HILLINGDON
LONDON

Health Impact Assessment

STEP A) Description of what is to be assessed and its relevance to health

What is being assessed? Please tick ✓

Review of a service ☐ Staff restructure ☐ Decommissioning a service ☐

Changing a policy ☐ Tendering for a new service ☐ A strategy or plan ✓

The Better Care Fund (BCF) Plan is a mechanism for providing better outcomes for residents and patients through closer integration between health and social care. This assessment updates the one undertaken for the 2015/16 BCF plan.

The focus of Hillingdon's plan in 2016/17, as in 2015/16, is the 65 and over population and there is a specific focus on:

- All of Hillingdon's residents aged 85 and over
- Frail older people aged 75 and over with two or more conditions
- Older people who are at risk of dementia
- Older people who are at risk of falling for a first time.

However, there are aspects of the 2016/17 plan that are extended to a broader population, e.g. scheme 6, which is intended to address the needs of all adults in supported living and scheme 7 which considers the needs of Carers of all ages.

There are eight schemes within the 2016/17 BCF and these are:

- ***Scheme 1*** - Proactive early identification of people with susceptibility to falls, dementia, stroke and/or social isolation
- ***Scheme 2*** - Better care for people at the end of their life
- ***Scheme 3*** - Rapid response and integrated intermediate care
- ***Scheme 4*** - Seven day working initiative
- ***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

Annex 1 provides a summary of each of the schemes.

What is the lead organisation for the service to be assessed? EG Hillingdon CCG or

London Borough of Hillingdon

The plan is jointly led by HCCG and Hillingdon Council (LBH)

Who is accountable for the service? E.g. Head of Service or Corporate Director

Chief Operating Officer, HCCG Director of Adults and Children and Young people's Services, LBH

Date assessment completed and approved by accountable person

Date assessment completed: 10th March 2016 Date assessment approved:

Names and job titles of people carrying out the assessment

Sally Chandler - CEO, Hillingdon Carers (post meeting input) Gary Collier - Better Care Fund Programme Manager, LBH Claire Eves - Head of Adult Services, CNWL Graham Hawkes - CEO, Hillingdon Healthwatch Jo Manley - Hillingdon ACP Programme Director Peter Okali - CEO, Age UK Hillingdon/H4All Shikha Sharma - Consultant in Public Health Jane Walsh - Older People's Commissioner, HCCG

A.1) What are the main aims and intended benefits of what you are assessing?

The following aims and objectives of the BCF Plan have been agreed with service users and partners:

- We will build on our present initiatives around admissions avoidance and supported discharge.
- Hillingdon's residents will experience a shared set of responsibilities exhibited by all the organisations working in health and care.
- Residents will be able to access the services appropriate to their needs on each day of the week.
- Our workforce will be better equipped and better skilled to face this challenge: to residents, they will appear as a single system, with an open culture that celebrates success.
- We will work together to proactively identify the health and care needs of older frail residents and will aim to better manage the care needs of younger people who may be susceptible to frailty as they get older.
- We will aim to reduce levels of health inequality in Hillingdon.
- We will work with care home providers to ensure that local supply is suitable to meet the needs of Hillingdon's older residents now and in the future.

- We will be better at predicting future health and care needs – both across the population and for individual residents.

The key benefits of the plan are:

a. A reduction in the number of non-elective admissions (NELs) attributed to the 65 and over population by 663 during 2016/17. This is s contribution to the overall CCG target for 2016/17;
b. A reduction in the number of permanent admissions of older people (65 + and over) to care homes, per 100,000 population;
c. Increase in the proportion of older people (65 + and over) who were still at home 91 days after discharge from hospital into reablement services;
d. Reduction in delayed transfers of care (delayed days) from hospital per 100,000 population (18 +).

A.2) Who are the service users or staff affected by what you are assessing?

The service users, residents and patients affected by the BCF Plan are Hillingdon's 65 and over population and their Carers. People affected would also include adults with learning disabilities and adults living with mental health conditions who are living in a supported living environment or who could benefit from this model.

A.3) Who are the stakeholders in this assessment and what is their interest in it?

Stakeholders	Interest
Residents and patients	People directly affected by the Plan
Carers	People directly affected by the Plan
GP Networks	Involved in delivery of the schemes
Hillingdon Hospital Trust	Involved in delivery of the schemes
CNWL	Involved in delivery of the schemes
Third sector (voluntary and community)	Involved in delivery of the schemes

A.4) Which health-related issues are relevant to the assessment? ✓ in the box.

