# BETTER CARE FUND PLAN 2017/19

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| **Relevant Board Member(s)** | Councillor Philip Corthorne<br>Dr Ian Goodman |
| **Organisation** | London Borough of Hillingdon<br>Hillingdon Clinical Commissioning Group |
| **Report author** | Paul Whaymand, Finance<br>Tony Zaman, LBH Social Care<br>Kevin Byrne, Policy and Partnerships<br>Caroline Morison, HCCG |
| **Papers with report** | Appendix 1 - BCF Draft Scheme Descriptions |

## HEADLINE INFORMATION

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|---|---|
| **Summary** | This report seeks the Board's approval for Hillingdon's draft 2017/19 Better Care Fund plan, pending formal publication of national guidance by NHS England. The report also seeks approval for the proposed use of the Improved Better Care Fund grant that will then permit access to this funding to support residents. The Board is also being asked to give direction on how it wishes to consider the final version of the draft plan that is likely to need to be submitted to NHS England during the summer. |
| **Contribution to plans and strategies** | The Better Care Fund plan is key to the delivery of the aspects of Hillingdon's Sustainability and Transformation Plan that are dependent on integration between health and social care or closer working between the NHS and the Council for delivery. It also contributes to the delivery of the Joint Health and Wellbeing Strategy. It enables the Council and partners to meet certain requirements of the Health and Social Care Act 2012. |
| **Financial Cost** | The proposed pooled funds for the BCF for 2017/18 are estimated to be £36.8m, an increase of £14.3m from 2016/17 with a further estimated increase of £8.5m for 2018/19. |
| **Ward(s) affected** | All |

## RECOMMENDATIONS

**That the Health and Wellbeing Board:**

a) **approves the approach to the 2017/19 BCF plan and the outlined schemes as described in the report.**

**b) approves the proposed use of the Improved Better Care Fund (IBCF) and note its intended impact.**

**c) directs officers as to how it wishes to consider the final and completed BCF plan, e.g., including narrative document and planning template, once the submission deadline has been announced, which is likely to be before the end of the summer.**

## INFORMATION

### Current Position

1. The national BCF guidance and submission dates have been delayed pending the conclusion of the general election, but it is possible that these may be published by the time of the Board's meeting. However, the draft guidance, supporting templates and assurance criteria were published by the Local Government Association (LGA) on 5 May 2017 and work has been underway to draft the Hillingdon plan reflecting the content of the draft guidance and assurance criteria. The content of this report, including the draft schemes appended to it (see Appendix 1), reflects discussions and progress at the point of the submission date for the Board reports.

### 2017/19 BCF Plan

2. The Board's March 2017 meeting agreed proposed priorities for the 2017/19 BCF plan that included extension of the scope of the plan to potential further initiatives and population groups, such as CAMHS, the Like Minded programme and integration of children and young people's services. These were suggested to reflect the mandate from the Board's September 2016 meeting and October 2016 HCCG Governing Body meeting to see a greater level of ambition for the next iteration of the plan.

3. It is now proposed to the Board that the focus of the 2017/19 plan continue to be on older people. Meeting the needs of older people represents by far the greatest demand on social care and health services and getting the model of care right for this population group presents an opportunity to then scale up into other areas thereafter, e.g., children and young people. It is suggested that a focus on fewer, higher impact actions at this stage will assist in achieving better outcomes for older residents and for improvements in Hillingdon's health and care system.

4. Table 1 below sets out the proposed schemes, their link to the relevant delivery area within the Sustainability and Transformation Plan (STP) and the proposed funding contributions from the Council and the CCG for the two years of the plan.

| Table 1: Proposed Schemes and Funding Contributions 2017/19 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Scheme** | **STP Delivery Area** | **Scheme Title** | **Funder 2017/18** | | | **Funder 2018/19** | | | **TOTAL 2017/19** £,000 |
| | | | **LBH** £,000 | **HCCG** £,000 | **TOTAL** £,000 | **LBH** £,000 | **CCG** £,000 | **TOTAL** £,000 | |
| 1 | 1 | Early intervention and prevention. | 5,060 | 2,281 | 7,341 | 5,060 | 2,281 | 7,341 | 14,682 |
| 2 | 1 | An integrated approach to supporting Carers. | 862 | 0 | 862 | 862 | 0 | 862 | 1,724 |
| 3 | 3 | Better care at end of life. | 50 | 1,213 | 1,263 | 50 | 1,213 | 1,263 | 2,526 |
| 4 | 3 | Integrating hospital discharge. | 4,607 | 11,531 | 16,138 | 4,566 | 11,531 | 16,096 | 32,234 |
| 5 | 3 | Improving care market management and development. | 8,597 | 2,251 | 10,848 | 16,725 | 2,251 | 18,976 | 29,824 |
| 6 | 3 | Living well with dementia. | 300 | 0 | 300 | 300 | 0 | 300 | 600 |
| `N/A | | Programme Support | 82 | 0 | 82 | 82 | 0 | 82 | 164 |
| Unallocated | | 2018/19 Inflation Uplift | | | | | | 372 | 372 |
| | | **TOTAL** | **19,558** | **17,276** | **36,834** | **27,644** | **17,276** | **45,292** | **82,126** |

