BETTER CARE FUND: PERFORMANCE REPORT (JULY - SEPTEMBER 2016)

Relevant Board Member(s)	Councillor Ray Puddifoot MBE Councillor Philip Corthorne Dr Ian Goodman
Organisation	London Borough of Hillingdon Hillingdon Clinical Commissioning Group
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Papers with report	Appendix 1) BCF Monitoring report - Month 4 - 6: July - Sept 2016 Appendix 2) BCF Metrics Scorecard Appendix 3) Hillingdon Hospital Discharges Day by Day (July - Sept 2014/15 to 2016/17) Appendix 3A) Hillingdon Hospital Discharges Before Midday (July - Sept 2015/16 and 2016/17)

HEADLINE INFORMATION

Summary	This report provides the Board with the second 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 £22,531k for 2016/17 as at month 6.
Ward(s) affected	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

a. **notes the contents of the report.**
b. **provides feedback to officers on outline proposals for the 2017 to 2019 BCF plan contained within the report (paras 6 to 12).**
c. **provides feedback to officers on the Board's preferred sign-off arrangements for submission to NHSE of any draft planning templates or narrative documents.**

INFORMATION

1. This is the second 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. **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:

- In Q2 there were 2,420 emergency (also known as non-elective) admissions to hospital of people aged 65 and over against a ceiling for the quarter of 2,345. Although above the ceiling for the quarter, this level of activity is actually lower than during the same period in 2015/16 when there were 2,468 admissions.

- During the first half of 2016/17 there were 355 falls-related emergency admissions during, which compares to 344 during the same period in 2015/16.

- During Q2 there were 196 admissions to Hillingdon Hospital from care homes compared to 197 admissions during the same period in 2015/16.

- Delayed transfers of care - There were 2,418 delayed days during Q2, which was above the ceiling of 924, which means that activity during the quarter was significantly higher than projected. The position in Q2 2015/16 was 1,002 delayed days. The projected outturn for 2016/17 based on Q1 and 2 activity is 7,730 delayed days against a ceiling of 4,117 for the year.

- There were 31 permanent admissions of older people to care homes in Q2, which suggests that the outturn for 2016/17 is going to be below the ceiling for the year of 150.

- The average number of older people aged 65 and over still at home 91 days after discharge from hospital to reablement during Q2 was 88% against a target for 2016/17 of 93.8%.

- Although there has been an increase in the number of people admitted to Hillingdon Hospital for planned procedures being discharged at weekends, initiatives to improve patient flow and produce a more even distribution of discharges across the week have yet to take effect.

- 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 Q2 33 people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs).

Delayed Transfers of Care

4. There are a number of factors contributing to the increase in Hillingdon's DTOC position and these include:
- Recording practice - It is unclear as to the extent to which the increase in DTOC reporting in 2016/17 is related to an under-reporting in 2015/16 or an actual increase in accordance with the legal definition. Ensuring consistency and compliance with the legal definition of a DTOC is included within the hospital discharge action plan referred to **Appendix 1**;
- Increasing complexity of need of people admitted to hospital;
- Inefficient post-admission processes, such as an inconsistently applied approach to discharge planning; and
- Care home market capacity and willingness to address the placement needs of people with complex needs, including challenging behaviours.

DTOCs Defined

A delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready leave this type of care but is still occupying a bed. A patient is ready for transfer when:
a) A clinical decision has been made that a patient is ready for transfer AND
b) A multi-discilpinary team decision has been made that the patient is ready for transfer AND
c) The patient is safe to discharge/transfer

A multi-disciplinary team (MDT) should be made up from people from different professions, including social workers where appropriate.

5. These issues are reflected in the Hospital Discharge action plan. However, the Board should be aware that whilst improvements in the efficiency of internal pathways within Hillingdon Hospital and establishing discharge to assess provision within care home settings should assist in reducing the rate of increase in DTOCs the ceiling for 2016/17 is unachievable. In addition, securing a market solution to addressing the needs of residents with more challenging needs is not something that can be achieved quickly. It should also be emphasised that Hillingdon's experience in seeking to address this issue is a reflection of a national problem and is not unique.

