BETTER CARE FUND: PERFORMANCE REPORT (APRIL - JUNE 2016)

Relevant Board Member(s)	Councillor Philip Corthorne Dr Ian Goodman
Organisation	London Borough of Hillingdon
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Papers with report	Appendix 1) BCF Monitoring report - Month 1 - 3: April - June 2016 Appendix 2) BCF Metrics Scorecard Appendix 3) Hillingdon Hospital Discharges Day by Day (April - June 2014/15 to 2016/17) Appendix 3A) Hillingdon Hospital Discharges Before Midday (April - June 2015/16 and 2016/17)

HEADLINE INFORMATION

Summary	This report provides the Board with the first performance report on the delivery of the 2016/17 Better Care Fund plan.
Contribution to plans and strategies	The Better Care Fund is a key part of Hillingdon's Joint Health and Wellbeing Strategy and meets certain requirements of the Health and Social Care Act 2012.
Financial Cost	This report sets out the budget monitoring position of the BCF pooled fund of £22,521k for 2016/17 as at month 3.
Ward(s) affected	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

a. **notes the contents of the report.**
b. **approves the reduction in the 2016/17 target for the proportion of older people still at home 91 days after discharge into Reablement from 93.8% to 90% for the reasons described in the report.**

INFORMATION

1. This is the first performance report to the HWBB on the delivery of Hillingdon's Better Care Fund (BCF) Plan for 2016/17 and the management of the pooled budget hosted by the Council. The plan and its financial arrangements are set out in an agreement established under section 75 of the National Health Service Act, 2006 and approved in March 2015 by both the Council's Cabinet and Hillingdon Clinical Commissioning Group's (HCCG) Governing Body.

2. Hillingdon's Plan received formal approval by NHS England (NHSE) on the 21st July 2016.

3. **Appendix 1** of this report describes progress against the agreed plan, including expenditure. **Appendix 2** is the BCF performance dashboard which provides the Board with a progress update against those of the six key performance indicators (KPIs) for which data is available.

3. The key headlines from the monitoring report are:

- The month 3 budget monitoring for the BCF has been undertaken jointly by the partners in accordance with the requirements set out in the s75 for the management of the pooled funds. This shows an underspend of £45k against the pooled budget of £22,521k.

- In Q1 there were 2,537 emergency (also known as non-elective) admissions to hospital of people aged 65 and over against a ceiling for the quarter of 2,442. This level of activity is broadly comparable with the same period in 2015/16 when there were 2,570 admissions.

- There were 208 falls-related emergency admissions during Q1, which is slightly above the ceiling for the quarter of 195 admissions. This compares unfavourably with same period in 2015/16 when there were 186 falls-related emergency admissions.

- Delayed transfers of care - There were 1,447 delayed days during Q1 2016/17 against a ceiling of 664, which means that activity during the quarter was significantly higher than projected. The position in Q1 2015/16 was 538 delayed days.

- There were 38 permanent admissions of older people to care homes in Q1, which means that the plan for 2016/17 is on track. The 2016/17 ceiling is 150 permanent placements.

- The average number of older people aged 65 and over still at home 91 days after discharge from hospital to reablement during Q1 was 89.4% against a target of 93.8%. This target was set based on a provisional outturn for 2015/16 of 92% but the actual outturn was 88%. The sample period for this metric nationally is Q3. As the 91 days period would be completed during the winter months in Q4 this report recommends that the 2016/17 target is reduced to 90%.

- In Q1 1,353 individuals have accessed Connect to Support and completed 2,163 sessions reviewing the information & advice pages and/or details of available services and support. This reflects a lower number of people accessing the system during the same period in 2015/16 but promotional activity being undertaken in Q2 and Q3 should see an increase in usage.

- In Q1 26 people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs).

Developing the 2017 to 2020 BCF Plan

4. In the 2015 Autumn Statement it was announced that each area will be required to produce a three-year BCF plan by the end of 2016/17 that will demonstrate how full integration between health and social care will be achieved by April 2020. At time of drafting the statutory guidance that will define what the Government means by 'full integration', as well as the other

requirements for the three-year plan, had not been published. However, the Council and the CCG have been working on proposals for increasing the level of ambition within the context of the Sustainability of Transformation (STP) Plan.

5. Draft proposals will be provided for Council member and CCG Governing Body consideration early in Q3 and will include:

- ***CAMHS*** - Options for a fully integrated Children and Adolescent Mental Health Service (CAMHS) that will entail a transfer of resources into prevention and wellbeing services and a subsequent reduction of treatments in specialist and highly specialist services, with a resultant reduction in the waiting times for these services, and a reduction in inpatient admissions.

- ***Intermediate Care*** - Options for a fully integrated intermediate care service that will result in a single point of access, a single accountability for the service, residents receiving the intervention of the most appropriate professional first time, a reduction of hand-offs between organisations and an improved experience of care for residents.

6. Other proposals will build on work undertaken during 2016/17 as well as looking at more integrated pathway commissioning in the following areas:

- ***Transforming Care*** - Developing an intensive intervention model to support step down from specialist (tier 4) provision and developing tailored housing options to support people with learning disabilities and/or autism;

- ***Like Minded*** - Developing a range of supported living options enabling people to transition from acute to least intensive community settings, designing and developing the model of care for Primary Care Mental Health Services and developing locally-based step-up facilities to support people in crisis.

Financial Implications

7. The Quarter 1 performance report for the Better Care Fund shows a forecast net underspend for 2016/17 of £45k arising from a favourable movement on the budget for community equipment. The demand management work undertaken during the last financial year and continuing into this year to manage the community equipment budget is now delivering an improved financial outcome. There are a number of minor overspends within the LBH - Protecting Social Care funding due to staffing and some increased demand on placement budgets.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

8. The monitoring of the BCF ensures effective governance of delivery via the Health and Wellbeing Board.

9. The proposed revision of the target for the percentage of older people still at home 91 days after discharge into the Reablement Service more accurately reflects what is achievable during 2016/17.

