BETTER CARE FUND: PERFORMANCE REPORT (OCTOBER - DECEMBER 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 7 -9: October - December 2016 Appendix 2) BCF Metrics Scorecard Appendix 3) Hillingdon Hospital Discharges Day by Day (October - December 2014/15 to 2016/17) Appendix 3A) Hillingdon Hospital Discharges Before Midday (October - December 2014/15 to 2016/17)

HEADLINE INFORMATION

Summary	This report provides the Board with the third 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 9.
Ward(s) affected	All

RECOMMENDATION

That the Health and Wellbeing Board notes the contents of the report.

INFORMATION

1. This is the third 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:

- *Emergency admissions* - In Q3 there were 2,478 emergency (also known as non-elective) admissions to hospital of people aged 65 and over, which is marginally above the ceiling for the quarter of 2,432. On a straightline projection this would suggest an outturn for 2016/17 of 9,913 admissions against a ceiling of 9,700.

- *Falls-related emergency admissions* - There were 190 falls-related admissions during Q3 against a ceiling of 180 for the quarter. The projected outturn of 806 admissions would exceed the ceiling for 2016/17 of 720 but would be similar to 2015/16 activity.

- *Emergency admissions from care homes* - 2016/17 to the end of Q3 has seen a 22% drop in the number of the emergency admissions from care homes supported by Hillingdon GPs, e.g. 401 admissions compared to 514 in the same period in 2016/17. This suggests that initiatives to support local care homes supported by Hillingdon GPs are being successful. However, this does not reflect attendances and admissions to Hillingdon Hospital from care homes outside of the borough or those care homes in the borough supported by GPs from outside of the borough.

- *Delayed transfers of care (DTOC)* - There were 2,122 delayed days during Q3, which was above the ceiling of 1,350. This activity was attributed to 36 people in an acute setting and 14 people in non-acute, primarily with CNWL. The projected outturn for 2016/17 based on Q1 to Q3 activity is 7,983 delayed days against a ceiling of 4,117 for the year.

- *Permanent admissions to care homes* - There were 40 permanent admissions of older people to care homes in Q3, which suggests that the outturn for 2016/17 is going to be below the ceiling for the year of 150.

- *Still at home 91 days after discharge from hospital to reablement* - The average number of older people aged 65 and over still at home 91 days after discharge from hospital to reablement during Q3 was 94.2% against a target for 2016/17 of 93.8%.

- *Seven day working* - There has been an increase in the number of people admitted to Hillingdon Hospital for planned procedures being discharged at weekends and an increase in the percentage of people being discharged on Saturdays before midday but there is little change to the discharge pattern for people admitted as emergencies.

- *Connect to Support* - 3,576 individuals accessed Connect to Support and completed 4,975 sessions reviewing the information & advice pages and/or details of available services and support. This represents an increase of 2,286 people and 3,037 sessions on the same period in 2015/16 and suggests that promotional activities are starting to have an impact.

- *Disabled Facilities Grants* - In Q3 31 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 were a total number of 5,987 delayed days between Q1 and Q3. The number of people to which delayed days in acute hospitals are attributed will be reported verbally to the

Board. The delayed days in non-acute beds during this period were attributed to 38 people (27 with CNWL).

5. The Q2 report to the December Board meeting identified the key reasons for Hillingdon's DTOC position, which remain unchanged and these include:

- Increasing complexity of need of people admitted to hospital;
- Inefficient post-admission processes, such as an inconsistently applied approach to discharge planning;
- A local health and care system that remains complex and fragmented; and
- A lack of care home market capacity and willingness to address the placement needs of people with complex needs, including challenging behaviours.

6. There is confidence amongst partners that the DTOC definition is being appropriately applied, which suggests that there was under-reporting in 2015/16.

7. Although Hillingdon Hospital has had its own transformation programme in place during 2016/17 that was looking at how to improve patient flow through the hospital, in Q2 the Trust requested support from NHS Improvement (NHSI)'s Emergency Care Improvement Programme (ECIP). In recent months ECIP has been supporting the Trust to diagnose, review and facilitate improving patient flow across the whole hospital. ECIP has also been looking at the whole system with a view to reducing the length of stay of people admitted to the Hospital who are medically fit to leave. Actions arising from ECIP's work with Hillingdon's emergency care system will be reflected in the Hospital Discharge Action Plan and overseen by a multi-agency task and finish group called the Joint Hospital Discharge Pathway Group. The escalation route from this group is to the A & E Delivery Board and the Health and Wellbeing Board.