Employment or financial well-being	✓	Self-care	✓
Access to healthcare (primary, secondary, specialised)	✓	Social inclusion	✓
Environmental exposures (eg noise, air quality, green space)		Mental wellness	✓
Lifestyle (e.g. diet, physical activity, smoking, alcohol)	✓	Health inequalities	✓

Infectious disease	✓	Community Safety (eg crime, road safety, defensible space)	
Scope of health care services	✓	Other – please state	

STEP B) Consideration of information; data, research, consultation, engagement

B.1) Consideration of information and data - what have you got and what is it telling you?

Overview

The 65 + population accounted for 40% of all non-elective admissions in 2014/15. The 75 + population account for 70% of the non-elective health spend and it is estimated that 35% of this is avoidable or deferrable.

Population 65 +

Hillingdon's Joint Strategic Needs Assessment (JSNA) shows that there are a total of 34,385 people over the age of 65 in Hillingdon, out of which 14,797 (43%) are men, and 19,588 (57%) are women. Older People's (65+) population is predicted to increase by 7.1% in the next 5 years compared with 5% overall increase in Hillingdon's population. This is approximately the same increase as the neighbouring boroughs of Hounslow and Harrow, but slightly higher than Ealing where there is a projected increase of 5% over the next 5 years. In addition the projected increase for Hillingdon is also in line with the projected increase for the London region.

Population 85 +

The biggest percentage increases in Hillingdon is expected to occur in those aged between 65 - 69 and 85 and over. The projected overall increase in the population of persons aged 85+ is 8% in the next five years compared with 5% in Hillingdon's total population. Currently, the total number of people aged 85+ is 4,716, out of which 1,529 (32.4%) are men and 3,187 (67.6%).

Population 65 + and Ethnicity

A key feature of Hillingdon's demography is that ethnic diversity is concentrated in the younger age groups. For each of the five year age bands for people aged 65 and over there is an increasing proportion of White British. It is expected that the lack of diversity within these older age groups will change over the coming decades as the younger age groups grow older.

Long-term Conditions

Within the next 5 years, there is a projected increase of 9% in the number of people aged 65 and over with a limiting long-term illness. This figure is slightly higher than the projections for Ealing and the London region, but close to the percentage increases projected for Hounslow and Harrow. Overall Hillingdon has the highest projected increase in relation to the London region and the forenamed neighbours.

The latest official data on dementia prevalence data (Joint Commissioning Panel for Mental Health, 2013) suggests that at mid-year 2014 there were 2,574 people in the borough living with dementia. This is projected to grow by 13.5% to 2,975 by 2021. The Projecting Older People's Population Information (POPPI) service developed by the Institute of Public Care (IPC) in partnership with Oxford Brookes University suggests that there are currently 2,670 people living with dementia and predicts an increase of 12% to 3,037 by 2020.

The Royal Society of Psychiatrists' 2009 study *Dementia and People with Learning Disabilities: Guidance on the assessment, diagnosis, treatment and support of people learning disabilities who develop dementia* shows that there is an increased susceptibility amongst this population group to develop dementia once they reach the age of 50. The following figures suggest that the risk is up to four times greater than the general population:

- 1 in 10 of those aged 50 to 64
- 1 in 7 of those aged 65 to 74
- 1 in 4 of those aged 75 to 84
- Nearly three-quarters of those aged 85 or over.

Research undertaken in partnership with the Alzheimers' Society estimates that 1 in 10 people with a learning disability will go on to develop dementia between the ages of 50 and 65 and approximately 50% of those aged 85 and over. For people living with Down's syndrome 1 in 50 are estimated to develop dementia in their 30s and 50% of those aged 60 and over will develop it. The Projecting Adult Needs and Service Information (PANSI) suggests that there are currently 5,393 adults in Hillingdon with a learning disability and that this will increase by 6% to 5,749 in the period up to 2020. There are approximately 117 people who have Down's syndrome in Hillingdon.

POPPI projections suggest that the number of people aged 65 and over with a body mass index of 30 + was 10,094 in 2015 and that this will increase by 8% to 10,943 by 2020. The numbers of older people living with types 1 & 2 diabetes are projected to increase by nearly 10% from 4,805 in 2015 to 5,307 in 2020.