Developing the 2017 to 2019 BCF Plan

6. From the information available from NHS England (NHSE) at the time of drafting, the expectation is that two documents will be published by the end of November 2016 critical to the completion and finalisation of the 2017 to 2019 plan:

- *BCF Policy Framework* - As for the 2016/17 plan, the purpose of this document will be to set out the national conditions that all Health and Wellbeing Board areas will be required to satisfy and also the assurance framework for the draft plans;

- *BCG Guidance and Key Lines of Enquiry* (KLOEs) - This will set out detailed requirements for completing the plan and the criteria against which plan assurance will be decided.

7. It is understood that the following requirements are likely to feature in the above documents:

   a) As with the 2016/17 plan, there will be a requirement to complete a planning template and a narrative document. How extensive the narrative document and any supporting information will need to be will be dependent on the KLOEs. National feedback to NHSE from local authorities and CCGs has been that the KLOEs should focus on encouraging joint working and integration and be significantly reduced in number;

   b) The plan will be required to identify how it will contribute to the delivery of the STP and the Government's vision of achieving *'full integration'* between health and social care by 2020;

   c) It is expected that nothing in the planning template or the narrative document would commit the Council or HCCG to anything until the HWB and HCCG Governing Body have formally agreed the final plan. This would reflect the process for the 2016/17 plan;

   d) There is a possibility that the 2017 to 2019 plan may be the last national iteration of the BCF as there is an expectation that by 2019 the integration agenda will have moved on considerably. What happens post April 2019 is likely to be dependent on the delivery of the broader integration agenda reflected in STPs and also the implications of devolution;

   e) Once again reflecting the 2016/17 plan, the assurance process will be undertaken at a regional rather than national level, which for Hillingdon means at a London level. This is to be welcomed as the people who will be involved in this process are known, e.g. Director of Adult Social Care at Newham, the London Better Care Manager and London NHSE Director of Commissioning Operations and have a better understanding of the different issues faced by boroughs and CCGs across London. They are also easily contactable.

8. Officers will update the Board with any additional information that becomes available prior to its December meeting.

9. In the meantime, partners are continuing to work on proposals for the next plan, which are being developed within the context of the Sustainability and Transformation Plan (STP). The September Board update advised that proposals under consideration included:

- ***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. CAMHS is the subject of a separate report on the agenda for the Board's December meeting.

- ***Intermediate Care*** - Options for a fully integrated intermediate care service that will lead to 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.

- ***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.

10. Other proposals also under consideration include:

- ***Children and Young People*** - This is considering integrated commissioning options for placements/services for children with complex needs as well as integrated approaches to addressing the education, health and/or care needs of young people aged 19 to 25 with special educational needs and disabilities.

- **Council participation in the Accountable Care Partnership (ACP)** - This looks at the scope for producing better outcomes for residents through the Council joining the ACP and how this might develop during the two year period of the new BCF plan and beyond.

Accountable Care Partnership Explained

An ACP is a partnership of organisations which:
- Is commissioned to deliver outcomes for local people;
- Includes the functions most necessary to deliver these outcomes;
- Is accountable for end to end care of the population;
- Built around a registered population, e.g. people aged 65 and over;
- Functions at a scale sufficient to hold clinical and financial accountability for a population;
- Makes decisions on resource allocation and performance within the partnership, sharing financial risks and benefits;
- Embeds service users in decision making and governance.

11. In accordance with the Board's mandate for officers to be more ambitious in the approach to the next iteration of the BCF plan, partners are also exploring a variety of lead arrangements between the Council and HCCG for major service areas. Subject to future Board, Council and HCCG Governing Body approval, this could result in different lead arrangements during the two year period of the plan. For illustrative purposes only, intermediate care and end of life are examples of where the bulk of the expenditure and provider contract management responsibility sits with the CCG and that therefore a CCG commissioning lead would seem to be logical. With both intermediate care and end of life care HCCG's intention is that its existing contracts will be reflected within its contract with the ACP. This therefore impacts on the development of the ACP and the role of the Council within it.

12. Homecare and care homes are areas where the majority of expenditure is with the Council and where a local authority lead may prove most appropriate. The sustainability of the local homecare and care home markets will be impacted by the development of the ACP, e.g. through availability of professional advice and support to providers. These proposals would also represent the development of a more collaborative approach to supporting the whole health and care system in Hillingdon, which would be new and reflect a greater level of ambition. This would greatly contribute to supporting the sustainability of the health and care system.

