BETTER CARE FUND: PERFORMANCE REPORT (JANUARY - MARCH 2017)

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

HEADLINE INFORMATION

Summary	This report provides the Board with the fourth and final 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 12.
Ward(s) affected	All

RECOMMENDATION

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

INFORMATION

1. This is the fourth and final performance report to the Health and Wellbeing Board (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 - Target missed*: During 2016/17 there were 10,252 emergency admissions (also known as non-elective admissions) which exceeded the ceiling for the year of 9,700. However, the performance was similar to the outturn for 2015/16, which was 10,210 emergency admissions.

- *Falls-related emergency admissions - Target missed*: There were 816 falls-related emergency admissions in 2016/17 compared to 764 in 2015/16.

- *Emergency admissions from care homes - Improved performance*: There were 787 emergency admissions from care homes of people aged 65 and over during 2016/17, which compares to 838 in 2015/16 and is an improvement in performance.

- *Delayed transfers of care (DTOC) - Target missed*: There were 8,364 delayed days during 2016/17 against a ceiling of 4,117 delayed days. 66% of the delayed days were attributed to the NHS, 22% to social care and 12% to both.

- *Permanent admissions to care homes - Target missed*: There were 161 permanent admissions to care homes in 2016/17 against a ceiling of 150 permanent admissions.

- *Still at home 91 days after discharge from hospital to reablement - Target missed*: The 2016/17 outturn was 86.1% against a target of 93.5%.

- *User experience metric: Social care-related quality of life - Target exceeded:* This metric was tested through the Adult Social Care Survey undertaken each year in Q4. The results are scored out of 24 and the higher the number the better. The target for 2016/17 was 18.6 and the outturn was 19.

- *User experience metric: People who have found it easy to access information and advice - Target missed*: This metric is also tested through the Adult Social Care Survey. The target for 2016/17 was 75.5% and the provisional outturn was 73.3%.

- *Seven day working* - In Q4, there was a 26% increase in discharges on a Saturday, which is solely attributed to the 59% increase in discharges of people admitted to Hillingdon Hospital for planned procedures.

- *Connect to Support* - 10,789 people accessed Connect to Support during 2016/17 and completed 15,412 sessions. This represents increases of 44% (4,791) and 39% (4,791) respectively on 2015/16 activity and suggests that not only was promotional activity during 2016/17 successful but also that residents found the system useful.

- *Disabled Facilities Grants* - In Q4, 23 people aged 60 and over were assisted to stay in their own homes through the provision of disabled facilities grants (DFGs). During 2016/17, 113 people aged 60 and over were supported to live at home through the provision of DFGs.

Delayed Transfers of Care (DTOC)

4. The reasons for Hillingdon's DTOCs have been highlighted to the Board in previous reports and continue to be:

- 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.

5. Hillingdon Hospital has been receiving support from NHS Improvement (NHSI)'s Emergency Care Improvement Programme (ECIP). 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 as well as actions identified by other partners, including Healthwatch, have been reflected in the draft Delayed Transfers of Care Action Plan that all areas are required to produce as one of the national conditions for the 2017/19 BCF plan. This will form part of the 2017/19 plan submission that the Board will be asked to approve in due course.

Financial Implications

6. The Outturn position for the Better Care Fund 2016/17shows a net forecast underspend of £226k, a decrease of £3k from quarter 3. The underspend arises from a favourable movement in the expenditure for both organisations of £216k on the Community Equipment budget. The demand management exercise undertaken during the last two financial years to manage the community equipment budget is now delivering an improved financial outcome. There are a number of offsetting minor movements within the LBH-Protecting Care funding due to 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?

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

Consultation Carried Out or Required

8. 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

9. None at this stage.

CORPORATE IMPLICATIONS

Corporate Finance Comments

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

Hillingdon Council Legal Comments

11. 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: June 2017	**Period covered:** Jan - March 2017 - Month 10 - 12
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**	**Outturn**	**Variance as at Month 12**	**Variance as at Month 9**	**Movement from Month 9**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned	11,965	11855	(110)	(110)	0

Services funding					
LBH - Protecting Social Care Funding	7,109	6,993	(116)	(119)	3
LBH - Protecting Social Care Capital Funding	3,457	3,457	0	0	0
Overall BCF Total funding	**22,531**	**22,305**	**(226)**	**(229)**	**3**

1.1 The outturn position continues to show an underspend on the BCF in 2016/17 of £226k due mainly to demand management action to bring the Community Equipment expenditure back in line with budget.