<u>2016/17 BCF Plan Evaluated</u>

8. A key achievement of the 2016/17 BCF plan has been the continued improvement in the working relationship between health and care professionals, which is of significant importance to the delivery of better outcomes for residents. Other achievements include:

- *Online information portal* - The online system called Connect to Support (C2S) is intended to enable residents to identify the services that are available to meet their needs and promotional activity has significantly increased the numbers accessing the system;

- *H4All Wellbeing Service* - This innovative service intended to prevent the needs of older people living with long-term conditions escalating so as to result in a loss of independence and increase demand on health and care services became operational and is starting to show positive results;

- *Coordinate My Care (CMC)* - Adult Social Care has gained read and write access to this advanced care planning tool that is used in London to ensure the coordination of care for people at end of life;

- *Hospital discharge* - A new patient information booklet has been produced that should contribute to a reduction in the number of DTOCs attributed to the patient/family choice reason. Partners have also worked together to establish bed-based discharge to assess arrangements in local care homes in order to relieve pressure on Hillingdon Hospital. Increased investment by the CCG has funded an additional consultant geriatrician post that will help to support community health teams to support discharge and prevent readmission.

Hillingdon Hospital has established and recruited to nine Patient Flow Coordinator posts that will help to ensure a more consistent discharge process across wards;

- *Seven day working* - Additional medical cover has enabled the Hawthorn Intermediate Care Unit (HICU) to accept referrals seven days a week;

- *Carers' hub contract* - A new contract delivering a single point of access for Carers of all ages started. This is provided by the consortium Hillingdon Carers' Partnership and led by Hillingdon Carers;

- *Dementia Resource Centre* - Planning consent was given for Grassy Meadow Court extra care sheltered housing scheme in which will be located the Dementia Resource Centre. When open in 2018 this will provide support to people living with dementia and their Carers;

- *Dementia training* - The Alzheimer's Society was funded through the BCF to deliver *Introduction to Dementia* training to staff working in GP surgeries as well as the Council's contact centre and libraries.

9. The Board and HCCG Governing Body agreed a number of metrics as a means of measuring the success of the 2016/17 plan. These included the four national metrics mandated by NHS England (NHSE) and eight local measures referred to as relationship maturity metrics. Paragraph 3 of this report highlights that the projected outturn for two of the national metrics will be missed, e.g. emergency admissions reduction and DTOCs. For DTOCs the target will be missed by a considerable margin. Performance against targets for the other two national metrics, e.g. permanent admissions to care homes and the people still at home 91 days after discharge to reablement, are on track to be achieved.

10. The relationship maturity metrics are set out in **Appendix 1** (table 4) but the following are examples and reflect an intention to have in place by 31/03/17:

- The preferred integration option and procurement route for intermediate care services;
- The preferred integration option and procurement route for end of life services;
- The model of wrap-around services for care homes and supported living schemes.

11. Five of the eight relationship maturity metrics are showing slippage, which reflects the challenges with the delivery of the 2016/17 plan, e.g. that it requires partners to make decisions on more ambitious models of integration within the context of a very difficult financial situation and a highly complex local health and care system, as well as the need to navigate the governance processes of sovereign partner organisations. This was less of an issue with the 2015/16 plan as this largely reflected work that was already in progress and for which business cases had been agreed. In addition, the ambition for 2015/16 was limited as it was the first plan and partners agreed to minimise risk.

12. In conclusion, although this report highlights some of the evident achievements in 2016/17, it is has been more of a positional year that has enabled relationships to develop to create the opportunity for greater integration to deliver the objectives within the STP and better outcomes for residents from 2017/18. This is subject to agreement on the level of ambition by the Board and HCCG Governing Body. The suggested priorities for the 2017/19 BCF Plan are set out in a separate report on the agenda for the Board's March meeting.

13. The Board may also wish to note that the joint work between partners has helped to prevent demand on Hillingdon Hospital being much greater than that experienced during the review

period. For example, in the period April to December 2016 there has been a 7% increase in the number of attendances at the Hospital of people aged 65 and over compared to the same period in 2015/16 but a 4% drop in admissions. The key issue that has not been addressed is the 24% increase in bed days during this period and this is reflected in the suggested priorities for the 2017/19 BCF plan.

Financial Implications

14. The Quarter 3 performance report for the Better Care Fund shows a forecast net underspend for 2016/17 of £229k an increase of £25k from Quarter 2 arising from a favourable movement on the budget for community equipment for both organisations of £153k. 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 mainly within the Reablement Service.

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 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: March 2017	**Period covered:** Oct - Dec 2016 - Month 7 - 9
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	Amber
	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 9	Variance as at Month 6	Movement from Month 6
	£000's	£000's	£000's	£000's	£000's
HCCG Commissioned Services funding	11,965	11,854	(110)	(100)	(10)
LBH - Protecting Social Care Funding	7,109	6,989	(119)	(104)	(15)
LBH - Protecting Social Care Capital Funding	3,457	3,457	0	0	0
Overall BCF Total funding	**22,531**	**22,301**	**(229)**	**(204)**	**(25)**

1.1 The financial position at Quarter 3 for the BCF shows a forecast underspend of £229k, increasing from £204k at Quarter 2, mainly due to unfilled vacancies within the Council's Reablement team continued efficiencies with the provision of community equipment offset by pressures arising from the increased cost of placements.