13. With Board approval, the proposals as outlined in paragraphs 10 and 11 above will be developed further within the detailed 2017 to 2019 BCF plan proposals to be brought before a future meeting of the Board and HCCG Governing Body.

Financial Implications

14. The Quarter 2 performance report for the Better Care Fund shows a forecast net underspend for 2016/17 of £204k an improvement of £159k from Quarter 1 arising from a favourable movement on the budget for community equipment for both organisations of £125k. 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 movements within the LBH - *Protecting Social Care* funding due increased demand on placement budgets offset by staffing underspends.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

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

Consultation Carried Out or Required

16. 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

17. None at this stage.

CORPORATE IMPLICATIONS

Corporate Finance Comments

18. 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

19. 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: December 2016	**Period covered:** July - Sept 2016 - Month 4 - 6
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 6**	**Variance as at Month 3**	**Movement from Month 3**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding	11,965	11,865	(100)	(110)	10
LBH - Protecting Social Care Funding	7,109	7,005	(104)	65	(169)
LBH - Protecting Social Care Capital Funding	3,457	3,457	0	0	0
Overall BCF Total funding	**22,531**	**22,327**	**(204)**	**(45)**	**(159)**

1.1 The financial position at Quarter 2 for the BCF shows an underspend of £204k, which is an improvement of £159k from Quarter 1

B. Outcomes for Residents: Performance Metrics

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

1.3 **Emergency admissions target (known as non-elective admissions)** - In Q2 there were 2,420 emergency (also known as non-elective) admissions to hospital of people aged 65 and over, which is above the ceiling for the quarter of 2,345. 1,742 of the admissions (nearly 72%) were to Hillingdon Hospital. Although activity is above the ceiling for the quarter it is actually lower than the same period in 2015/16 when there were 2,468 emergency admissions.

1.4 **Delayed transfers of care (DTOCS) -** There were 2,418 delayed days during Q2, which was above the ceiling of 924. The Q2 2016/17 position represents a significant increase on the same period in 2015/16 when the outturn was 1,002 delayed days. It is unclear as to the extent to which the increase in DTOC reporting in 2016/17 is related to an under-reporting in 2015/16 or an actual increase in accordance with the legal definition. Ensuring consistency and compliance with the legal definition of a DTOC is included within the hospital discharge action plan referred to paragraph 1.11.

1.5 If activity during Q1 and 2 continues at the same level during the remainder of 2016/17 then the projected outturn for the year could be 7,730 against a ceiling of 4,117. Although measures are in place to make improvements in the efficiency of internal pathways within Hillingdon Hospital and establish discharge to assess provision within care home settings, which should assist in reducing the rate of increase in DTOCs, the ceiling for 2016/17 is unachievable.

1.6 London comparative position - With a total of 3,865 delayed days for both Q1 and 2 Hillingdon had the 8th highest level of DTOCs in London (London average 483; highest was Ealing at 5,073; City of London was lowest with 502). Hillingdon had the 12th lowest number of DTOCs in London in 2015/16. The Q1 and 2 2016/17 social care DTOC position of 642 delayed days was 11th lowest in London (London average 173; highest was Ealing at 2,560; City of London was lowest with 0). Hillingdon's social care delays in 2015/16 were the 9th lowest in London.

1.7 Table 2 provides a breakdown of the delayed days during Q2 2016/17.

Table 2: Q2 DTOC Breakdown			
Q2 DTOC Breakdown			
Delay Source	**Acute**	**Non-acute**	**Total**
NHS	1,268	651	1,919
Social Care	270	45	315
Both NHS & Social Care	0	184	
Total	**1,538**	**880**	**2,418**

1.8 36% (880) of the delayed days concerned people with mental health needs in non-acute beds and of these nearly 62% (542) arose due to difficulties in securing suitable placements. 91% (802) of the non-acute delayed days concerned patients in beds provided by CNWL.