Consultation Carried Out or Required

10. The 2015/16 BCF Plan was developed with key stakeholders in the health and social care sector and through engagement with residents and the 2016/17 plan represents a logical progression of that plan and an extension in some areas, e.g. care home and home care market development. Hillingdon Hospital, CNWL and H4All have been consulted in the drafting of this report.

Policy Overview Committee comments

11. None at this stage.

CORPORATE IMPLICATIONS

Corporate Finance Comments

12. Corporate Finance has reviewed the report and notes the financial position as set out in the financial implications set out above.

Hillingdon Council Legal Comments

13. As is indicated in the body of the report, the statutory framework for Hillingdon's Better Care Fund is Section 75 of the National Health Service Act, 2006. This allows for the Fund to be put into a pooled budget and for joint governance arrangements between the Governing Body of Hillingdon's HCCG and the Council. A condition of accessing the money in the Fund is that the HCCG and the Council must jointly agree a plan for how the money will be spent. This report provides the Board with progress in relation to the plan.

BACKGROUND PAPERS

NIL.

Appendix 1

BCF Monitoring Report

Programme: Hillingdon Better Care Fund	
Date: September 2016	**Period covered:** April - June 2016 - Month 1 - 3
Core Group Sponsors: Caroline Morison/Tony Zaman /Paul Whaymand/Jonathan Tymms/ Kevin Byrne	
Finance Leads: Paul Whaymand/Jonathan Tymms	

Key: RAG Rating Definitions and Required Actions		
	Definitions	**Required Actions**
GREEN	The project is on target to succeed. The timeline/cost/objectives are within plan.	No action required.
AMBER	This project has a problem but remedial action is being taken to resolve it OR a potential problem has been identified and no action may be taken at this time but it is being carefully monitored. The timeline and/or cost and/or objectives are at risk. Cost may be an issue but can be addressed within existing resources.	Escalate to Core Officer Group, which will determine whether exception report required. Scheme lead to attend Core Officer Group.
RED	Remedial action has not been successful OR is not available. The timeline and/or cost and/or objectives are an issue.	Escalate to Health and Wellbeing Board and HCCG Governing Body. Explanation with proposed mitigation to be provided or recommendation for changes to timeline or scope. Any decision about resources to be referred to the Council's Cabinet/HCCG Governing Body.

1. Summary and Overview		
	Plan RAG Rating	**Amber**
	a) Finance	**Green**
	b) Scheme Delivery	**Amber**
	c) Impact	**Amber**

A. Financials

Key components of BCF Pooled Fund 2016/17 (Revenue Funding unless classified as Capital)	**Approved Pooled Budget**	**Forecast Outturn**	**Variance as at Month 3**
	£000's	**£000's**	**£000's**

HCCG Commissioned Services funding (including non elective performance fund)	11,965	11,855	(110)
LBH - Protecting Social Care Revenue Funding	7,109	7,174	65
LBH - Protecting Social Care Capital Funding	3,457	3,457	0
Overall BCF Total funding	22,531	22,486	(45)

B. Plan Delivery Headlines

1. 1 This report includes the financial outturn position on each scheme within the BCF for Q1. The reported financial position at 30th June 2016 was an underspend of £45k against the budget of £22,531k.

1.2 *Emergency admissions position* - In Q1 there were 2,537 emergency (also known as non-elective) admissions to hospital of people aged 65 and over against a ceiling for the quarter of 2,442. This compares favourably to Q1 2015/16 when there were 2,570 admissions.

1.3 *Falls-related emergency admissions position* - There were 207 falls-related emergency admissions during Q1, which is slightly above the ceiling for the quarter of 195. This compares unfavourably with same period in 2015/16 when there were 186 falls-related emergency admissions.

1.4 *Emergency admissions from care homes* - During Q1 there were 191 admissions to Hillingdon Hospital from care homes at a cost of £609k. In Q1 2015/16 there were 202 emergency admissions at a cost of £579k. The lower number of admissions in 2016/17 but higher cost than in the same period in 2015/16 can be explained by a longer length of stay.

1.5 *Delayed transfers of care* - There were 1,447 delayed days during Q1 2016/17 against a ceiling of 664, which means that activity was significantly higher than projected.

1.6 *Permanent admissions to care homes* - There were 38 permanent admissions of older people to care homes in Q1, which slightly exceeded the Q1 ceiling of 37.5.

1.7 *People aged 65 and over still at home 91 days after discharge from hospital to reablement* - The average for Q1 was 89.4% against an annual target for 2016/17 of 93.8%.

C. Outcomes for Residents: Performance Metrics

1.8 This section comments on the information summarised in the Better Care Fund Dashboard (**Appendix 2**).

1.9 **Emergency admissions target (known as non-elective admissions)** - There were 2,537 emergency admissions in Q1 and 1,809 of these were to Hillingdon Hospital. The 2016/17 Q1 plan ceiling is 2,442 emergency admissions, which means that there has been a higher level of activity than forecast. However, the Q1 2016/17 activity is slightly lower than the same period in 2015/16, which was 2,570 admissions

1.10 **Delayed transfers of care (DTOCS) -** There were 1,447 delayed days during Q1, which was above the ceiling of 664. The Q1 position in 2015/16 was 538 delayed days. Table 2 provides a breakdown of the delayed days during Q1.

Table 2: Q1 DTOC Breakdown			
	Q1 DTOC Breakdown		
Delay Source	**Acute**	**Non-acute**	**Total**
NHS	521	395	916
Social Care	230	97	327
Both NHS & Social Care	11	193	204
Total	**762**	**685**	**1,447**

1.11 47% (685) of the delayed days concerned people with mental health needs in non-acute beds and of these 88% (603) arose due to difficulties in securing suitable placements, which includes beds in secure rehabilitation units and care home settings for people with challenging behaviours. Nearly 88% (601) of the non-acute delayed days concerned patients in beds provided by CNWL.