Stroke

In 2013/14 there were 3,246 people who had been diagnosed with a stroke in Hillingdon. In the same period there were 310 admissions recorded on the Sentinel Stroke National Audit Programme. Atrial fibrillation is a known risk factor for stroke. The diagnosed prevalence in Hillingdon is 1.1% and the estimated prevalence is 2.0%. There could be an additional 2,500 people with undiagnosed atrial fibrillation in Hillingdon.

Falls and Fractures

The consequences of falls have a significant impact on both NHS and social care services. Falling can precipitate loss of confidence, the need for regular social care support at home, or even admission to a care home. Fractures of the hip require major surgery and inpatient care in acute and often rehabilitation settings, on-going recuperation and support at home from NHS community health and social care teams. In addition, hip fractures are the event that prompts entry to a care home in up to 10% of cases. Indeed, fractures of any kind frequently require a care package for older people to support them at home.

In the UK, 35% of over-65s experience one or more falls each year. About 45% of people aged over 80 who live in the community fall each year. Between 10% and 25% of such fallers will sustain a serious injury.

757 patients aged 65 years or over were admitted as an emergency admission to The Hillingdon Hospital (THH) as a result of a fall in 2012/13. The total cost was £1,767,175. The average cost per patient for the acute inpatient stay was £2,334. 146 patients aged 65 years or over were admitted to THH with a fractured neck of femur as a result of a fall in 2012/13. The average cost of the acute inpatient stay was £5,762.

Life Expectancy

Life expectancy in Hillingdon is estimated at 79.4 years for males and 83.5 years for females (data from 2008-12). This is similar to the averages for London and England & Wales.

There are inequalities within the Borough at ward level. The gap in male life expectancy between Eastcote and East Ruislip and Botwell is 6.7 years and the gap in female life expectancy between Eastcote & East Ruislip and Botwell is 8.5 years.

Sedantary Lifestyle

Health Survey for England 2008 Volume 1 Physical activity and fitness shows that approximately 50% of Hillingdon's population aged 65 - 74 year olds spend 6 or more hours sedentary time day during the week and over 50% at weekends. For the over 75s it is 62% for both week days and at weekends.

Older People Living Alone

The 2011 census identified that 31% of older people lived alone. POPPI projections suggest that there are currently 14,094 older people living alone and that this will increase by approximately 10% to 15,580 by 2020. This does not necessarily mean that an older person living on their own is socially isolated but it can act as an indicator.

The study *Preventing Suicide in England - a cross-governmental outcomes strategy to save lives* (DH 2012) shows that living alone and becoming socially isolated and experiencing bereavement are contributory factors that can lead to suicide. Available figures show that the number of suicides amongst the 65 + age group in Hillingdon is small, e.g. 5 in 2010, 4 in 2011 and 3 in 2012, but they predominantly occur amongst

men.

Supported Living Schemes

There are currently 15 schemes comprising of 106 self-contained flats for people with learning disabilities and a further scheme comprising of 14 self-contained flats due to open in 2018. There are an additional 60 rooms in 12 shared houses with the objective being to step-down people to the least restrictive environment.

There are also 48 self-contained flats in four supported living schemes for adults of working age with mental health needs and a further scheme comprising of 12 self-contained flats is due to open in 2018.

Two extra care sheltered housing schemes for the 55 and over population comprising of 95 self-contained flats for rent were opened in 2011 and 2012 respectively and two further schemes comprising of a total of 146 self-contained flats are due to open in 2018.

Consultation

B.2) Did you carry out any consultation or engagement as part of this assessment?

Please tick ✓ NO ✓ YES ☐

If no, explain why:
The timescale for delivering the HIA did not permit wider consultation to be undertaken. However, the development of the 2016/17 BCF Plan is consistent with feedback from consultation previously undertaken for the development of the 2015/16 plan and feedback from stakeholders through a range of fora.

If yes, what did you do or are planning to do? What were the outcomes?

B.3) Provide any other information to consider as part of the assessment

MTFF/QIPP context

The Council is required to find £13.3m of savings in 2016/17.
The HCCG is required to find £8.6m of savings in 2016/17.