1.9 Nearly 59% (1,057) of the 1,789 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.

1.10 Table 3 shows the breakdown of delayed days by NHS trust for Q2.

Table 3: Distribution of Delayed Days by NHS Trust	
Trust	**Number of Delayed Days (Q2)**
CNWL	802
Chelsea & Westminster	1
Hillingdon Hospitals	1,315
Imperial College, London	24
Luton & Dunstable	
North West London (Northwick Park and Ealing)	107
Oxford University	1
Royal Brompton and Harefield	13
Royal Orthopaedic Hospital	16
University College	4
West Hertfordshire (Watford General)	102
West London Mental Health Trust	33
TOTAL	**2,418**

1.11 **Care home admission target** - During Q2 there were 31 permanent placements into care homes (11 nursing homes and 20 residential homes) against a ceiling of 37, which means that the level of activity was below the ceiling. On a straight line projection, activity in Q1 and Q2 would suggest an outturn for 2016/17 138 permanent placements against a ceiling of 150.

1.12 It should be noted that the new permanent admissions figure in paragraph 1.11 above is a gross figure that does not reflect the fact that there were 33 people who were in permanent care home placements also left during the period 1st July 2016 to 30th September 2016. As a result, at the end of Q2 there were 457 older people permanently living in care homes (228 in residential care and 229 in nursing care). This figure also includes people who reached their sixty-fifth birthday in Q2 and were, therefore, counted as older people.

1.13 **Percentage of people aged 65 and over still at home 91 days after discharge from hospital to reablement** - Of the 166 people discharged from hospital to Reablement in Q1 2016/17, 88% (146) were still at home 91 days later, i.e. in Q2 2016/17. Of the 20 people who were not at home at the end of the 91 day period 9 people passed away and 11 were readmitted. 9 of the readmissions were for reasons unrelated to the original cause of admission. The reporting period for the national metric that is used for national comparison purposes is Q3 and for these residents their 91 period will be completed in Q4.

C. Relationship Maturity Metrics

1.14 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 4: 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.	**Some slippage (Amber)** - Approval for revised proposals that will include nursing home placements, bed-based short-term respite, homecare as well as an expansion of Personal Health Budgets (PHBs) 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) -** Discussions about an integrated model of homecare between health and social care will take place in Q3.
6.	An integrated outcomes framework for older people.	**On track (Green)** - 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 Q4.
8.	The risk and benefits share arrangements following a shadow arrangement in 2016/17.	**On track (Green)** - This will developed as part of the process of developing the 2017 - 2019 BCF plan.

2. Scheme Delivery

Scheme 1 Funding	Approved Budget	Forecast Outturn	Variance as at Month 6	Variance as at Month 3	Movement from Month 3
	£000's	£000's	£000's	£000's	£000's
LBH - Protecting Social Care	657	659	2	3	(1)
HCCG Commissioned Services funding	390	390	0	0	0
Total Scheme 1	**180**	**1,049**	**2**	**3**	**(1)**

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 *Connect to Support* - From 1st July 2016 to 30th September 2016, 1,516 individuals accessed Connect to Support and completed 2,292 sessions reviewing the information & advice pages and/or details of available services and support. This represents a reduction of 132 people and 258 sessions on the same period in 2015/16.

2.3 During Q2, 17 people completed online social care assessments and 7 were by people completing it for themselves and 10 by Carers or professionals completing on behalf of another person. 12 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 4 self-assessments undertaken by Carers in Q2.

2.4 A range of activity to promote Connect to Support took place during Q2 and this included training for GP receptionists, attendance at District Nurse and Community Matron team meetings as well as running stalls at the Carers', Citizens' Advice and Age UK 60 + fairs. There were also articles in *Hillingdon People*. The impact of this activity in terms of increased utilisation of Connect to Support will be reported in future performance reports.

2.5 *H4All Wellbeing Service* - During the first half of 2016/17 668 residents have accessed the service and nearly 77% (514) of were aged 75 and over. In this period 357 assessments have taken place using the Patient Activation Model (PAM), which tests how motivated a person is to manage their long-term condition and helps to identify the level of support required from the service. 73 people had a second assessment following a period of support and 48 showed an increased score and therefore increased confidence and motivation. However, 25 people either had a reduced score or there was no difference. The service is now testing how different types and levels of support will impact on increasing confidence and motivation for all residents accessing it. This evidence is also being evaluated to demonstrate how these PAM scores translate in terms of actual A&E and GP attendances.