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)** - During 2016/17 there were 10,252 emergency admissions (also known as non-elective admissions) which exceeded the ceiling for the year of 9,700. However, the performance was at a similar level to the outurn for 2015/16, which was 10,210 emergency admissions. Emergency admissions of older people represent nearly 30% of all emergency admissions.

1.4 **Delayed transfers of care (DTOCS) -** There were 8,364 delayed days during 2016/17 against a ceiling of 4,117 delayed days. 66% of the delayed days were attributed to the NHS, 22% to social care and 12% to both. Table 2 provides a breakdown of the delayed days during 2016/17.

Table 2: Q1 - 4 DTOC Breakdown			
Delay Source	**Acute**	**Non-acute**	**Total**
NHS	2,783	2,753	5,536
Social Care	1,013	853	1,866
Both NHS & Social Care	36	926	926
Total	**3,832**	**4,532**	**8,364**

1.5 Nearly 60% (4,953) of all delayed days during 2016/17 were as a result of difficulties in securing appropriate placements and actions to address this are reflected in the 2017/19 DTOC action that will form part of Hillingdon's 2017/19 Better Care Fund plan submission.

1.6 Table 3 shows the breakdown of delayed days by the five NHS trusts that are hosting nearly 95% of the delays in 2016/17.

Table 3: Distribution of Delayed Days by NHS Trust	
Trust	**Number of Delayed Days (Q1-4)**
1. CNWL	3,917
2. Hillingdon Hospitals	2,747
3. North West London (Northwick Park and Ealing)	700
4. West London Mental Health Trust	282

5. West Hertfordshire (Watford General)	274
TOTAL	**7,920**

1.7 **Care home admission target** - During Q4 there were 26 permanent placements into care homes (12 nursing homes and 14 residential homes) and conversion of another 26 short-term placements into permanent placements. As a result the total number of permanent placements in 2016/17 was 161 against a ceiling of 150.

1.8 It should be noted that the new permanent admissions figure in paragraph 1.7 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 January 2017 to 31st March 2017. As a result, at the end of Q4 there were 462 older people permanently living in care homes (225 in residential care and 237 in nursing care). This figure also includes people who reached their sixty-fifth birthday in Q4 and were, therefore, counted as older people.

1.9 **Percentage of people aged 65 and over still at home 91 days after discharge from hospital to reablement** - The 2016/17 outturn was 86.1% against a target of 93.8%, which means that the target was not achieved. The sample period for this metric was people being discharged from hospital into reablement during Q3, which was 115 and of these 99 were still at home 91 days later. Of the 16 people who were not at home 91 days after discharge 7 had passed away, 1 person had been admitted to a care home and the remaining 8 had experienced a readmission to hospital. The needs of the population group to which this metric applies means that deaths and readmissions for reasons unrelated to the original cause of admission are inevitable. Improved performance against the metric could be achieved by limiting access to reablement to older people with less complex needs, which would have implications for the wider health and care system.

1.10 ***User experience metric: Quality of life*** - *Social care-related quality of life:* This metric was tested through the annual Adult Social Care Survey undertaken in Q4 2016/17. The results for this metric are scored out of 24 and the higher the number the better. The target for 2016/17 was 18.6 and the outturn was 19. The questionnaire is sent to a sample of adults in receipt of social care services and asks questions about issues such as control over daily life, social contact, personal safety, personal appearance, nutrition, etc.

1.11 ***User experience metric: People who have found it easy to access information and advice*** - This metric is also tested through the Adult Social Care Survey. The target for 2016/17 was 75.5% and the provisional outturn was 73.3%.