National policy context

The Better Care Fund has been introduced as part of national policy as a tool to implement the new general duty under the 2014 Care Act to integrate services between health and social care. The intention behind integration is to achieve efficiencies through better coordination and provide patients and residents with an improved experience of care and support. In the 2015 Autumn Statement the Government announced its intention that the BCF would be the mechanism to deliver

full integration between health and social care by 2020.

A further objective is that there are timely and appropriate interventions by the statutory agencies working with primary care and the third sector to prevent non-elective attendances at A & E that are avoidable as well as avoidable hospital admissions. Integration through the BCF is also intended to be used as a mechanism for preventing escalation in the needs of older people that result in a loss of independence and the need for more expensive forms of intervention by health and social care.

C) Assessment

What did you find in B1? Who is affected? Is there, or likely to be, an impact on certain groups?

C.1) Describe any **NEGATIVE** impacts (actual or potential):

Health-related issues	Impact on this issue and actions you need to take
Employment or financial wellbeing	The 2016 assessment review confirmed that there were no negative impacts on this health-related issue arising from the proposed 2016/17 plan. There could be a potential negative impact on staff as a result of the development of further integration options (structural as well as functional) for early supported discharge and intermediate care services. This will be mitigated through the application of good employment practice procedures. The seven day working scheme (*scheme 4*) could also result in staff coming under pressure, real or perceived, to work extended hours to ensure that services are available. This will again be mitigated through the application of good employment practice procedures.
Access to healthcare	The 2015/16 assessment considered whether the BCF Plan would lead to resources being diverted from other user groups. It was identified that as the funding going into the 2015/16 BCF plan was predominantly existing money that was already being used to support older people, there should not have been any effect on other user groups. There is no evidence from the experience of the 2015/16 plan that there has been any diversion of resources for the reasons stated above. Additional demands on health services could arise from the pro-active early identification work proposed to be undertaken as part of *schemes 1 and 5*. The compensation for this is the potential

	for avoiding or delaying increased costs as a result of a more anticipatory model of care. The assessment team identified a potential concern about clinical treatment decisions being influenced negatively by the early identification of a person as being within the last year of life. This is mitigated by the benefits of early identification for enabling advanced planning to take place and therefore reducing the likelihood of crisis situations occurring that will inevitably be distressing for everyone involved. In addition, the multi-agency advanced planning process should also mitigate against the concerns mentioned above from occurring. *Scheme 6* includes the development of wrap-around services to support the independence of residents in supported living schemes, such as extra care sheltered for older people, could result in initial cost pressures. The scheme also includes a similar approach with care homes. It is expected that any financial outlay will be matched by reductions in A & E attendances and emergency admissions. The outcomes of the scheme both in terms of resource outlay and reductions in avoidable demand on hospital resources will be monitored and reported to the Health and Wellbeing Board. The Plan is aligned with the key integration enablers such as care and support planning being delivered by GP networks, shifting to planning for anticipated needs with GPs as lead professional. This will result in more services being delivered from local GP practices and may create access issues for some people who might otherwise have gone to Hillingdon Hospital. However, the compensation is the probable increased access and convenience that there will be for others as a result of health services being delivered closer to home. For those for whom transport may be an issue this is being addressed through amendments to provider contracts to ensure that patient transport is provided where needed. The GP Networks are at different levels of development which means that they may not all be in a position to be as responsive to needs identified from the proactive work within the BCF Plan as would be desirable. The extent to which this is an issue will need to be kept under review as the different schemes are rolled out and their full implications become apparent. The implementation of a communications plan will help with the delivery of the 2016/17 plan as well as assisting in shaping the 2017/18 – 2019/20 plan, which will be developed early in the new financial year.
Self-care	The assessment team identified that the proposed work under the 2016/17 plan to support people to self-manage their long-

	term conditions was predicated on the assumption that when people have access to all the relevant information that they will make reasonable decisions. It was acknowledged that people with capacity had the right to make 'bad' decisions and that an objective of the plan was to ensure that people had access to information and support to enable them to make informed decisions.
Social inclusion	No negative impacts were identified from the eight schemes within the 2016/17 plan on these health-related issues by the assessing team.
Mental wellness	
Lifestyle	
Infectious disease	
Health inequalities	
Scope of healthcare services	The proactive approach to identification of need required under *schemes 1 and 5* and the expanded remit of *scheme 7* which includes all carers and not just adult carers of other adults, which is covers legal duties under the 2014 Children and Families Act and the 2014 Care Act, may lead to the identification of health needs for which the appropriate services may not currently be in place and which may therefore have additional resource implications. There is no evidence that this occurred in 2015/16 but it is a potential issue as the work under the schemes becomes more embedded and the effects of demographic pressures are felt. This would potentially be compensated for by the cost avoidance arising from the reduction in need resulting from the earlier intervention. The individual benefits of the schemes versus additional resource requirements will be kept under review as part of the BCF monitoring process.