2.6 *Falls-related Admissions* - There were 355 falls-related emergency admissions during the first half of 2016/17, which is marginally above the 344 total for the same period in 2015/16. The total cost of the falls-related admissions in Q1 and 2 2016/17 was £1,193k, which compares to £1,149k during the same period in 2015/16.

2.7 *Making Every Contact Count* - A training package for delivering Making Every Contact Count (MECC) was developed by the Council's Wellbeing Service and tested out on staff within the team. MECC is about making use of the interactions that staff have with residents in the community to identify those at risk of escalating needs where small changes in their lifestyle, e.g. stopping smoking, increasing physical activity, moderating alcohol consumption, could make a significant difference to their health and wellbeing. This type of prevention can help reduce future demand on health and care services. Face to face training will be delivered to Library staff in Q4.

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

Scheme 2: Better care at the end of life

Scheme 2 Funding	**Approved Budget**	**Forecast Outturn**	**Variance as at Month 6**	**Variance as at Month 3**	**Movement from Month 3**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
LBH - Protecting Social Care	50	50	0	0	0
HCCG Commissioned Services funding	106	106	0	0	0 0
Total Scheme 2	**156**	**156**	**0**	**0**	**0** **0**

Scheme Financials

2.8 The forecast outturn is in line with HCCG contracted spend. LBH spend on end of life care is forecast to be on budget.

Scheme Delivery

2.9 An action in the 2016/17 BCF plan is to commission an integrated specialist end of life care at home service. This had been delayed pending the outcome of the bid for external funding to develop an integrated end of life service in Hillingdon. The results of the bid process were due in Q3 but are now unlikely to be known until Q4. 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. However, partners are currently exploring the value of establishing a short-term integrated service as a test of concept to be commissioned from a local third sector organisation by the Council. Award of contract approval from the Leader of the Council and the Cabinet Member for Social Services, Housing, Health and Wellbeing will be sought in Q3.

2.10 An information sharing agreement between the Council and the Royal Marsden NHS Hospital Foundation Trust was signed in respect of the advanced planning tool Coordinate My Care (CMC) and Adult Social Care read and write access to this system went live. This will help to improve coordination between organisations providing care for people at end of life.

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

Scheme 3 Funding	Approved Budget	Forecast Outturn	Variance as at Month 6	Variance as at Month 3	Movement from Month 3
	£000's	£000's	£000's	£000's	£000's
HCCG Commissioned Services funding	5,347	5,347	0	0	0
LBH - Protecting Social Care funding	2,920	2,857	(63)	99	(162)
Total Scheme 3	**8,267**	**8,203**	**63**	**99**	**(162)**

Scheme Financials

2.11 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 which is offset by forecast staffing underspends following the restructure of the Reablement Service .

Scheme Delivery

2.12 During Q2 the Reablement Team received 211 referrals and of these 161 were from hospitals, primarily Hillingdon Hospital and the other 50 were from the community. The community referrals represented potential hospital attendances and admissions that were consequently avoided. During this period, 122 people were discharged from Reablement with no on-going social care needs.

2.13 In Q2 the Rapid Response Team received 923 referrals, 55% (510) of which came from Hillingdon Hospital, 20% (182) from GPs, 12% (108) from community services such as District Nursing and the remaining 13% (123) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 510 referrals received from Hillingdon Hospital, 367 (72%) were discharged with Rapid Response input, 117 (23%) following assessment were not medically cleared for discharge and 26 (5%) were either out of area or inappropriate referrals. All 413 people referred from the community source received input from the Rapid Response Team.

2.14 The Board may wish to note that the first half of 2016/17 saw an increase of 12.6% on the same period in 2015/16 in the number of people aged 80 and over attending Hillingdon Hospital but a reduction of 3.4% in the number being admitted. This is largely attributable to the proactive work being undertaken by the Rapid Response Team.

2.15 The Council's Hospital Discharge Team supported the early discharge of 157 people from Hillingdon Hospital and 62 people from other hospitals during the first half of 2016/17. 'Early discharge' means that people were identified and supported into an alternative care setting before an assessment notice under the Care Act was served.

2.16 During Q2 the ACP established four task and finish groups that are looking in detail at redesigning the services being delivered by the organisations within the ACP to improve care planning, reduce fragmentation, improve effectiveness and, most importantly, improve the resident experience of care. Adult Social Care is involved with these groups to ensure alignment between health and social care and with the objectives of Hillingdon's BCF plan. The work of these groups will help to inform the development of the 2017 to 2019 plan for the Board and CCG Governing Board approval.