5. Subject to Board and HCCG Governing Body approval, the ambition for the 2017/19 plan can be seen in the areas below. These are also reflected in the more detailed scheme descriptions attached to this report as Appendix 1. The scheme descriptions will be included in a narrative document that will form part of Hillingdon's formal BCF submission to NHSE in due course following consideration by the Board and HCCG's Governing Body:

- *Developing the Accountable Care Partnership (ACP)* and the Council giving full consideration to its involvement - The ACP currently comprises CNWL, Hillingdon Hospital, the GP Confederation and the local third sector consortium H4All. The Council is not currently part of the ACP but it is proposed that focused work be undertaken between Adult Social Care and the Care Connection Teams (CCTs) in the north of the Borough to undertake a retrospective review of people identified during the NHS integrated care pilot who are being supported by both health and social care. The objective would be to explore opportunities for supporting residents more efficiently and more effectively and sharing any resultant benefits that may arise. It is also proposed to allocate social care staff to the CCTs supporting extra care schemes, especially where there are also clusters of care homes, e.g., Grassy Meadow Court. The outcomes from this work will enable the Council to fully evaluate the merits and benefits of formally joining the ACP.

**Care Connection Teams Explained**

The 15 CCTs being established in the Borough are intended to take a more proactive approach to identifying the needs of Hillingdon's older residents who may be at risk of their needs escalating, resulting in a loss of independence and increased demand on the local health and care system. Each CCT is comprised of:

a) *Practice GP lead* – They have oversight over the whole care pathway within primary care, with additional time spent with those patients at most risk of becoming unstable;
b) *Guided Care Matron (GCM)* – They are responsible for case management, daily monitoring of patients and referring to other services; in-reach support to care homes and supported housing and linking with Rapid Response for out of hours care.
c) *Care Coordinator (CC)* – They assist the Guided Care Matron in proactive care of patients, pulling practice and system intelligence on patients and updating care plans and communicating with other providers.

- In order to increase direct social care support for extra care and improve linkages with the Care Connection Teams, it is proposed to redirect £40k of the Protecting Adult Social Care element of the funding passported to the Council from the CCG from contributing to the cost of a mental health nurse in Rapid Response to fund a social work post from 2018/19.

- *Developing a single point of access for older people (scheme 1)* - Bringing services together into a single service with a single point of access has proved successful for Carers in Hillingdon. It is proposed within the plan to use the opportunities presented by the H4All Wellbeing Service to reduce fragmentation in third sector services provided to older people to replicate the Carers' integrated service model for older people.

- *Getting hospital discharge right (scheme 4)* - The plan is proposing to bring together the various services involved in facilitating discharge from hospital into the community, e.g., Homesafe, Rapid Response, Reablement, the Night Sitting Service and Prevention of Admission/Readmission to Hospital Service (PATH) into a single, integrated hospital discharge service delivered by a lead provider within the ACP. It is also intended that creating a single hospital discharge service will support the effective implementation of the discharge home to assess model that will reduce the number of older people who are still in hospital when there is no medical reason for them to be there, e.g., people who are referred to as being '*medically optimised*', as well as reducing the number of delayed transfers of care (DTOCs). This will be achieved by ensuring that the right professional is allocated to support a resident in meeting their need first time.

- *Joint market management and development approach (scheme 5)* - With the objective of ensuring the supply of sufficient quality providers to meet demand, this area represents potential step-change for Hillingdon. It includes the development of joint brokerage arrangements for homecare, short and long-term nursing home placements and Direct Payments and Personal Health Budgets. Also included is the development of integrated homecare and June Cabinet will have received a report seeking permission for the Council to undertake a tender to establish a dynamic purchasing system (DPS) to meet the homecare needs of adults and children for both its own needs and those of the CCG. If this is approved, then Hillingdon will be only the second area in London to have similar arrangements in place. It is also proposed to explore the Council leading on the procurement for nursing home placements in time for the expiry of current, separate contractual arrangements that the Council and CCG have in place.