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 Q3 there were 2,478 emergency (also known as non-elective) admissions to hospital of people aged 65 and over, which is above the ceiling for the quarter of 2,432. 1,829 of the admissions (nearly 74%) were to Hillingdon Hospital. Although activity is above the ceiling for the quarter it is marginally lower than the same period in 2015/16 when there were 2,560 emergency admissions.

1.4 **Delayed transfers of care (DTOCS) -** There were 2,122 delayed days during Q3, which was above the ceiling of 1,350. The Q3 2016/17 position represents a significant increase on the same period in 2015/16 when the outturn was 1,369 delayed days.

1.5 If activity during Q1 and 3 continues at the same level during the remainder of 2016/17 then the projected outturn for the year could be 7,983 against a ceiling of 4,117.

1.6 Table 2 provides a breakdown of the delayed days during Q3 2016/17.

Table 2: Q1 - 3 DTOC Breakdown			
Delay Source	**Acute**	**Non-acute**	**Total**
NHS	2,271	1,794	4,065
Social Care	773	558	1,331
Both NHS & Social Care	12	579	591

Total	**3,056**	**2,931**	**5,987**

1.7 65% (1,366) of the delayed days concerned people with mental health needs in non-acute beds and of these nearly 52% (703) arose due to difficulties in securing suitable placements. Nearly 99% (1,346) of the non-acute delayed days concerned people in beds provided by CNWL.

1.8 Nearly 59% (3,862) of all delayed days during the period Q1 to Q2 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.

1.9 Table 3 shows the breakdown of delayed days by NHS trust for the Q1 to Q3 period.

Table 3: Distribution of Delayed Days by NHS Trust

Trust	Number of Delayed Days (Q1-3)
Bucks Healthcare	26
Chelsea & Westminster	1
CNWL	2,749
Hillingdon Hospitals	2,178
Imperial College, London	55
Luton & Dunstable	11
North West London (Northwick Park and Ealing)	513
Royal Brompton and Harefield	31
Royal Orthopaedic Hospital	24
United Lincolnshire Hospitals	25
University College	24
West Hertfordshire (Watford General)	261
West London Mental Health Trust	88
TOTAL	**5,987**

1.10 **Care home admission target** - During Q3 there were 40 permanent placements into care homes (24 nursing homes and 16 residential homes) against a ceiling of 37, which means that the level of activity was marginally above the ceiling. On a straight line projection, activity from Q1 to Q3 would suggest an outturn for 2016/17 of 145 permanent placements against a ceiling of 150.

1.11 It should be noted that the new permanent admissions figure in paragraph 1.12 above is a gross figure that does not reflect the fact that there were 50 people who were in permanent care home placements also left during the period 1st October 2016 to 31st December 2016. As a result, at the end of Q3 there were 456 older people permanently living in care homes (220 in residential care and 236 in nursing care). This figure also includes people who reached their sixty-fifth birthday in Q3 and were, therefore, counted as older people.

1.12 **Percentage of people aged 65 and over still at home 91 days after discharge from hospital to reablement** - Of the 132 people discharged from hospital to Reablement in Q2

2016/17, 94.2% (126) were still at home 91 days later, i.e. in Q3 2016/17. Of the 8 people who were not at home at the end of the 91 day period 5 people passed away and 3 were readmitted. 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. This information will be reported in the 2016/17 outturn performance report to the Board at its June 2017 meeting.

C. Relationship Maturity Metrics

1.13 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 4 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.	**Slippage (Amber)** - The delivery of the closer integration of intermediate care services is reflected in the proposals for the 2017/19 BCF plan.
2.	The preferred integration option and procurement route for end of life services.	**Slippage (Amber) -** The delivery of the closer integration of end of life services is reflected in the proposals for the 2017/19 BCF plan.
3.	The integrated brokerage and contracting model for nursing care home placements.	**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) was approved in Q3 and will be implemented in 2017/18.
4.	The model of wrap-around services for care homes and supported living schemes.	**Slippage (Amber)** – Proposal being developed for additional input from GP primary care for agreement and proposed implementation in 2017/18. This will be in addition to new care of the care of the elderly consultant and care connection teams already agreed and currently being implemented.
5.	An integrated approach to home care market development and management.	**On track (Green) -** HCCG approval for the development of an integrated model as part of 2017/19 BCF is being sought.
6.	An integrated outcomes framework for older people.	**On track (Green)** - A draft framework is being consulted on in Q4.
7.	An agreed understanding of the impact for health of the reduction by the Council in the use of residential care.	**Slippage (Amber)** - A health impact assessment (HIA) is in development following a stakeholder workshop and will be finalised 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: Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.	**Scheme RAG Rating**	**Amber**
	a) Finance	**Green**
	b) Scheme Delivery	**Amber**

Scheme 1 Funding	**Approved Budget**	**Forecast Outturn**	**Variance as at Month 9**	**Variance as at Month 6**	**Movement from Month 6**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
LBH - Protecting Social Care	657	657	0	2	(2)
HCCG Commissioned Services funding	390	390	0	0	0
Total Scheme 1	**1,047**	**1,047**	**0**	**0**	**0**

Scheme Financials

2.1 The forecast outturn is on track with the budget.

Scheme Delivery

2.2 *Connect to Support* - From 1st October to 31st December 2016, 3,576 individuals accessed Connect to Support and completed 4,975 sessions reviewing the information & advice pages and/or details of available services and support. This represents an increase of 2,286 people and 3,037 sessions on the same period in 2015/16.