2. Scheme Delivery

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

Scheme 1 Funding	**Approved Budget**	**Outturn**	**Variance as at Month 12**	**Variance as at Month 9**	**Movement from Month 9**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
LBH - Protecting Social Care	657	657	0	0	0
HCCG Commissioned Services funding	390	390	0	0	0
Total Scheme 1	**1,047**	**1,047**	**0**	**0**	**0**

Scheme Financials

2.1 The outturn expenditure is in line with the approved budget.

Scheme Delivery

2.2 *Connect to Support* - From 1st January to 31st March 2017, 4,344 individuals accessed Connect to Support and completed 5,982 sessions reviewing the information & advice pages and/or details of available services and support. This represents an increase of 3,178 people and 3,997 sessions on the same period in 2015/16.

2.3 During Q4, 21 people completed online social care assessments and 12 were by people completing it for themselves and 9 by Carers or professionals completing on behalf of another person. 11 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 8 self-assessments undertaken by Carers in Q4.

2.4 *H4All Wellbeing Service* - 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 During Q4 the service supported 807 residents and dealt with 2,026 enquiries. There were 5,439 contacts, e.g. telephone calls, home visits and letters. 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. Health coaching, which is bespoke to the needs of residents who have been identified with a low PAM scoring following an assessment, was provided to 111 people during Q4. The purpose of this coaching is to increase PAM score, which would indicate that residents have improved motivation to manage their long-term condition (s).

2.6 H4All has employed a Community Development Officer (CDO) who has responsibility for finding innovative solutions to emerging needs and challenges, engaging with community groups and developing the community 'offer' to residents. The work of the CDO in Q4 has resulted in a Continence Support Group being established from April 2017. Working in partnership with the NHS Continence Service, this is a support group that also provides information sessions for residents living with continence issues and their Carers. It is for people who want to engage in the community and/or community services but are afraid or embarrassed by the issues related to their condition. A new buddy-up service will start in June 2017 that offers 1:1 initial support and transport for residents undertaking new activities, e.g. attending a new club for the first time, who require someone to accompany them where they are unable to attend be themselves or lack the confidence to do so.

2.7 *Falls-related Admissions* - There were 209 falls-related admissions during Q4 against a ceiling of 180 for the quarter, which contributed to a total of 816 admissions in 2016/17 against a ceiling of 720. It is also higher than the 2015/16 outturn of 764 and reflects Hillingdon's ageing population.

2.8 The Atrial Fibrillation (AF) screening pilot started in three community pharmacies and officers continue to work with other pharmacies with the intention of extending the pilot to 12 providers across the borough. Evaluation of the pilot is dependent on securing the additional community pharmacies and the volume of checks undertaken.

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

Scheme 2 Funding	**Approved Budget**	**Outturn**	**Variance as at Month 12**	**Variance as at Month 9**	**Movement from Month 9**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
LBH - Protecting Social Care	50	46	(4)	1	(5)
HCCG Commissioned Services funding	106	106	0	0	0
Total Scheme 2	**156**	**152**	**(4)**	**(1)**	**(5)**

Scheme Financials

2.9 The outturn shows 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 was delayed pending the outcome of the bid for external funding to develop an integrated end of life service in Hillingdon. Following remodelling of the bid to reflect the creation of a single people of access this has been resubmitted by the CCG to the external funder and the results are awaited. Options for delivering the specialist care at home service are now reflected in the integrated homecare proposals contained within the draft 2017/19 BCF plan.

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

Scheme 3 Funding	**Approved Budget**	**Outturn**	**Variance as at Month 12**	**Variance as at Month 9**	**Movement from Month 9**
	£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	2,696	(224)	(191)	(33)
Total Scheme 3	**8,267**	**8,043**	**(224)**	**(191)**	**(33)**

Scheme Financials

2.11 The outturn is line with HCCG contracted spend. For LBH, there has been an underspend that is attributed to staff vacancies within the Reablement Service.

Scheme Delivery

2.12 During Q4 the Reablement Team received 208 referrals and of these 148 were from hospitals, primarily Hillingdon Hospital and the other 60 were from the community. The community referrals represented potential hospital attendances and admissions that were consequently avoided. During 2016/17, there were 487 new referrals to the service and of these 86.2% (420) completed their period of reablement with no on-going social care needs, which is above the target of 85%.