1.12 Nearly 57% (434) of the 762 delayed days in an acute setting were as a result of difficulties in securing appropriate placements. This is again related to difficulties in securing providers prepared to accept people with challenging behaviours and there is work underway across partners to support existing local providers to accept people with more challenging needs and to build resilience and capacity within the market to enable it to respond to Hillingdon's ageing population.

1.13 Table 3 shows the breakdown of delayed days by NHS trust for Q1.

Table 3: Distribution of Delayed Days by NHS Trust	
Trust	**Number of Delayed Days (Q1)**
Bucks Healthcare	26
CNWL	601
Hillingdon Hospitals	388
Imperial College, London	20
Luton & Dunstable	11
North West London (Northwick Park and Ealing)	196
Royal Brompton and Harefield	5
Royal Orthopaedic Hospital	8
University College	20
West Hertfordshire	122
West London Mental Health Trust	50
TOTAL	**1,447**

1.14 In compliance with the national 2016/17 BCF plan conditions, Hillingdon has developed a DTOC action plan that is intended to address the key causes of delayed transfers locally. There has been slippage on the delivery of key tasks for Q1 and table 4 below describes the action being taken to address this.

Table 4: DTOC Action Plan Update		
Task	**Update**	**RAG Rating**
1. Complete development of a joint discharge policy and procedure.	All three actions are dependent on the completion of the proposal for the Integrated Discharge Team (IDT) by Hillingdon Hospital. HCCG will then need to consider the proposal.	**Amber**
2. Develop information for patients.		
3. Establish electronic transfer of assessment, discharge notices, withdrawal and change of circumstances notices.		

1.15 **Care home admission target** - During Q1 there were 38 permanent placements into care homes (15 nursing home and 23 residential home) against a ceiling of 37.5, which means that the level of activity was slightly higher than projected. If this was replicated throughout the remainder of 2016/17 then there would be 152 permanent placements against a ceiling of 150. 29 of these placements were of people living with dementia, 7 people with functional mental health conditions, e.g. schizophrenia, and 2 requiring extensive physical support because of their physical frailty. It should be noted that the delivery of the extra care sheltered housing schemes, Grassy Meadow and Parkview, in 2018 will provide a realistic alternative to residential care home placements for older people.

1.16 It should be noted that the new permanent admissions figure in paragraph 11.4 above is a gross figure that does not reflect the fact that there were 34 people who were in permanent care home placements also left during the period 1st April 2016 to 30th June 2016. As a result, at the end of Q1 there were 435 older people permanently living in care homes (211 in residential care and 224 in nursing care). This figure also includes people who reached their sixty-fifth birthday in Q1 and were, therefore, counted as older people.

1.17 **Percentage of people aged 65 and over still at home 91 days after discharge from hospital to reablement** - Of the 207 people discharged from hospital to Reablement in Q4 2015/16, 89.4% (185) were still at home 91 days later, i.e. in Q1 2016/17. Of the 22 people who were not at home at the end of the 91 day period 11 people passed away and 11 were readmitted. The reporting period for the national metric that is used for comparison purposes is Q3 and for these residents their 91 period will be completed in Q4, e.g. during the winter months.

D. Relationship Maturity Metrics

1.18 Eight metrics were agreed by both the Health and Wellbeing Board and HCCG's Governing Body as proxy measures for the success of the 2016/17 BCF plan in developing the working relationship between the Council and the CCG. Table 5 below provides a progress update on these metrics.

Table 5: Relationship Maturity Metrics Update		
Metric		**RAG Status**
1.	The preferred integration option and procurement route for intermediate care services.	**On track (Green)** - Model options to be available for consideration in October.
2.	The preferred integration option and procurement route for end of life services.	**Some Slippage (Amber) -** Decision on Social Finance bid due in October, which will inform shape of an integrated end of life care model.

3.	The integrated brokerage and contracting model for nursing care home placements.	A revised proposal has been received that would lead to the creation of an integrated brokerage service based within the Council covering nursing home placements, homecare and Personal Health Budgets. The proposal details, including implementation timetable, are currently under discussion and approval will be sought in Q3.
4.	The model of wrap-around services for care homes and supported living schemes.	**Some slippage (Amber) -** Model (including medical support) on track to be agreed in Q3 but implementation unlikely to take place until Q4. Cross borough coverage by end of Q4 dependent on agreed model.
5.	An integrated approach to home care market development and management.	**On track (Green) -** Some initial discussions have taken place with Nicky Yiasoumi but need to link her with Mike Bibby, LBH project lead for homecare.
6.	An integrated outcomes framework for older people.	**Some slippage (Amber)** - A framework has been drafted and this will be finalised in Q3.
7.	An agreed understanding of the impact for health of the reduction by the Council in the use of residential care.	**On track (Green)** - Public Health will be working with partners to complete a Health Impact Assessment for consideration by the HWB and HCCG GB in December.
8.	The risk and benefits share arrangements following a shadow arrangement in 2016/17	**Some slippage (Amber)** - This will be drafted in Q2 and finalised as part of the process of agreeing the 2017 - 2020 BCF plan.

2. Scheme Delivery

Scheme 1: Early identification of people susceptible to falls, stroke, dementia and/or social isolation.	**Scheme RAG Rating**	**Green**
	a) Finance	**Green**
	b) Scheme Delivery	**Green**

Scheme 1 Funding	Approved Pooled Budget	Forecast Outturn	Variance as at Month 3
	£000's	**£000's**	**£000's**
LBH - Protecting Social Care	657	660	3
HCCG Commissioned Services funding	390	390	0
Total Scheme 1	**1,047**	**1,050**	**3**

Scheme Financials

2.1 The forecast outturn is in line with HCCG contracted spend. For LBH, there is a minor adverse variance forecast on staffing costs.