2.3 During Q3, 21 people completed online social care assessments and 7 were by people completing it for themselves and 14 by Carers or professionals completing on behalf of another person. 10 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 Q3.

2.4 *H4All Wellbeing Service* - With a staff complement comprising of 8 Wellbeing Support Officers, 1 Triage Officer, 1 Community Development Officer and 1 Service Manager, the Wellbeing Service has supported 1,099 residents in the period 1st April to 31st January 2017 by dealing with 2,729 enquiries resulting in 11,675 contacts with or for Hillingdon residents. The service provides older residents in Hillingdon with:

- Information and advice
- Home visits
- Practical support, e.g. welfare benefits advice, falls prevention advice, counselling, home help, transport.
- Individual motivational interviewing, goal setting and ongoing support to enable them to manage their long-term conditions.
- Befriending and mentoring
- Sign-posting and referral to voluntary or statutory sector services
- Input into care plans and care planning.

2.5 The Wellbeing Service has been using the Patient Activation Measure (PAM) tool for identifying the extent to which people are motivated to manage their own health and wellbeing. Under a PAM assessment a person is asked to complete a short survey and based on their responses, they receive a PAM score (between 0 and 100). The resulting score places the person at one of four levels of activation, level 1 showing the least motivation and requiring the most intervention and level 4 the highest level and therefore potentially requiring no more than sign-posting. People who are more motivated are significantly more likely to attend screenings, check-ups and immunisations, to adopt positive behaviours (e.g., diet and exercise), and have clinical indicators in the normal range (body mass index, blood sugar levels, blood pressure and cholesterol). During the Q1 to Q3 period 576 PAM assessments were undertaken, including 153 second assessments and 9 third assessments. In nearly 69% (111) of cases there was an improvement in their scoring, which suggested that they were better equipped to manage their long-term condition. The remaining 51 people experienced either no change or a reduction in their score.

2.6 *Falls-related Admissions* - There were 190 falls-related admissions during Q3 against a ceiling of 180 for the quarter. The projected outturn of 806 admissions would exceed the ceiling for 2016/17 of 720 but would be similar to 2015/16 activity.

Scheme Risks/Issues

2.7 This scheme is RAG-rated amber for service delivery due to delays in implementing the Atrial Fibrillation (AF) pilot in 12 community pharmacies across Hillingdon. AF is a major cause of stroke and increasing early detection will assist in preventing occurrences of stroke that are avoidable. This equipment has now been purchased and distribution to community pharmacies will take place in Q4.

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

Scheme 2 Funding	**Approved Budget**	**Forecast Outturn**	**Variance as at Month 9**	**Variance as at Month 6**	**Movement from Month 6**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
LBH - Protecting Social Care	50	51	1	0	1
HCCG Commissioned Services funding	106	106	0	0	0
Total Scheme 2	**156**	**157**	**1**	**0**	**1**

Scheme Financials

2.9 There is a minor variance on the provision of services by Harlington Hospice.

Scheme Delivery

2.10 An action in the 2016/17 BCF plan was 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 are still awaited. Options for delivering the specialist care at home service are now reflected in proposals for 2017/19 BCF plan.

Scheme Risks/Issues

2.11 This scheme is RAG-rated as amber for scheme delivery for the reasons outlined in paragraph 2.10 above.

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

Scheme 3 Funding	**Approved Budget**	**Forecast Outturn**	**Variance as at Month 9**	**Variance as at Month 6**	**Movement from Month 6**
	£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	2,728	(191)	(63)	(128)
Total Scheme 3	**8,267**	**8,075**	**(191)**	**(63)**	**(128)**

Scheme Financials

2.12 The forecast is line with HCCG contracted spend. For LBH, there has been a reduction in the financial pressure on spot purchase of intermediate care beds and further underspends in the Reablement team due to staff vacancies.

Scheme Delivery

2.13 During Q3 the Reablement Team received 196 referrals and of these 137 were from hospitals, primarily Hillingdon Hospital and the other 59 were from the community. The community referrals represented potential hospital attendances and admissions that were consequently avoided. During this period, 295 people completed their period of reablement with no on-going social care needs, which represents 84.8% of the people new to social care referred to the service. This is against a target of 85%.

2.14 In Q3 the Rapid Response Team received 1052 referrals, 60% (632) of which came from Hillingdon Hospital, 20% (206) from GPs, 10% (105) from community services such as District Nursing and the remaining 10% (109) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 632 referrals received from Hillingdon Hospital, 468 (74%) were discharged with Rapid Response input, 150 (24%) following assessment were not medically cleared for discharge and 14 (2%) were either out of area or inappropriate referrals. All 420 people referred from the community source received input from the Rapid Response Team.