2.13 In Q4 the Rapid Response Team received 1,099 referrals, 58% (644) of which came from Hillingdon Hospital, 22% (238) from GPs, 9% (99) from community services such as District Nursing and the remaining 11% (118) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 644 referrals received from Hillingdon Hospital, 488 (76%) were discharged with Rapid Response input, 145 (22%) following assessment were not medically cleared for discharge and 11 (2%) were either out of area or inappropriate referrals. All 455 people referred from the community source received input from the Rapid Response Team.

2.14 The Council's Hospital Discharge Team supported the early discharge of 364 people from Hillingdon Hospital and Mount Hospital during 2016/17 and also 108 people from other, out of Hillingdon hospitals. 'Early discharge' means that people were identified and supported into alternative care settings before the Estimated Date of Discharge (EDD). The early discharge from the Hillingdon Hospitals amounted to 689 bed days avoided, thereby assisting the Hospital with patient flow.

2.15 The Hospital has started to implement the 'red to green' initiative as part of the process of implementing a consistent discharge process across all wards. Under this initiative every patient on a ward is discussed by the discharge team as to whether the day ahead is 'red', e.g. a day where there is little or no value towards discharge or 'green', e.g. a day of value for the patient's progress towards discharge. If 'red', action needs to be agreed by the team to create a 'green' day instead.

2.16 The 2014 Care Act sets out the process for the Hospital to refer people who have been admitted and identified as possibly having care and support needs for a social care assessment. During 2016/17 1,418 assessment notices were received by Adult Social Care. Adult Social Care also received 1,494 discharge notices advising of the date of discharge of people admitted to hospital identified as having care and support needs. 46% (686) of these discharge notices were withdrawn during 2016/17. This has implications for provider capacity, e.g. where notification has been received too late to inform a homecare provider. It also impacts on social care staff workloads. The work underway within the Hospital as well as the work between the Hospital and other health and care partners should help to address this issue. However, the fact that Q1 2017/18 activity is showing that a similar trend with 45% of discharge notices having been withdrawn indicates that this has yet to have an impact. The percentage of discharge notices that are withdrawn is one of the indicators that will be monitored by Hillingdon's A & Delivery Board, a multi-agency partnership group that NHSE has mandated be established that has director-level representation from health and care partners and is jointly chaired by the Chief Executive of HCCG and Hillingdon Hospital.

2.17 Other actions relevant to the delivery of this scheme are addressed within the Hospital Discharge action plan and the report to the March Board provided a progress update on its delivery for which there is no further update.

Scheme Risks/Issues

2.18 This scheme is RAG rated as red because of the DTOC performance and the extent of the underspend.

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

Scheme 4 Funding	**Approved Budget**	**Outturn**	**Variance as at Month 12**	**Variance as at Month 9**	**Movement from Month 9**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
LBH - Protecting Social Care funding	100	100	0	2	(2)
Total Scheme 4	**100**	**100**	**0**	**2**	**(2)**

Scheme Financials

2.19 The outturn shows no movement from budget.

Scheme Delivery

2.20 The actions within this scheme are reflected in the hospital discharge action plan required as part of the national conditions for the 2016/17 BCF plan. As stated in paragraph 1.5 above, this is currently being revised as part of the 2017/19 BCF submission requirements.

2.21 In Q4 there was a 26% (517) in discharges on a Saturday compared with the same period in 2015/16. This was solely attributed to the 59% (546) increase in discharges of people admitted for planned (also known as elective) procedures. Discharges on a Saturday of people admitted as emergencies reduced by nearly 3% (29), but those on a Sunday increased by nearly 2% (16).

2.22 The number of people discharged before midday during Q4 decreased by nearly 3% (101) compared to the same period in 2015/16.

2.23 In conclusion, Q4 activity confirms the trend reported in the Q3 performance report that initiatives to facilitate or a more even distribution of discharges across the week are having an effect in respect of people admitted for planned procedures but not for people admitted as emergencies. Actions to increase the number of people being discharged before midday have yet to have any impact.