Scheme Delivery

2.2 As at 30th June, Connect to Support Hillingdon had 241 private and voluntary sector organisations registered on the site offering a wide range of products, services and support. This represents an additional 39 organisations from the position at the end of March 2016. The target for 2016/17 is to achieve an additional 100 organisations/service providers registered on the system by the end of Q4 and the Q1 performance shows that this target is on track.

2.3 From 1st April 2016 to 30th June 2016, 1,353 individuals accessed Connect to Support and completed 2,163 sessions reviewing the information & advice pages and/or details of available services and support. This represents a reduction of 541 people and 731 sessions on the same period in 2015/16. However, more active promotion work during Q2 should see these figures increase.

2.4 During Q1 15 people completed online social care assessments and 11 were by people completing it for themselves and 4 by Carers or professionals completing on behalf of another person. 6 self-assessments have been submitted to the Council to progress and the remainder have been sent to residents at their request in order for them to decide in their own time how they wish to proceed. There have been 9 self-assessments undertaken by Carers in Q1.

2.5 The H4All Health and Wellbeing Service became operational in April with staff being seconded from the organisations within H4All, including the five Primary Care Navigators. The operational base for the service is Key House in Yiewsley but there are Wellbeing Support Officers working from GP practices and referrals during the start up phase were primarily from GP practices. From Q2 the service will start to accept referrals from a broader range of sources, including the Council. Q1 also saw the appointment of a Service Manager and a Community Development Officer with responsibility for developing the links with the voluntary and community sector.

2.6 By the end of Q1 approximately 340 people had been referred to the service from GP surgeries and 108 assessments using the Patient Activation Model (PAM) had been completed. This tests how motivated a person is to manage their long-term condition and helps to identify the level of support required from the service. Someone with a high PAM score will generally be sign-posted onto existing services but a person with a low score will receive more one to one support and an improved scoring following intervention from the service is a positive outcome.

2.7 There were 207 emergency admissions of people aged 65 and over related to falls during Q1, which is slightly above the ceiling for the quarter of 195. The ceiling for 2016/17 is 780. There were 186 emergency admissions during the same period in 2015/16. The total cost of the falls-related admissions in Q1 2016/17 was £675k.

2.8 In April classes specifically for people who have fallen or who are at risk of falls were set up as part of the Let's Get Moving Hillingdon programme. The purpose of the classes is to help address some of the issues that can make a person susceptible to falls, e.g. excess weight and/or high blood pressure, through physical exercise programmes. During Q1 an average of 28 older residents benefitted from these classes that are held three times a week.

2.9 As a result of a review of the tea dances on offer to older people, an online booking system will be introduced in October. This will help to ensure that priority for access is given to Hillingdon residents. Support for residents to access the system will be provided through Hillingdon's libraries.

Scheme 2: Better care at the end of life	Scheme RAG Rating	Amber
	a) Finance	Green
	b) Scheme Delivery	Amber

Scheme 2 Funding	Approved Pooled Budget	Forecast Outturn	Variance as at Month 3
	£000's	£000's	£000's
LBH - Protecting Social Care	50	50	0
HCCG Commissioned Services funding	106	106	0
Total Scheme 2	**156**	**156**	**0**

Scheme Financials

2.9 The forecast outturn is in line with HCCG contracted spend. LBH spend on end of life care is forecast to be on budget. The funding included in this scheme is the Community Palliative Care Team that is included within the community health services contract held by the CCG with CNWL and also the Council's budget for specialist care at home for people at end of life.

Scheme Delivery

2.10 Training was provided for Social Care staff in the use of Coordinate My Care (CMC). Information sharing agreements are on track to be signed in Q2 which will then enable social care staff to have read and write access to this system, which should facilitate a more coordinated approach to the provision of care and support to Hillingdon residents who at the end of their life as well as supporting their Carers.

Coordinate My Care Explained

CMC is an electronic advanced care plan intended to link up the organisations and the individuals who provide care for a resident, including doctors, nurses, social care providers and emergency services, including the ambulance service, NHS 111 and the out of hours GP service. This service was developed by the Royal Marsden NHS Foundation Trust and in London is primarily used to support end of life care.

2.11 An action in the 2016/17 BCF plan is to commission an integrated specialist end of life care at home service. Pursuing this has been delayed pending the outcome of the bid to Social Finance for up to £1.5m over three years to develop an integrated end of life service in Hillingdon. Social Finance is a not for profit organisation that partners with the government, the third sector and the financial community to find better ways of tackling social problems in the UK and the results of the bid will be known in Q3. Once the result is known further consideration can be given to the procurement route for an integrated model and appropriate approvals sought from the Council and HCCG's Governing Body. A key reason for postponing development of the specialist service is to avoid adding to the level of fragmentation that already exists within end of life services. In the meantime need is being addressed through spot purchases from a local third sector provider.

Scheme Risks/Issues

2.12 This scheme is RAG rated as amber because of the slippage in delivering a single specialist care at home service for people within the last six months of life. Delaying the commissioning of this service pending the outcome of the Social Finance bid referred to in paragraph 2.11 prevents creating further fragmentation in the provision of services for people at end of life when there is an opportunity to develop and deliver a more integrated service model.

Scheme 3: Rapid response and integrated intermediate care.	**Scheme RAG Rating**	**Amber**
	a) Finance	**Amber**
	b) Scheme Delivery	**Green**

Scheme 3 Funding	**Approved Pooled Budget**	**Forecast Outturn**	**Variance as at Month 3**
	£000's	**£000's**	**£000's**
HCCG Commissioned Services funding	5,347	5,347	0
LBH - Protecting Social Care funding	2,920	3,019	99
Total Scheme 3	**8,267**	**8,286**	**99**

Scheme Financials

2.13 The forecast outturn is in line with HCCG contracted spend. For LBH, there is a forecast pressure on the spot purchase of intermediate care beds, due to increasing demand for placements.