C.2) Describe any **POSITIVE** impacts

The assessing team felt that the comments raised as part of the 2015/16 plan assessment were still valid. Additions have been made to those comments where the team felt that this was appropriate in view of the content of the 2016/17 proposed plan.

Health-related issues	**Impact on this issue and actions you need to take**
Employment or financial well-being.	*Scheme 7*: The broadening of the definition of who is considered to be a carer and the extension of support to carers in their own right creates opportunities for those in work to be able to retain

	their employment for longer. This has positive implications for their mental and financial well-being and also for duration of the period for which they are willing and able to undertake a caring role. *Scheme 1:* Should lead to early identification of carers who may be in employment and provision of timely support following a Carer's assessment may enable them to continue in employment for longer with the benefits as described above. *Schemes 1 and 8*: Early identification of people living with dementia may help to ensure early access to appropriate treatments that may enable them to retain employment longer. This becomes more of an issue for older people with changes to the retirement age as well as the abolition of the mandatory retirement age.
Access to healthcare	*Scheme 1*: Early identification of people at risk of falls, dementia and/or social isolation will ensure timely access to appropriate healthcare as well as other care and support services. This will allow for more effective care planning where required and prevent deterioration in need that can lead to a loss of independence and more expensive healthcare interventions. Expanding the scope of the scheme to cover people with susceptibilities to stroke potentially could help prevent one of the main causes of disability amongst older people. *Scheme 2:* This will support people to die in their preferred place of care, which is generally at home. As well as being a more comforting environment for the person in the last days of their life (as well as their family). The scheme will lead to a more effective coordination of the required services. The scheme will lead to a more effective coordination of the required services. *Scheme 5:* Integrated Community-based Care and Support should result in the health needs of residents being addressed at a more local level. Taken in conjunction with the other schemes within the BCF Plan and other integrated care system enablers such as improved care planning, care navigation and multi-disciplinary team working, the result should be a more efficient use of resources.
Self-care	*Schemes 1, 2, 3* and 5 promote self-care as a means of putting individuals more in control of managing their own health and care needs, thus preventing or delaying a deterioration in their needs and the loss of independence that can arise from this. The H4All Health and Wellbeing

	Service should have a significant impact in empowering people to take more control and navigate the health and care system in a better way. *Scheme 6* also promotes the supported living model to enable people to live more independently in the community with care and support based on a reablement model.
Social inclusion	*Scheme 1* seeks to identify people at risk of social isolation and present them with options to engage with their local communities. This could include opportunities to volunteer with third sector organisations. The expended remit of *scheme 7* to include all Carers increases the scope for ensuring that Carers of all ages can have a life of their own, which will extend the time that they are willing and able to continue in their caring role.
Mental wellness	*Scheme 1*: Early identification of those living with dementia can help to ensure timely access to treatment that may arrest the progress of the condition. Access to advice about changes in lifestyle habits that may contribute to and otherwise accelerate progress could also have the same effect. Engaging with people who are socially isolated can help prevent adverse health impacts, such as depression, that can also lead to other physical health problems. *Scheme 2*: Better management of the end of life pathway should relieve some of the stress experienced both by the person at the end of their life and also their family. The study *Preventing Suicide in England - a cross-governmental outcomes strategy to save lives* (DH 2012) shows that living alone and becoming socially isolated and also bereavement are contributory factors in leading to suicides. Living with a long-term condition is also a contributory risk factor. Available figures show that the number of suicides amongst the 65 + age group is small, e.g. 5 in 2010, 4 in 2011 and 3 in 2012, and these predominantly occur amongst men. *Schemes 1, 2* and *8* in particular would seek to address some of the issues that can lead to suicide. The creation of a specific scheme focusing on the needs of people living with dementia (scheme 8) will help to promote the parity of esteem between physical and mental health whilst addressing the specific needs of patients living with this condition and supporting their Carers.

