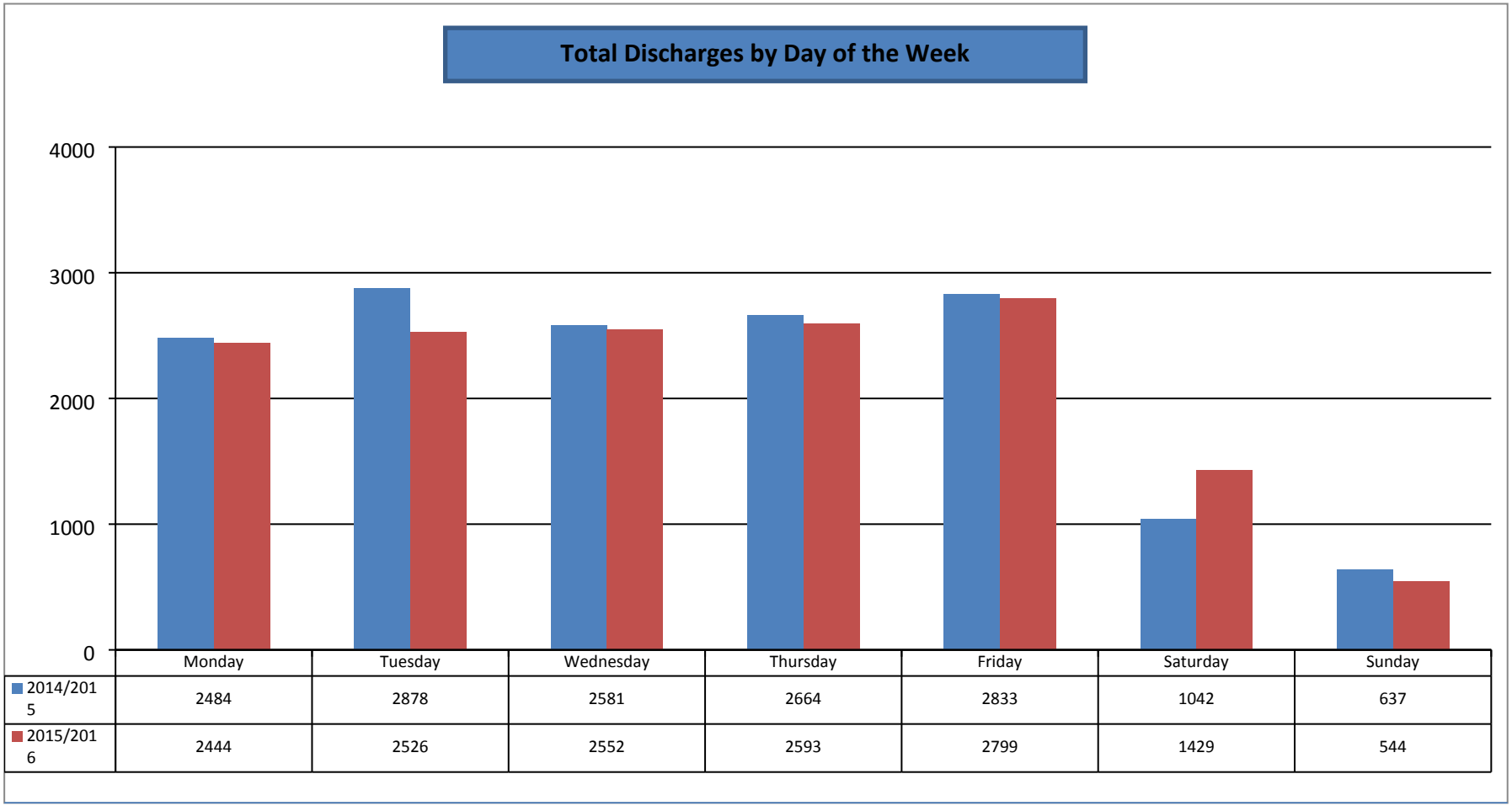
- Develop the local care home market to ensure it is suitable to meet current and future demand, e.g. people with dementia and challenging behaviours and younger adults with dementias.
- Support care homes to encourage them to admit people with higher levels of need, e.g. challenging behaviours
- Provide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

Scheme 7: Care Act implementation

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

Appendix 4

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



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