Scheme Delivery

2.14 During Q1 the Reablement Team received 227 referrals and of these 51 were from the community; the remainder were from hospitals, primarily Hillingdon Hospital. The community referrals represented potential hospital attendances and admissions that were consequently avoided. During this period, 102 people were discharged from Reablement with no on-going social care needs.

2.15 In Q1 the Rapid Response Team received 886 referrals, 56% (500) of which came from Hillingdon Hospital, 19% (169) from GPs, 11% (99) from community services such as District Nursing and the remaining 13% (118) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 500 referrals received from Hillingdon Hospital, 340 (68%) were discharged with Rapid Response input, 138 (28%) following assessment were not medically cleared for discharge and 22 (4%) were either out of area or inappropriate referrals. All 386 people referred from the community source received input from the Rapid Response Team.

2.16 As identified in Table 5, officers are currently working on proposals for a more integrated model for intermediate care and options will be developed for consideration and consultation in Q3.

Scheme Risks/Issues

2.17 This scheme is RAG rated as amber because of the over-spend in the provision of bed-based step-down accommodation.

Scheme 4: Seven day working.	Scheme RAG Rating	Green
	a) Finance	Green
	b) Scheme Delivery	Green

Scheme 4 Funding	Approved Pooled Budget	Forecast Outturn	Variance as at Month 3
	£000's	£000's	£000's
LBH - Protecting Social Care funding	100	100	0
Total Scheme 4	**100**	**100**	**0**

Scheme Financials

2.18 Expenditure on seven day working which relates to Mental Health Social Workers is forecast to be on budget.

Scheme Delivery

2.19 Table 6 below identifies the key deliverable under the Out of Hospital Seven day Working Standard action plan for Q1. Hillingdon was required to develop an action plan as one of the national conditions for the 2016/17 BCF plan.

Table 6: Out of Hospital Seven Day Working Action Plan Update		
Task	**Update**	**RAG Rating**
A requirement for nursing homes to have suitably qualified staff available to undertake assessments in an acute setting 7-day a week included into WLA DPS tender specification.	It was agreed by councils participating in the consortium for the dynamic purchasing system (DPS) tender led by LB Ealing to include this provision in the specifications for residential and nursing care home placements. The Council's October Cabinet meeting will be asked to approve the results of the tender process. The DPS will enable the Council to comply with procurement regulations in respect of spot placements in care homes.	Completed (Green)

2.20 **Appendix 3** shows the comparison in discharge activity at Hillingdon Hospital in Q1 from 2014/15 to 2016/17. This shows a significant drop in the number of discharges on a Saturday compared to 2015/16, e.g. 347 (2016/17) compared to 546 (2015/16). This is largely accounted for by a drop in discharges of people admitted for planned (also known as elective) procedures from 332 in 2015/16 to 171 in Q1 2016/17. There has also been a reduction in the number of Saturday discharges of people who were admitted in an emergency (non-elective admissions).

2.21 **Appendix 3A** shows the comparison of discharges taking place before midday in Q1 from 2014/15 to 2016/17. Discharges taking place before midday provides a better experience of the discharge

process for residents as they are able to return home earlier in the day. Approximately 25% of all discharges occurred before midday in Q1 2016/17 and this is comparable with the previous year. There was an increase in the number of pre-midday discharges from Monday through to Thursday but a reduction on Saturday and Sunday.

Scheme Risks/Issues

2.22 The Q1 data demonstrates that although the delivery of the action plan is on track being able to impact on the pattern of discharges across the week is going to take longer to materialise, which is because all of the component parts of a seven day system in Hillingdon need to be in place for this to work consistently.

2.23 This scheme RAG rated as green on the basis that the Q1 action requirements have been delivered.

Scheme 5: Integrated Community-based Care and Support	**Scheme RAG Rating**	**Green**
	a) Finance	**Green**
	b) Scheme Delivery	**Green**

Scheme 5 Funding	**Approved Pooled Budget**	**Forecast Outturn**	**Variance as at Month 3**
	£000's	**£000's**	**£000's**
HCCG Commissioned Services funding	6,021	5,911	(110)
LBH - Protecting Social Care funding	5,405	5,368	(37)
Total Scheme 5	**11,426**	**11,279**	**(147)**

Scheme Financials

2.24 Both HCCG and LBH are currently showing an underspend for the 1st Qtr due to lower than budgeted costs for Community Equipment, which results from the success of the joint work carried out between the partners to manage the demand on this budget. For LBH, this scheme also includes the capital funding grant for Disabled Facilities, which is currently forecast to be fully spent.

Scheme Delivery

2.25 The use of risk stratification tools within GP practices to identify older people living with long-term conditions who could benefit from care planning as part of a more anticipatory model of care has been expanded to all practices. The intention is to extend the use of these tools to other adults during 2016/17.

2.26 In Q1 2016/17 26 people aged 60 and over were assisted to stay in their own home through the provision of disabled facilities grants (DFG'S), which represented 39% of the grants provided. 64% (43) of the people receiving DFG's were owner occupiers, 33% (22) were housing association tenants, and 3% (2) were private tenants. The total DFG spend on older people (aged 60 and over) during Q1 2016/17 was £68k, which represented 30% of the spend during the quarter (£227k).