**Dynamic Purchasing System (DPS) Explained**

A DPS is like having an electronic list of approved providers. Procurement of services through a DPS takes place electronically and is subject to certain criteria being met.

New providers can join a DPS at any time as long as they satisfy the membership rules.

6. By ensuring greater intelligence about the market, preventing competition between the Council and HCCG and creating a central point of access for providers to make it easier for them to do business with the statutory partners, it is intended that this scheme will deliver better outcomes for residents and support the health and care system in a more cost effective way.

7. The Board will note that it is proposed to include the Council's brokerage and older people's homecare budget within the BCF pooled budget from 2017/18 and also the older people's care home budget from 2018/19. The HCCG is proposing to follow suit. The CCG's brokerage team costs have not been included in the costings set out in this report but will be included in the first submission document, subject to HCCG Governing Body approval.

8. The proposals set out above represent an additional contribution by the Council of £5,604k in 2017/18 and £9,195k in 2018/19 and £6,463k by the CCG in 2017/18 and £6,463k in 2018/19, subject to HCCG Governing Body confirmation. A key benefit of this funding being included in the pooled budget is that the service will be provided according to need and a change of funding responsibility will not necessarily require a change of provider, unless the existing provider is not qualified to meet the need.

9. If the proposals described above are approved by the Board, Hillingdon will be set on a direction to meeting some of the characteristics of a health and care system deemed by the Government to be showing progress towards achieving full integration by 2020. These characteristics are reflected in 2017/19 Integration and Better Care Fund Policy Framework and summarised in Table 2 below.

**Table 2: Characteristics of Full Integration**

| | **Joint Commissioning** | **Lead Commissioning** | **Accountable Care Organisation (ACO)** |
|---|---|---|---|
| **Characteristics** | Some or all LA/CCG commissioning decisions are made jointly.<br><br>Budgets (and other resources) are pooled or aligned in line with the extent of joint commissioning. | One body exercises some or all functions of both the CCG and the LA, with relevant resources delegated accordingly. | The CCG and LA pay a set figure (possibly determined by capitation) to an Accountable Care Organisation to deliver an agreed set of outcomes for all health and care activity for a whole population group, using a multi-year contract.<br><br>The ACO decides what services to purchase to deliver those outcomes. |

**Improved Better Care Fund Grant: Proposed Use 2017/18 and 2018/19**

10. An additional £4.1m was allocated to Adult Social Care in 2017/18 **reducing to** £2.9m in 2018/19. This additional funding is issued by the Department of Communities and Local

Government (DCLG) under section 31 of the Local Government Act, 2003, and the grant conditions are that is used for the following purposes:

- Meeting adult social care needs;
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and
- Ensuring that the local social care provider market is supported.

11. The Council is required to report quarterly to the DCLG on the use and impact of this funding. The local NHS has also been asked to report on the intended impact. The impact of this funding will also need to be reflected in a quarterly BCF reporting template that will go to NHSE, which reflects national BCF requirements over the last two years. Hillingdon's Sustainability and Transformation Plan (STP) identifies the need to prioritise stabilisation of the care home and homecare markets in order to reduce pressure on the NHS, including supporting hospital discharge. The Council and HCCG have discussed the direct impact that stabilising the provider market has on the health and care system's ability to support admission avoidance and reducing hospital delays. It is proposed to the Board that the additional allocations of £4.1m in 2017/18 and £2.9m in 2018/19 be used to meet this aim, which will in turn lead to reducing pressures on the NHS.

12. Hillingdon's care home and home care markets face vulnerabilities due to difficulties in providers being able to recruit and retain staff. Whilst this is a national problem, it is particularly acute in Hillingdon, where there are many alternative employment options available to care industry workers. This impacts on the capacity of the market to meet the care needs of residents, including meeting the needs of people admitted to hospital. In order to help stabilise the market, the Council is requiring providers to pay their staff a minimum rate of £9.75 per hour, which is equivalent to the London Living Wage and which, in turn, significantly increases the headline price of care the Council pays to providers. These increases will stabilise the market and, as described above, support the effectiveness of both admission avoidance and transfers of care.

Intended Impact

13. A measure for delayed transfers of care is the number of delayed days. In 2016/17, 59% of Hillingdon's delayed days, e.g., NHS and Social Care, were attributed to difficulties in securing care home placements, e.g., residential care homes and nursing care homes, and nearly 6% were attributed to difficulties in securing packages of care, e.g., homecare. 58% of social care delays in 2016/17 were attributed to difficulties in securing care home placements and 16% to issues in securing packages of care. The impact of the proposed use of the IBCF grant is illustrated below:

- *Care home providers - Estimated reduction in care-home related delayed days in 2017/18 3% (31 delayed days) and 5% (51 delayed days) in 2018/19*: This target has been set taking into consideration the fact that the self-funder market is and will continue to be the most lucrative source of placements for providers. Paying higher rates to providers encourages them to retain existing placements as well as accepting new local authority referrals. However, there are many other factors that contribute to whether a care home will accept a referral, including the complexity of need and the availability of qualified staff.