Lifestyle	*Schemes 1, 3 and 5* will identify particular lifestyle issues, e.g. diet, smoking, alcohol abuse, through visits to patients' homes. The result will be referrals to appropriate professionals and/or third sector organisations to provide advice and support.
Infectious disease	Key objectives of the BCF Plan are to prevent non-elective admissions and to reduce Length of Stay (LOS) in the event of an admission. Achieving this will help to prevent the risk of hospital acquired infections. *Scheme 6*: Training and support provided to care homes should help to improve standards and reduce the number of care home acquired infections acquired by residents that can lead to hospital admission and a rapid deterioration in mental wellbeing as well as physical health.
Health inequalities	The BCF Plan seeks to address health inequalities faced by Hillingdon's more vulnerable older population. However, given the disparity in social and economic wellbeing between older people in the north of the borough and those in the relatively more deprived, more culturally diverse wards in the south, particular consideration will have to be given as to how communities will be accessed. It is envisaged that this will be accomplished by close working with faith and other community-based groups. The provision of Personal Health budgets for people meeting Continuing Health Care (CHC) thresholds and Personal Budgets for people meeting the National Adult Social Care eligibility criteria provides opportunities for a more personalised approach to addressing need that would reflect cultural and religious diversity. Promotion of Personal Health Budgets is addressed within *scheme 5* of the plan. Proposals within *scheme 6* of the plan to provide wrap-around support for supported living schemes will also help to address health inequalities experienced by people with learning disabilities and people living with mental health conditions as well as maximising their independence within the least restrictive care setting.

D) Conclusions

The assessment has shown that the health implications of the 2016/17 BCF Plan are overwhelmingly positive for the residents of Hillingdon, which should consequently result in financial benefits for the local health and social care economy.

There were concerns that not all of the GP Networks to be able to respond to the needs identified from the implementation of the Plan, e.g. supporting care homes and supported living schemes. This is something that will have to be kept under review as the schemes within the plan are rolled out. Inclusion of GP and consultant geriatrician representatives on the project group for the development of the care and support specification for the extra care sheltered housing schemes in the borough should help to mitigate this and an on-going dialogue in respect of medical support for care homes.

The assessment also identified that there may be access issues for some residents, as more health services are delivered locally from GP practices. The conclusion was that more people were likely to benefit from local provision and that individual solutions would need to be identified to address the needs of those who are disadvantaged. Transport-related access issues were also being addressed through provider service specifications.

Key areas that need further consideration are:

- The suitability of existing services to meet the needs of people identified from the more proactive case finding approach set out in *scheme 1*.
- A number of the schemes require proposals to be developed during 2016/17 for potential delivery in 2017/18, e.g. intermediate care integration options under scheme 3, and specific assessments will be required in these circumstances.

The impact of all of the schemes will be monitored as part of the governance process for the BCF Plan.

Signed and dated:……..

Name and position:……

Annex 1

Scheme Number	Scheme Title	Scheme Aim(s)
1.	Proactive early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.	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.
2.	Better care for people at the end of their life	To realign and better integrate the services provided to people towards the end of their life. To develop the ethos of 'a good death' for people and for their families and carers within the provision of adult services.
3.	Rapid Response and integrated intermediate care	Prevention of admission to acute care following an event or 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.
4.	Seven day working	To improve quality and patient safety through reducing inconsistent care provision by: • Enabling discharge from the acute trust seven days a week for people admitted for either planned or unplanned procedures; • Enabling access to community services seven days a week thereby preventing unnecessary emergency department attendances and admission and reducing length of stay

		for people admitted to hospital for either planned or unplanned procedures; • **Reducing the uneven rate of hospital discharge across the week.**
5.	**Integrated Community-based Care and Support**	**To ensure that community based resources work as effectively and as efficiently as possible with primary care for the benefit of patients.**
6.	**Care Home and Supported Living Market Development**	**Through market reshaping secure:** • **A vibrant, quality care home market that meets current and future local need; and** • **An appropriate mix of supported living provision that provides people with a realistic alternative to care home admission.**
7.	**Supporting Carers**	The aims of this scheme are that Carers are 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"
8.	**Living well with dementia**	The aim of this scheme is that people with dementia and their family carers are enabled to live well with dementia.