Scheme 6: Care Home and Supported Living Market Development	**Scheme RAG Rating**	**Green**
	a) Finance	**Green**
	b) Scheme Delivery	**Green**

Scheme 6 Funding	Approved Pooled Budget	Forecast Outturn	Variance as at Month 3
	£000's	£000's	£000's
LBH - Protecting Social Care	150	157	7
HCCG Commissioned Services funding	83	83	0
Total Scheme 6	**233**	**240**	**7**

Scheme Financials

2.23 There is forecast to be a minor staffing pressure on this budget for LBH.

Scheme Delivery

2.24 There were 430 emergency admissions from care homes in Q1 against a ceiling of 427, which means that activity is broadly on target. The annual ceiling for 2016/17 is 1,715 emergency admissions. The cost to the NHS of the admissions from care homes in Q1 was £995k.

2.25 The tender for the DPS referred to in table 6 and led by the London Borough of Ealing, resulted in seven of Hillingdon's care homes joining this electronic framework agreement, which is intended to ensure that the procurement process for spot purchases is competitive, fair and transparent. A key benefit of the DPS is that providers can join it at any time and officers will be undertaking promotional activity in October to encourage more of the local care home providers to join.

2.26 A task and finish group comprising of GP representatives, a consultant geriatrician and a representative from CNWL's community health and community mental health teams and also the third sector has met to help shape the care and wellbeing specification for the extra care sheltered housing schemes, including two new schemes that will open early in 2018. The service will be tendered in Q3 2016/17.

Risks/Issues

2.27 The limited availability of care homes in the borough willing to accept local authority and NHS placements is a significant problem. Officers will be undertaking a dialogue with providers over the coming months to discuss current and future needs as well as the impact on the care home market of the opening of the Grassy Meadow and Parkview extra care schemes in 2018.

Scheme 7: Supporting Carers	Scheme RAG Rating	Green
	a) Finance	Green
	b) Scheme Delivery	Green

Scheme 7 Funding	Approved Pooled Budget	Forecast Outturn	Variance as at Month 3
	£000's	£000's	£000's
LBH - Protecting Social Care	899	906	7
HCCG Commissioned Services funding	18	18	0
Total Scheme 7	**917**	**924**	**7**

Scheme Financials

2.27 For LBH, there is forecast to be a pressure on respite services to Carers due to increased placement cost being charged by providers.

Scheme Delivery

2.28 Work was undertaken during Q1 to ensure that all Carers' assessments undertaken are reflected in activity reporting, e.g. sole assessments, joint assessments and reviews. This identified that there were 286 assessments in Q1. On a straight line projection, this would result in 1,144 assessments being completed in 2016/17, which would represent an 8.5% (106) reduction on the 2015/16 outturn.

2.29 During Q1 130 Carers were provided with respite or another carer service at a cost of £230.7k. This compares to 106 Carers being supported at a cost of £217.4k in Q1 2015/16. The increase in the number of Carers supported and the cost of the support services reflects that the Council is now able to identify replacement care provided by homecare providers in order to meet the need of Carers, which it was not possible to do in 2015/16.

2.30 A new Carers' Café was launched in Ruislip, therefore creating increased support opportunities for Carers in this part of the borough.

2.31 A successful Carers Fair was delivered on 7th June 2016. 45 partner organisations held information stalls and 58 new carers were identified.

2.32 Following the launch of the Carers' Recognition Scheme at the end of Q4 2015/16 an event was held on the 10th May that resulted in 48 Carers who had been nominated by the people they are caring for being presented with a framed certificate by the Council's Carers' Champion, Councillor Haggar.

Scheme 8: Living Well with Dementia	Scheme RAG Rating	Green
	a) Finance	Green
	b) Scheme Delivery	Green

Scheme 8 Funding	Approved Pooled Budget	Forecast Outturn	Variance as at Month 3

	£000's	£000's	£000's
LBH - Protecting Social Care	305	289	(15)
Total Scheme 8	305	289	(15)

Scheme Financials

2.33 This budget reflects the cost of providing the Wren Centre, which is currently forecasting an underspend of £15k.

Scheme Delivery

2.34 Approximately 100 people were trained during Q1 by Alzheimer's Society to be Dementia Friends. This means that Hillingdon now has 3,500 trained Dementia Friends.

Dementia Friends Explained

A Dementia Friend learns a little bit more about what it is like to live with dementia and the little ways in which it is possible to help, such as:

- Getting in touch and staying in touch with someone living with dementia
- Volunteering for an organisation that helps people with dementia.
- Telling 5 friends about the Dementia Friends initiative.
- Carrying out a personal action e.g. being more patient when out in the community

2.35 The Council's Wellbeing Service developed a '5-ways to Wellbeing' training package for people living with dementia. The next stage involves working with the Alzheimer's Society and Memory Assessment Service to identify people who may be able to benefit from the training.

2.36 **Dementia Resource Centre** - Final planning consent was given for the Grassy Meadow extra care sheltered housing scheme, including the Dementia Resource Centre included within it. Officers from Adult Social Care, Resident Services, the architects and developer for both the Grassy Meadow and Parkview extra care schemes that are due to open in 2018 visited a best practice site that has the Stirling gold standard for dementia friendly environments. The learning taken from this visit will help to inform the fitting out of the new schemes.

2.37 **Dementia training** - Tier 1, or Introduction to Dementia, training was provided by the Alzheimer's Society to staff in the Contact Centre, Hillingdon Library staff and staff from GP practices (clinical and non-clinical).

BCF Programme Management Costs

	Approved Pooled Budget	Forecast Outturn	Variance as at Month 3
	£000's	£000's	£000's

BCF Programme Management	80	81	1
Total	**80**	**81**	**1**

3. Key Risks or Issues

Sustainability and Transformation Plan (STP) and the Three-year BCF Plan

3.1 The ten priorities of the Hillingdon's STP have been agreed by both the Health and Wellbeing Board and HCCG's Governing Body. The requirement to produce a three-year BCF plan provides an opportunity to demonstrate how integration between health and social care will contribute to the delivery of the broader STP priorities to make a positive difference to the lives of Hillingdon's residents.