2.17 The detail of a proposal for a bed-based Discharge to Assess Service based within a local nursing home to address a possible winter demand surge have been agreed between partners with the intention of the Council acting as lead commissioner. Provider appointment approval will be sought during Q3 in accordance with the Council's governance process.

2.18 Other actions relevant to the delivery of this scheme are addressed within the DTOC action plan update referred to in table 5 below. The development of the action plan was an NHSE requirement as part of the development of the 2016/17 BCF plan.

Table 5: DTOC Action Plan Update		
Task	**Update**	**RAG Rating**
1. Complete development of a joint discharge policy and procedure.	A draft setting out roles and responsibilities of partners has been completed. This will be taken forward by the Joint Hospital Discharge Pathway Group for formal sign-off by partners in Q4.	
2. Develop information for patients.	Drafts have been produced using templates provided by NHSE. An application to a one off BCF Small Grant Fund (e.g. ≤£5K) provided by NHSE is being made to for printing. If approved this should be available for	**Amber**

	residents in Q4.	
3. Establish electronic transfer of assessment, discharge notices, withdrawal and change of circumstances notices.	A funding bid has been approved that will enable this action to be implemented in Q4.	
4. Develop a consistent approach to discharge planning across all THH wards.	These actions are being addressed as part of Hillingdon Hospital's transformation programme. Progress on delivery will be seen in Q4, although all actions are unlikely to be fully implemented in 2016/17.	
5. Embed earlier referrals to Hospital transport		
6. Ensure that patient medication is available by midday on the day of discharge.		
7. Ensure the availability of sufficient capacity for timely Continuing Healthcare assessments to be undertaken.	Discharge to assess pilot includes additional CHC nurse assessor capacity to better meet demand. This will be operational in Q4.	
8. Secure accommodation on main THH site for Adult Social Care Hospital Discharge Team.	A lack of space on the main site means that this action is not deliverable in the foreseeable future.	**Red**

Scheme Risks/Issues

2.19 Service delivery has been RAG rated as red for scheme 3 because of the level of DTOCs. The Board may wish to note that were not for the some of the positive work taking part as part of the delivery of this scheme, the DTOC situation would be much worse.

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

Scheme 4 Funding	**Approved Budget**	**Forecast Outturn**	**Variance as at Month 6**	**Variance as at Month 3**	**Movement from Month 3**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
LBH - Protecting Social Care funding	100	102	2	0	2
Total Scheme 4	**100**	**102**	**2**	**0**	**2**

Scheme Financials

2.20 A minor overspend is forecast on seven day working which relates to Mental Health Social Workers.

Scheme Delivery

2.21 Table 6 below identifies the key deliverable under the Out of Hospital Seven day Working Standard action plan for Q2. 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**
Key acute healthcare professionals are accessible 7-days a week.	A & E consultants are contactable until midnight 7-days a week. There is an acute physician on site seven days a week and for 8 hours on Saturdays and Sundays.	Completed (Green)
Ensure that there is sufficient transport capacity 7-day a week.	Hillingdon Hospital will be tendering its transport contract in the New Year and the results of this will not be completed in 2016/17.	Slippage (Amber)
Develop care home provision for older people with challenging behaviours, including people with dementia, able to admit 7-days a week.	Addressing the supply issues within the care home market is unlikely to be resolved in-year.	Slippage (Amber)

2.22 During Q2 the Hawthorne Intermediate Care Unit (HICU) started to accept referrals on Saturdays, which means that the unit now accepts referrals six days a week. This will assist with patient flow out of the Hospital.

2.23 By the end of Q2 arrangements were put in place to enable the management of complex wound care delivered by CNWL to be available seven days a week for patients of the Ambulatory Emergency Care Unit at Hillingdon, which helps to prevent admissions that are avoidable.

2.24 Improved communication between the Emergency Department and the Psychiatric Liaison Team has led to earlier involvement of the team in supporting people in A & E exhibiting mental distress and this has helped to prevent admissions.