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 that will be included within the 2017/18 DTOC action plan to form part of the 2017/19 BCF plan submission.

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

Scheme 5 Funding	**Approved Budget**	**Outturn**	**Variance as at Month 12**	**Variance as at Month 9**	**Movement from Month 9**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
HCCG Commissioned Services funding	6,021	5911	(110)	(110)	0
LBH - Protecting Social Care funding	5.405	5639	234	179	55
Total Scheme 5	**11,426**	**11,550**	**124**	**69**	**55**

Scheme Financials

2.25 Both HCCG and LBH show an underspend of £216k against the Community Equipment budget , which results from the success of the joint work carried out between the partners to manage the demand on this budget. The outturn for forecast includes a pressure of £355k 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.

2.26 Under the risk and benefit share arrangements contained within the BCF section 75 agreement the underspend on the community equipment service contract will be shared equally between the Council and the CCG.

Scheme Delivery

2.27 In Q4 2016/17 23 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.

2.28 29% (11) of the people receiving DFG's were owner occupiers, 66% (25) were social housing tenants, and 5% (2) were private tenants.

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

Scheme 6 Funding	**Approved Budget**	**Outturn**	**Variance as at Month 12**	**Variance as at Month 9**	**Movement from Month 9**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
LBH - Protecting Social Care	150	142	(8)	(7)	(1)
HCCG Commissioned Services funding (including non elective performance fund)	83	83	0	0	0
Total Scheme 6	**233**	**225**	**(8)**	**(7)**	**(1)**

Scheme Financials

2.29 The outturn shows a small underspend on staffing.

Scheme Delivery

2.30 *Emergency admissions from care homes* - There were 787 emergency admissions from care homes of people aged 65 and over during 2016/17, which compares to 838 in 2015/16 and is an improvement in performance. 601 of the emergency admissions were at Hillingdon Hospital and 186 in acute trusts in other areas.

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

Scheme 7 Funding	**Approved Budget**	**Outturn**	**Variance as at Month 12**	**Variance as at Month 9**	**Movement from Month 9**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
LBH - Protecting Social Care	899	847	(52)	(48)	(4)

HCCG Commissioned Services funding	18	18	0	0	0
Total Scheme 7	**917**	**865**	**(52)**	**(48)**	**(4)**

Scheme Financials

2.31 The outturn shows an underspend on the cost of Carers' assessments.

Scheme Delivery

2.32 138 Carer's assessments were completed in Q4. This is made up of 33 sole assessments completed by Hillingdon Carers, 8 sole assessments completed by LBH and 97 joint assessments completed by LBH. It is projected Carers' assessment outturn for 2016/17 is 516, which reflects full assessments and not triage assessments that have been undertaken by Hillingdon Carers that have not proceeded to full assessments.

2.33 During Q4 193 Carers were provided with respite or another carer service at a cost of £391k. This compares to 118 Carers being supported at a cost of £340k in Q4 2015/16.This includes bed-based respite and home-based replacement care as well as voluntary sector provided services and services directly purchased via Direct Payments.

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

Scheme 8 Funding	Approved Budget	Outturn	Variance as at Month 12	Variance as at Month 9	Movement from Month 9
	£000's	£000's	£000's	£000's	£000's
LBH - Protecting Social Care	305	243	(62)	(56)	(6)
Total Scheme 7	**305**	**243**	**(62)**	**(56)**	**(6)**

Scheme Financials

2.34 The outturn showed an underspend of £62k which results from the running of the Wren Centre.

Scheme Delivery

2.35 The development of the Grassy Meadow Court extra care scheme that will contain Hillingdon's purpose built dementia resource centre is on track for handover in June 2018 and work will be undertaken with partners to ensure that maximum benefit is obtained from it for the support of residents living with dementia and their Carers and families.

BCF Programme Management Costs

	Approved Budget	Forecast Outturn	Variance as at Month 12	Variance as at Month 9	Movement from Month 9
	£000's	£000's	£000's	£000's	£000's
BCF Programme Management	80	81	1	1	0
Total	**80**	**81**	**1**	**1**	**0**