3.2 The latest information through the BCF network suggests that the statutory guidance on the requirements for the development of the three-year BCF plan is unlikely to be published before the end of October. In view of the uncertainty about when this will actually be published, it is suggested partners continue to develop a plan that is appropriate to meet the needs of Hillingdon's population going forward. As with the development of the 2016/17 plan, the detail of this can then be adapted to suit NHSE requirements.

Delivering Change in a Complex System

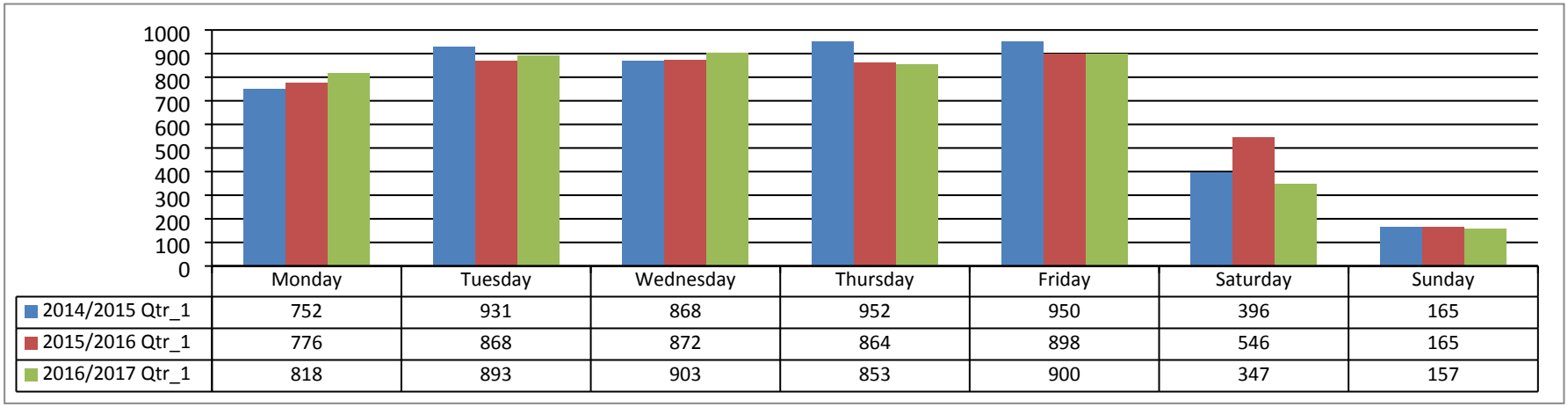
3.3 The 2015/16 BCF largely reflected work that was already in progress and for which, where additional resources were required, business cases had already been agreed. This is not the case with the 2016/17 plan and many of the schemes in the plan entail work that will require partners to make decisions about more ambitious models of integration that are unlikely to be delivered until into 2017/18 and beyond. This is due to such factors such as organisational governance processes and the logistics of delivering significant change in a complex health and care system that is under considerable pressure. Examples of some of these complexities include fragmentation within the NHS, the challenges and opportunities presented by the emerging Accountable Care Partnership (ACP) and the dynamics of the private health and care market.

DTOCs

3.4 The national conditions for 2016/17 BCF plan required the production of specific action plans to address Delayed Transfers of Care and the Out of Hospital Seven Day Working standard. The intention has been to manage delivery of these plans through existing groups but this has not delivered the required ownership and presents risks for delivery of key actions as set out in these plans. In view of the co-dependencies between the two plans, a single task and finish group is being created with senior representation from partner organisations.