2.15 The Council's Hospital Discharge Team supported the early discharge of 275 people from Hillingdon Hospital in the period from Q1 to Q3. 'Early discharge' means that people were identified and supported into alternative care settings before the Estimated Date of Discharge (EDD). This equates to 525 bed days avoided, thereby assisting the Hospital with patient flow.

2.16 Other actions relevant to the delivery of this scheme are addressed within the Hospital Discharge Action referred to in table 5 below that also incorporates the Out of Hospital Seven Day Working Standard Action Plan.

Table 5: Hospital Discharge 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 finalised in Q4 for sign-off by partner organisations early in 2017/18.	**Amber**
2. Develop information for patients.	A £5k grant has been awarded by NHSE under the BCF Small Grants Programme to fund production of revised patient information. A multi-agency task and finish group is working on this.	**Green**
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, subject to transfer of funds to the Council.	**Amber**
4. Develop a consistent approach to discharge planning across all THH wards.	The Hospital has recruited 9 Patient Flow Coordinators who will be allocated specific wards with the intention of ensuring consistency in the discharge process across the Hospital. The Hospital is also receiving support under the NHS Improvement's Emergency Care Improvement Programme to implement actions that will assist patients to be discharged at the earliest opportunity. Measures will not be fully implemented in 2016/17.	**Red**
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.	**Amber**
8. Secure accommodation on main THH site for Adult Social Care Hospital Discharge Team.	Following intervention of the Hospital's CEO options are under consideration for delivery in Q1 2017/18.	**Amber**

Scheme Risks/Issues

2.17 This scheme is RAG rated as red because of the DTOC performance and the delay in the delivery of actions within the Hospital Discharge Action Plan and also the extent of the underspend.

2.18 The action plan is overseen by a task and finish group called the Joint Hospital Discharge Pathway Group. With the support of the A & E Delivery Board that is jointly chaired by the Chief Executive of the Brent, Harrow and Hillingdon CCGs and the Chief Executive of Hillingdon Hospital and with executive representation from other health and care partners (including Adult Social Care), the ownership for the delivery of the actions within the plan is being clarified. Partners identified as owners will be accountable to the A & E Delivery Board for task delivery with an escalation route to the Health and Wellbeing Board.

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	2	0
Total Scheme 4	**100**	**102**	**2**	**2**	**0**

Scheme Financials

2.19. There is a minor overspend forecast on seven day working which relates to Mental Health Workers.

Scheme Delivery

2.20 The actions within this scheme are now reflected in the Hospital Discharge Action Plan referred to in paragraph 2.16 above.

2.21 **Appendix 3** shows the comparison in discharge activity across the week at Hillingdon Hospital in Q3 from 2014/15 to 2016/17. From this it is possible to see that there was a 26% (137) increase in discharges on Saturdays compared to the same period in 2015/16 but a 3% (6) reduction in Sunday discharges. As in Q2, 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 12% (27). There was a 5% (8) reduction in discharges on Sundays.

2.22 **Appendix 3A** shows the comparison of discharges taking place before midday in Q3 from 2014/15 to 2016/17. It is possible to see from this information that activity is broadly the same as 2015/16, although there has been a 5.4% increase in the number of discharges taking place on Saturdays before midday.

2.23 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 are starting to have an impact in respect of people admitted for planned procedures but there is as yet little impact in respect of people admitted as emergencies.

Risks/Issues

2.24 This scheme is RAG rated as amber due to slippage in the delivery of tasks reflected in the Hospital Discharge Action Plan.

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 9**	**Variance as at Month 6**	**Movement from Month 6**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding	6,021	5,910	(110)	(100)	(10)
LBH - Protecting Social Care funding	5.405	5,584	179	12	167
Total Scheme 5	**11,426**	**11,495**	**69**	**(88)**	**157**

Scheme Financials

2.25 Both HCCG and LBH are currently showing an underspend for the 3rd Qtr due to lower forecast expenditure of £153k than budgeted 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 £236k 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

2.26 The tender for an integrated community equipment contract to provide aids of daily living to support people in their own homes and expedite the hospital discharge process was undertaken. Hillingdon was part of the London Community Equipment Consortium comprising of 17 London boroughs and CCGs, which was led by the London Borough of Hammersmith and Fulham. The Council is the lead for this contract locally and approval for an award of contract will be sought from the Council's Cabinet in Q4.

2.27 In Q3 2016/17 31 people aged 60 and over were assisted to stay in their own home through the provision of disabled facilities grants (DFG's), which represented 55% of the grants provided.

2.28 30% (17) of the people receiving DFG's were owner occupiers, 62% (35) were housing association tenants, and 7% (4) were private tenants.