- In order to secure care home capacity for social care placements, the Council is in negotiation with providers to convert spot placements into block arrangements. Negotiations

are being undertaken with the CCG in order to ensure a joint approach. In addition, as part of the proposed BCF plan, a joint Council/CCG approach is also being taken to explore other affordable options for increasing the local supply for public sector placements, including for people with the more challenging behaviours.

- *Home care providers - Estimated reduction in homecare related delayed days in 2017/18 5% (14 delayed days) and 15% (40 delayed days) in 2018/19:* The proposed target takes into consideration that there is currently a gap in provision in the central part of the Borough that will be addressed by the DPS integrated homecare model tender referred to earlier in this report. This will also secure access to additional capacity in other parts of the Borough for both social care and the NHS referrals. The DPS will go live in November and, in the meantime, packages of care will be sourced through spot purchasing, but there is a time lag between higher pay rates for care workers being agreed and this resulting in additional care worker capacity.

**Next Steps**

14. Subject to approval of the recommendations in this report, officers will complete the narrative document in accordance with the draft assurance criteria. Governance arrangements will also be finalised for incorporation into the narrative document for Board and HCCG Governing Body approval.

15. Work is already in progress to develop the targets for the national metrics for the Board and HCCG Governing Body's consideration. The national metrics are:

- Reduction in emergency (also known as non-elective) admissions.
- Reduction in permanent admissions to care homes.
- Increase in the number of people still at home 91 days after discharge from hospital into reablement.
- DTOC reduction.

16. The Board may wish to be aware that NHSE has set Hillingdon Hospital and CNWL DTOC reduction targets that are predicated on there being no social care delays. This approach has been applied by NHSE without any consultation about deliverability; it is understood that this approach has been applied across the country. A result of this action by NHSE is that it may not be possible to recommend to the Board a DTOC reduction target that is both acceptable to NHSE and that officers are confident can be delivered. Officers are in discussion with NHSE's Better Care Support Team and will be able to update the Board by the time of its meeting.

**Draft Plan Approval Process**

17. If the process set out in the draft BCF guidance and assurance framework is retained, then two submissions of the draft plan will be required. In view of the publication of the draft guidance and assurance criteria, it is likely that areas will be given a short period of time for the submission of the initial draft of the plan. Feedback will then be given to inform the final, second submission.

18. For the 2016/17 plan, the Board agreed to delegate responsibility to officers in consultation with the Chairman, the Chairman of HCCG's Governing Body and the Chairman of Healthwatch Hillingdon Board to consider the final plan that reflected NHSE feedback. The Board is being

asked to instruct officers on its desired consideration arrangements for both the first submission and also the final version of the plan.

**Financial Implications**

**Improved Better Care Fund Grant 2017/19**

19. On 9 March, DCLG published funding allocations for the additional Improved Better Care Fund (IBCF), which is issued by the DCLG under the conditions described in paragraph 10 above. The Council's share of this increased funding is £4.1m available in 2017/18 declining to £1.5m by 2019/20. There have been no indications of funding available from 2020/21 onwards. In order to access the funding, the Council's Director of Corporate Finance is required to set out how the Council proposes to use the funding from the additional funding in 2017-18 for adult social care.

20. The Council has committed the IBCF funding to stabilise the local social care provider market which will have a direct impact on the health and care system's ability to support admission avoidance, e.g., by facilitating more expedient activation of services in liaison with the Care Connection Teams and to support reducing hospital delays, e.g., by supporting the Discharge to Assess model.

21. The Council is required to report quarterly to the DCLG on the use of the impact of this funding in addition to the current requirement for quarterly updates on the progress of the BCF plan to NHSE.

**Proposed increased contribution to BCF pooled funds 2017/18.**

22. The pooled funding for 2016/17 totalled £22,531k, with contributions from both CCG and the Council set out in the table below. The minimum level of pooled revenue funding was set by central Government at £16,588k. This was made up of £10,621k to cover CCG expenditure and £5,937k revenue funding to 'Protect Social Care'. The Council also included the Capital funding for the Disabled Facilities Grant (£3,457k) and, in addition, contributed further £1,172k revenue funding (which included grants to H4All organisations, the budgets for the Adult Safeguarding service and the Wren Centre, etc). The HCCG contributed a further £1,346k (which included funding for H4All organisations and community services provided under contract by CNWL, etc).