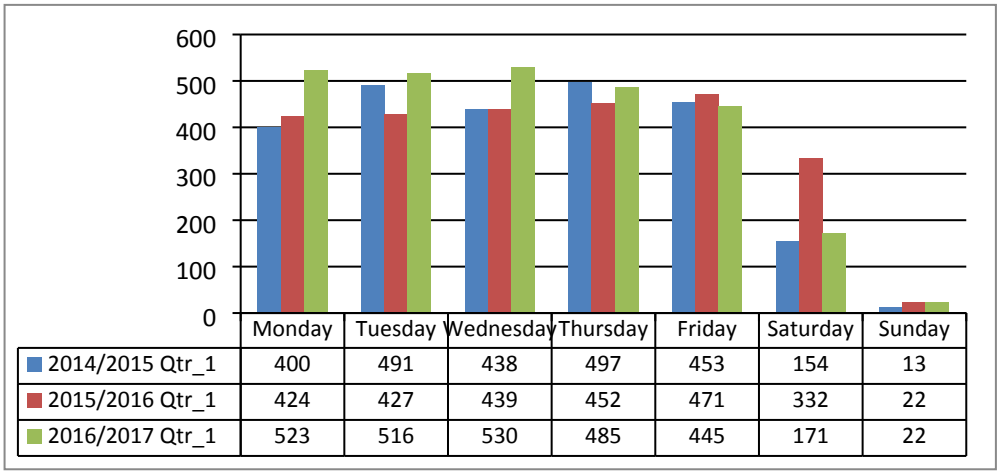
Appendix 3

Total Discharges by Day of the Week April - June 2014/15 to 2016/17



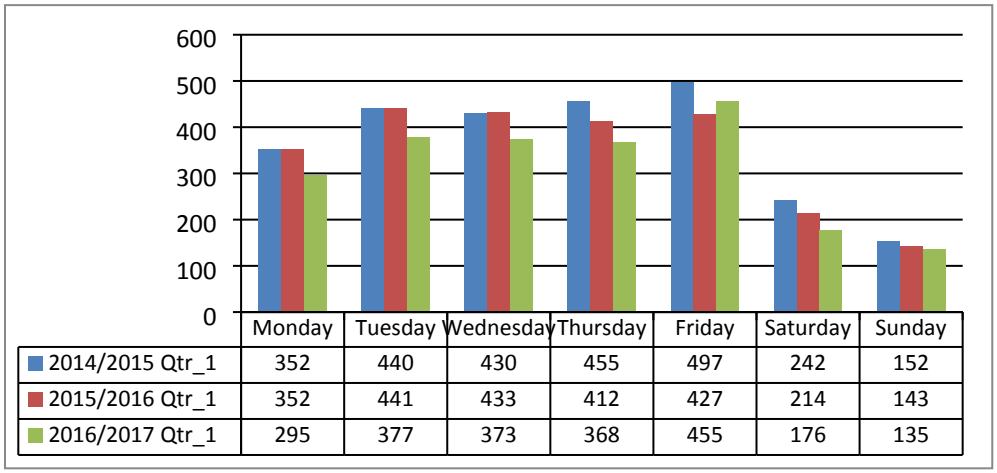
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_1	752	931	868	952	950	396	165
2015/2016 Qtr_1	776	868	872	864	898	546	165
2016/2017 Qtr_1	818	893	903	853	900	347	157

Discharges following Planned Admissions



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_1	400	491	438	497	453	154	13
2015/2016 Qtr_1	424	427	439	452	471	332	22
2016/2017 Qtr_1	523	516	530	485	445	171	22

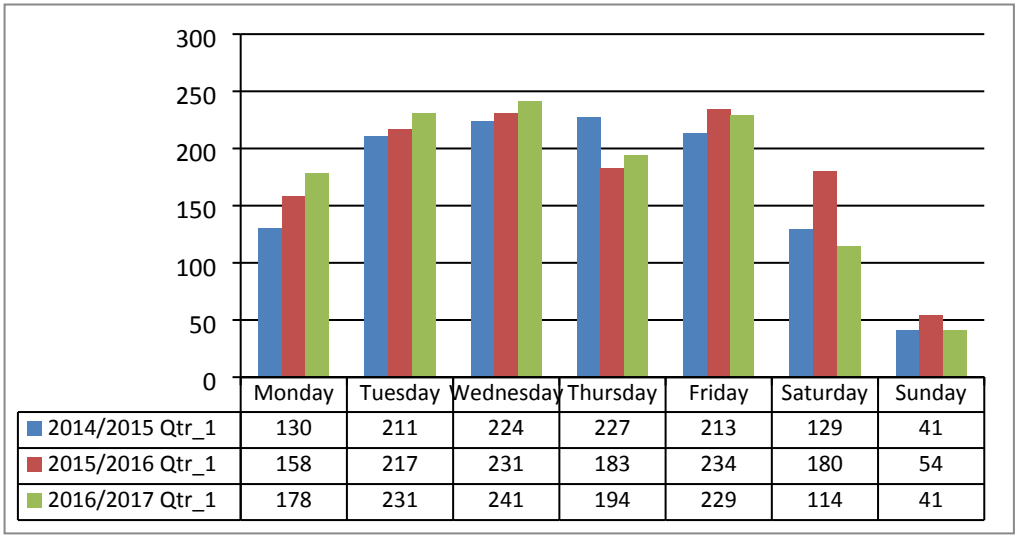
Discharges Following Unplanned Admissions



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_1	352	440	430	455	497	242	152
2015/2016 Qtr_1	352	441	433	412	427	214	143
2016/2017 Qtr_1	295	377	373	368	455	176	135

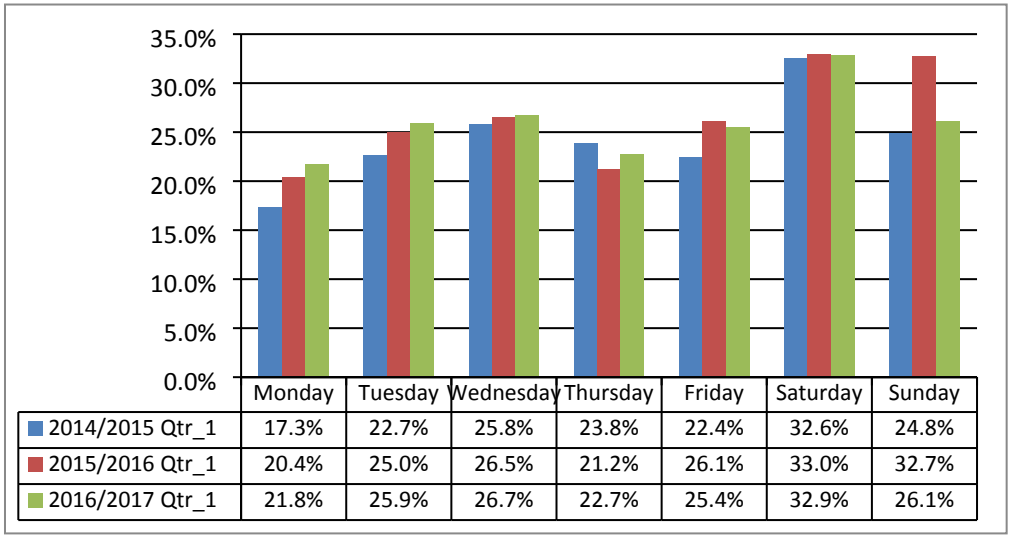
Discharges Taking Place before Midday April - June 2014/15 to 2016/17

Number of Patients Discharged Before Midday



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_1	130	211	224	227	213	129	41
2015/2016 Qtr_1	158	217	231	183	234	180	54
2016/2017 Qtr_1	178	231	241	194	229	114	41

% of Patients Discharged Before Midday



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_1	17.3%	22.7%	25.8%	23.8%	22.4%	32.6%	24.8%
2015/2016 Qtr_1	20.4%	25.0%	26.5%	21.2%	26.1%	33.0%	32.7%
2016/2017 Qtr_1	21.8%	25.9%	26.7%	22.7%	25.4%	32.9%	26.1%