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 9	Variance as at Month 6	Movement from Month 6
	£000's	£000's	£000's	£000's	£000's
LBH - Protecting Social Care	150	143	(7)	(7)	0
HCCG Commissioned Services funding (including non elective performance fund)	83	83	0	0	0
Total Scheme 6	**233**	**226**	**(7)**	**(7)**	**0**

Scheme Financials

2.29 There is forecast to be a minor staffing underspend on this budget for LBH.

Scheme Delivery

2.30 *Emergency admissions from care homes* - There were 401 emergency admissions from care homes from Q1 to Q3 2016/17. This represents a 22% reduction from 514 admissions in the same period in 2015/16 and would suggest an outturn for 2016/17 of 535 emergency admissions, which compares to 650 in 2015/6. This suggests that initiatives to reduce emergency admissions from care homes are having a positive impact. However, it should be noted that this data does not reflect the impact on Hillingdon Hospital of attendances and admissions of people living in care homes in the borough with non-Hillingdon GPs and also from care homes from outside of the borough.

Risks/Issues

2.31 This scheme has been RAG rated amber because of slippage in a number of pieces of work including the modelling of care home requirements to 2020 and beyond and the development of a related market position statement to give the market advanced warning of Hillingdon's requirements. A workshop is taking place in March that will enable this work to be delivered in 2017/18.

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 9	Variance as at Month 6	Movement from Month 6
	£000's	£000's	£000's	£000's	£000's
LBH - Protecting Social Care	899	851	(48)	(28)	(20)
HCCG Commissioned Services funding	18	18	0	0	0
Total Scheme 7	**917**	**869**	**(48)**	**(28)**	**(20)**

Scheme Financials

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

Scheme Delivery

2.33 159 Carer's assessments were completed in Q3. This is made up of 27 sole assessments completed by Hillingdon Carers, 9 sole assessments completed by LBH and 123 joint assessments completed by LBH. It is projected Carers' assessment outturn for 2016/17 is 538, which reflects full assessments and not triage assessments that have been undertaken by Hillingdon Carers that have not proceeded to full assessments.

2.34 During Q3 178 Carers were provided with respite or another carer service at a cost of £376k. This compares to 118 Carers being supported at a cost of £358k in Q3 2015/16.

2.35 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. Some key outputs and outcomes from the first quarter of the operation of the contract are:

- 352 new adults Carers registered with Hillingdon Carers.
- 31 new Carers of people living with dementia were identified
- 24 new young Carers also registered.
- 2,335 volunteer hours providing extra support and capacity.
- 504 respite breaks were provided to 278 adult Carers
- 728 breaks were provided through social clubs to young Carers.
- £121,486 in new grants were secured, e.g. funded second Dementia Support Worker employed by the Alzheimer's Society.

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 9	Variance as at Month 6	Movement from Month 6
	£000's	£000's	£000's	£000's	£000's
LBH - Protecting Social Care	305	249	(56)	(38)	(18)
Total Scheme 7	**305**	**249**	**(56)**	**(38)**	**(18)**

Scheme Financials

2.36 This budget reflects the cost of providing the Wren Centre, which is currently forecasting an underspend of £56k.

Scheme Delivery

2.37 No update.

BCF Programme Management Costs

	Approved Budget	Forecast Outturn	Variance as at Month 9	Variance as at Month 6	Movement from Month 6
	£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

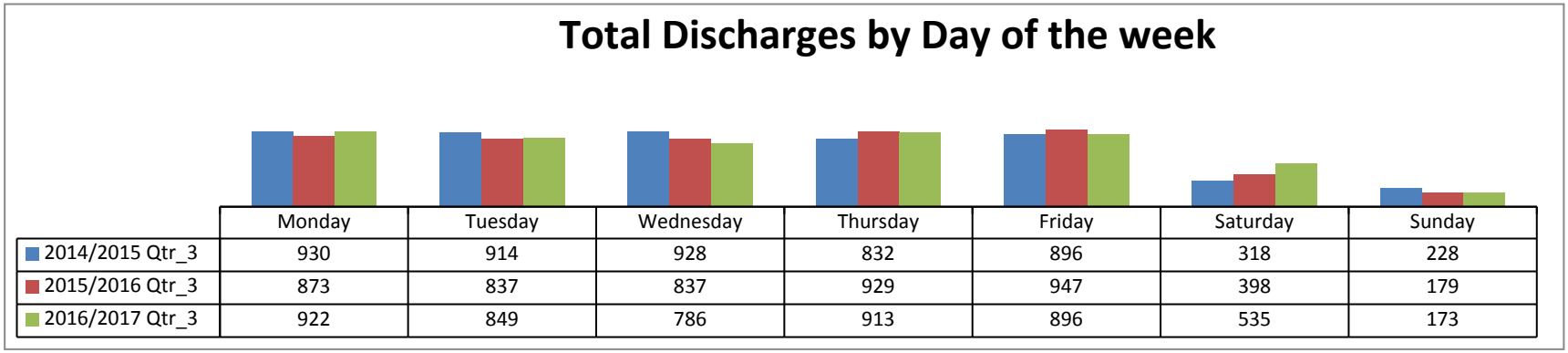
IT Interoperability

3.1 *North West London Information Sharing Agreement (NWLISA)* - The Council has yet to sign the NWLISA, which all local health providers, including GPs, and the H4All consortium have signed up to. Once some queries raised by the Council's Legal Team have been resolved the Council should be in a position to become a signatory. The target is to have this matter resolved by the end of 2016/17.