2.25 **Appendix 3** shows the comparison in discharge activity at Hillingdon Hospital in Q2 from 2014/15 to 2016/17. From this it is possible to see that there was a nearly 5% (24) increase in discharges on a compared to the same period in 2015/16 but a 24% (48) reduction in Sunday discharges. The increase in Saturday discharges was entirely attributable to an increase in discharges of people admitted for planned procedures. The number of people discharged on a Saturday who were admitted as emergencies declined by nearly 16% (34). There was a 17% (29) reduction in discharges on Sundays.

2.26 **Appendix 3A** shows the comparison of discharges taking place before midday in Q2 from 2014/15 to 2016/17. It is possible to see from this information that there has been an overall reduction in the proportion of people discharged before midday in comparison with the same period in 2015/16. For weekend discharges this has reduced from 35.5% of Saturday discharges in 2015/16 to 31.2 in 2016/17 and from 27% to 23.7% for Sunday discharges.

2.27 The conclusion from this data is that initiatives to improve patient flow through the Hospital and produce a more even distribution of discharges across the week have yet to take effect.

Risks/Issues

2.28 Although all the tasks scheduled to be completed within Q2 are on track, there are tasks due to be completed in Q3 where there is slippage. These are noted in table 6 above and result in this scheme being RAG rated amber.

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

Scheme 5 Funding	**Approved Budget**	**Forecast Outturn**	**Variance as at Month 6**	**Variance as at Month 5**	**Movement from Month 5**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding	6,021	5,921	(100)	(111)	11
LBH - Protecting Social Care funding	5.405	5,417	12	(37)	49
Total Scheme 5	**11,426**	**11,338**	**(88)**	**(148)**	**60**

Scheme Financials

2.28 Both HCCG and LBH are currently showing an underspend for the 2nd Qtr due to lower spend 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. The forecast includes a pressure of £37k for Older People placements. For LBH, this scheme also includes the capital funding grant for Disabled Facilities, which is currently forecast to be fully spent.

Scheme Delivery

2.29 Reference to the development of the four service redesign task and finish groups by the ACP referred to in paragraph 2.15 is relevant to the delivery of this scheme.

2.30 In Q2 2016/17 33 people aged 60 and over were assisted to stay in their own home through the provision of disabled facilities grants (DFG'S), which represented 61% of the grants provided.

2.31 22% (12) of the people receiving DFG's were owner occupiers, 72% (39) were housing association tenants, and 6% (3) were private tenants. The total DFG spend on older people (aged 60 and over) during Q2 2016/17 was £85k, which represented 30% of the spend during the quarter (£287k).

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

Scheme 6 Funding	**Approved Budget**	**Forecast Outturn**	**Variance as at Month 6**	**Variance as at Month 3**	**Movement from Month 3**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
LBH - Protecting Social Care	150	157	7	7	0
HCCG Commissioned Services funding (including non elective performance fund)	83	83	0	0	0
Total Scheme 6	**233**	**240**	**7**	**7**	**0**

Scheme Financials

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

Scheme Delivery

2.33 Emergency admissions from care homes - There were 327 emergency admissions from care homes during the first half of 2016/17 at a total cost of £1,106k. This compares to 362 admissions in 2015/16 at a cost of £924k. The increased cost of the lower number of admissions in 2016/17 can be explained by increased lengths of stay.

2.34 A soft market testing exercise was undertaken with four potential providers of care and support for older residents living in extra care sheltered housing. The purpose of the exercise was to identify whether the proposed model was attractive to the market as well as identifying what other factors would encourage providers to bid. This exercise has helped to finalise the content of the service specification for the care and wellbeing in extra care service which will be the subject of a competitive tendering exercise in Q4.

Risks/Issues

2.35 This scheme has been RAG rated amber on scheme delivery due to delays in the undertaking the modelling work to project the need for bed-based services over the next five years. Discussions are currently in progress between the Council and HCCG about the scope for jointly engaging an external organisation to undertake this work and necessary approvals will be sought in due course if required. This work is intended to lead to the development of a care home market position statement which will give the market advanced notice of Council and NHS requirements over the next five to ten years.