3.2 *DTOC Fines* - Under the 2014 Care Act the Hillingdon Hospital has the power to fine the Council for delayed transfers of care that are the responsibility of Adult Social Care. In most areas there is recognition that this is counter-productive and just reduces the funding available to support the social care needs of residents at a time of increasing pressure on social care budgets. In the spirit of partnership and in recognition of the support that Adult Social Care is providing and will continue to provide to the Hospital in expedite discharge, the Council and the Hospital are establishing a formal no fine agreement.

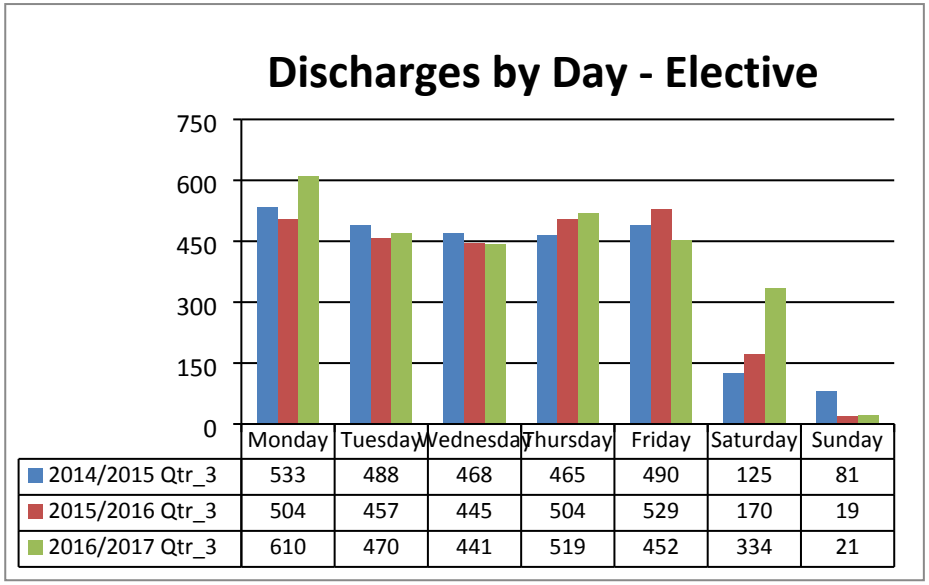
Appendix 3

Total Discharges by Day of the Week Oct - Dec 2014/15 to 2016/17



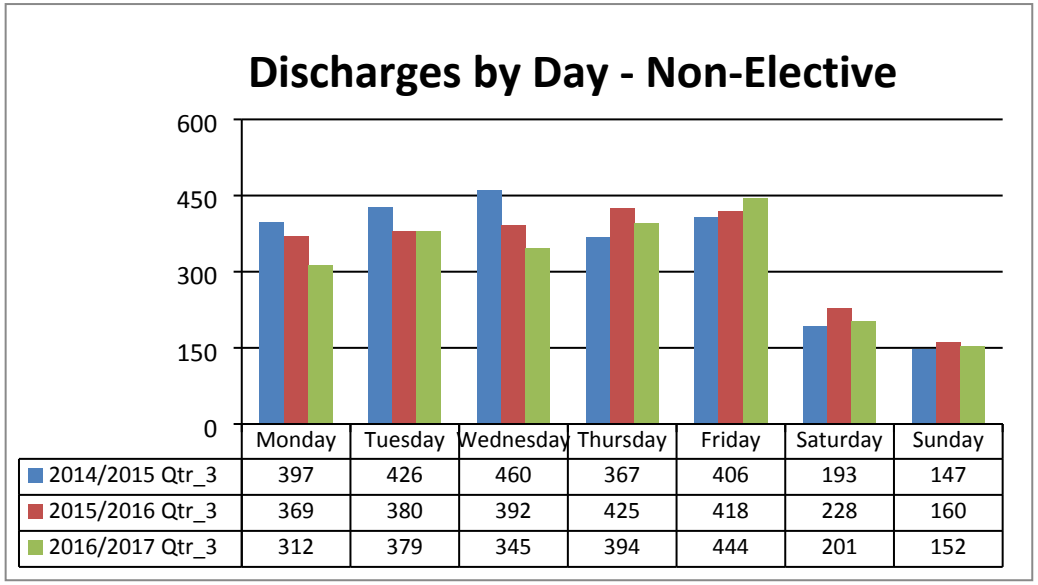
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_3	930	914	928	832	896	318	228
2015/2016 Qtr_3	873	837	837	929	947	398	179
2016/2017 Qtr_3	922	849	786	913	896	535	173