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

Scheme 7 Funding	Approved Budget	Forecast Outturn	Variance as at Month 6	Variance as at Month 3	Movement from Month 3
	£000's	£000's	£000's	£000's	£000's
LBH - Protecting Social Care	899	871	(28)	9	(37)
HCCG Commissioned Services funding	18	18	0	0	0
Total Scheme 7	**917**	**889**	**(28)**	**9**	**(37)**

Scheme Financials

2.36 For LBH, there is forecast to be a pressure on respite services to Carers due to increased placement cost being charged by providers which is offset by a reduction in the cost of carers' assessments.

Scheme Delivery

2.37 There has been further refinement of the recording of carers' assessments to ensure greater accuracy of recording and reporting. What is recorded is the first assessment taking place within the financial year and any subsequent assessments that are completed within 90 days of the previously counted assessment. Assessment figures include sole assessments, joint assessments and reviews. Using this methodology there were 191 assessments in Q2, compared to 259 in Q1. On a straight line projection this would result in 900 assessments being completed in 2016/17, which would represent a 14.9% reduction on the 2015/16 outturn (1,058).

2.38 During Q2 183 Carers were provided with respite or another carer service at a cost of £430.7kk. This compares to 123 Carers being supported at a cost of £372.9k in Q2 2015/16.

2.39 In Q2 the Carers in Hillingdon contract started provided by the Hillingdon Carers Partnership and led by Hillingdon Carers. This new contract creates a single point of access for Carers. It should lead to better outcomes for Carers and therefore the people they care for.

2.40 A multi-agency Young Carers' Strategy was established and held its first meeting during Q2. This enables partners to work collaboratively to take a much more strategic approach to addressing the needs of young carers. The long standing Carers' Strategy Group for adults has proved successful in enabling partners to work together to deliver better outcomes for adult Carers.

2.41 Two local Carer Forum meetings took place in Hayes and Northwood, both of which were attended by approximately 30 Carers. The local Carer Fora are intended to create an opportunity for Carers to meet other Carers and identify what support is available to them, including how they can be assisted to support one another.

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

Scheme 8 Funding	Approved Budget	Forecast Outturn	Variance as at Month 6	Variance as at Month 3	Movement from Month 3
	£000's	£000's	£000's	£000's	£000's
LBH - Protecting Social Care	305	267	(38)	(15)	(23)
Total Scheme 7	305	**267**	**(38)**	**(15)**	**(23)**

Scheme Financials

2.42 This budget reflects the cost of providing the Wren Centre, which is currently forecasting an underspend of £38k.

Scheme Delivery

2.43 Stirling University ran a training session for the designers of Grassy Meadow Court and Parkview Court extra care schemes to ensure that the gold standard for having a dementia friendly environment is achieved.

2.44 90 staff across health and social care, including GP surgery staff, took part in dementia awareness training.

2.45 A new health service for people with learning disabilities was implemented in July with a specific focus on identification of people with dementia. This is intended to assist with the early identification, diagnosis and treatment of people with dementia. People with learning disabilities, especially people living with Down's syndrome, have a particular susceptibility to dementia that increases with age.

BCF Programme Management Costs

	Approved Budget	Forecast Outturn	Variance as at Month 6	Variance as at Month 3	Movement from Month 3
	£000's	£000's	£000's	£000's	£000's
BCF Programme Management	80	81	1	1	0
Total	80	**81**	**1**	**1**	**0**

3. Key Risks or Issues

IT Interoperability

3.1 *Carer Information Exchange* - There have been delays in starting the Care Information Exchange (CIE) pilot, which is intended to test a software system that will enable organisations involved in a person's care to update details of their intervention electronically onto an online system that would also be accessible to the resident. The system is intended to enable Hillingdon's care community to get to the point where residents/patients only have to tell their story once. The delays in starting the pilot are due to information governance concerns of the Local Medical Council (LMC). Discussions are in progress to address these.

2017 to 2019 BCF Plan Delivery Timescale

3.2 It is expected that the timescale for developing and finalising the plan is likely to be very tight and this will inevitably limit the scope for involving residents and service users and other stakeholders, e.g. health, social care and third sector staff, in the development process. A communications plan will be drafted once the plan has been agreed by the Board and HCCG Governing Body and has cleared the NHSE assurance process. Consultation will be undertaken as part of the development and delivery of the specific elements within the plan, many of which, in mitigation, will be seeking to address issues that have been identified in the many consultation exercises undertaken in recent years.