Discharges following Planned Admissions



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_3	533	488	468	465	490	125	81
2015/2016 Qtr_3	504	457	445	504	529	170	19
2016/2017 Qtr_3	610	470	441	519	452	334	21

Discharges Following Unplanned Admissions

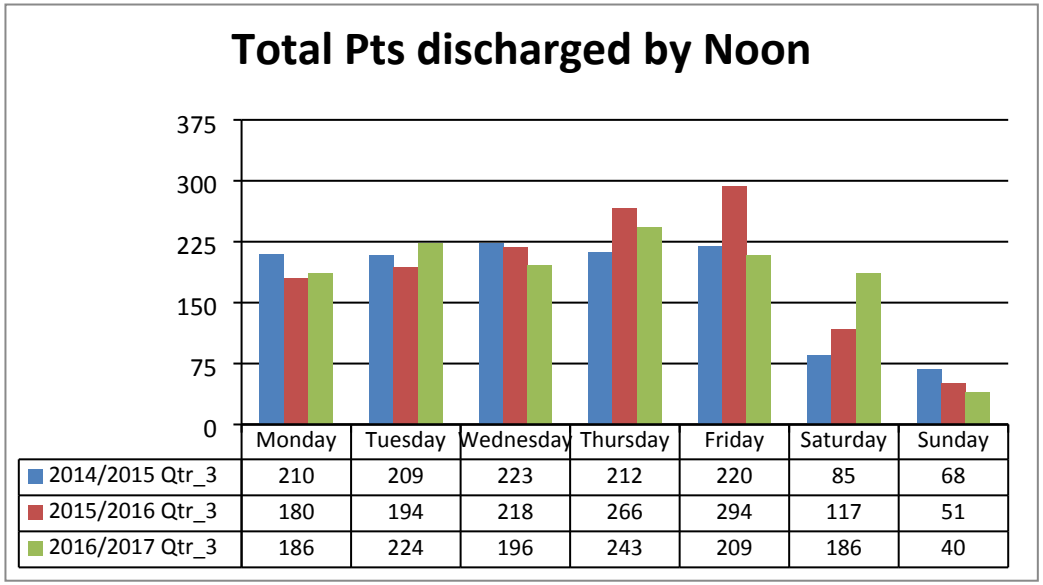


	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_3	397	426	460	367	406	193	147
2015/2016 Qtr_3	369	380	392	425	418	228	160
2016/2017 Qtr_3	312	379	345	394	444	201	152

Appendix 3A

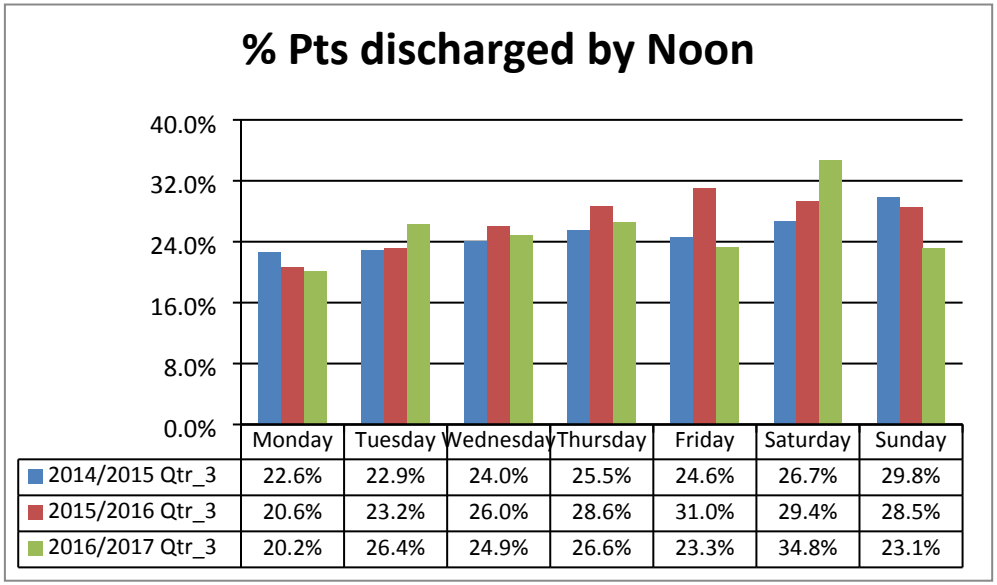
Discharges Taking Place before Midday July - September 2014/15 to 2016/17

Number of Patients Discharged Before Midday



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_3	210	209	223	212	220	85	68
2015/2016 Qtr_3	180	194	218	266	294	117	51
2016/2017 Qtr_3	186	224	196	243	209	186	40

% of Patients Discharged Before Midday



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2014/2015 Qtr_3	22.6%	22.9%	24.0%	25.5%	24.6%	26.7%	29.8%
2015/2016 Qtr_3	20.6%	23.2%	26.0%	28.6%	31.0%	29.4%	28.5%
2016/2017 Qtr_3	20.2%	26.4%	24.9%	26.6%	23.3%	34.8%	23.1%