23. For 2017/18, the minimum level of BCF pooled funding is set at £16,896k. The draft pooled budget proposals set out in this report total £36,869k made up of HCCG funding of £23,361k and Council funding of £13,508k. The key movements from 2016/17 are set out in Table 3 below and include the inflation uplift in the minimum level of pooled BCF funds funded by HCCG, the additional IBCF section 31 grant to the Council which is explained above, and additional Council and HCCG contributions reflected in the detail as set out in the proposed plan which includes pooling homecare and residential placements budgets (from 2018/19) for both organisations.

| Table 3: Draft Funding Summary 2017/19 | | | | | |
|---|---|---|---|---|---|
| | **2016/17** | **Changes** | **2017/18** | **Changes** | **2018/19** |
| | ***£,000's*** | ***£,000's*** | ***£,000's*** | ***£,000's*** | ***£,000's*** |
| Protecting Social Care | £5,937 | £148 | £6,085 | £178 | £6,263 |
| CCG Share of Minimum Contribution | £10,621 | £190 | £10,811 | £194 | £11,005 |
| **Total Minimum Level of Pooled BCF funding** | **£16,558** | **£338** | £16,896 | £372 | £17,268 |
| Disabled Facilities Grant | £3,457 | £358 | £3,815 | £0 | £3,815 |
| Additional Council Contribution | £1,172 | £4,432 | £5,604 | £6,895 | £12,499 |
| IBCF Section 31 Grant | £0 | £4,054 | £4,054 | -£1,107 | £2,947 |
| Original BCF grant Contribution | £0 | £0 | £0 | £2,300 | £2,300 |
| Additional CCG Contribution | £1,344 | £5,119 | £6,463 | | £6,463 |
| **Total BCF Funding 2017/19** | **£22,531** | **£14,301** | **£36,832** | **£8,460** | **£45,292** |

24. Table 3 includes a £372k provisional inflationary uplift to the BCF by the CCG. This has not been allocated to specific schemes at this point.

## EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

**What will be the effect of the recommendation?**

25. The recommendations will enable a Hillingdon BCF plan to be submitted in accordance with national guidance. The BCF plan will contribute to the development of a sustainable health and care system in Hillingdon that will support residents to regain or maintain their independence. The proposed use of the IBCF grant will assist in stabilising the local care market that will help support Hillingdon's health and care system, including supporting patient flow through Hillingdon Hospital.

**Consultation Carried Out or Required**

26. There has been consultation with Hillingdon's GP confederation, Hillingdon Hospital, CNWL (community health and community mental health) and the voluntary sector (H4All). The Older People's Assembly has also been consulted and Healthwatch Hillingdon has been engaged throughout the plan development process.

**Policy Overview Committee comments**

27. None at this stage.

## CORPORATE IMPLICATIONS

**Hillingdon Council Corporate Finance comments**

28. Corporate Finance has reviewed the report and concurs with the Financial Implications set out above.

**Hillingdon Council Legal comments**

29. Section 223GA of the NHS Act, 2006, provides the legal basis for the BCF and gives NHSE power to make any conditions it considers reasonable in respect of the release of NHS funding to the BCF. Where it considers that an area has not met these conditions, it also has the power, in consultation with the DH and DCLG, to make directions in respect of the use of the funds and/or impose a spending plan and impose the content of any imposed plan.

30. Grant conditions for the Improved Better Fund Grant issued under Section 31 of the Local Government Act 2003, empower the DCLG to require repayment of the grant funding in the event that the Secretary of State considers that the conditions have not been met.

## BACKGROUND PAPERS

- 2017/19 Integration and Better Care Fund Policy Framework (DH March 2017)
- Integration and Better Care Fund Planning Requirements for 2017/19 (Draft April 2017)
- Better Care Fund 2017/19: A guide to assurance of plans (Draft April 2017)

**Appendix 1**

# Draft 2017/19 Better Care Fund Plan Scheme Descriptions

## Scheme 1: Early Intervention and Prevention

### a) Strategic Objectives

This scheme seeks to manage demand arising from demographic pressures by reducing the movement of Hillingdon residents/patients from lower tiers of risk into higher tiers of risk through proactive early identification and facilitating access to preventative pathways, that includes a focus on promoting self-care. It builds on the work undertaken under Hillingdon's 2015/16 and 2016/17 BCF plans and also the broader programme of integration to taking forward the anticipatory model of care and apply a more preventative approach to addressing health and social care need.

### b) Scheme Overview

As with previous iterations of the Hillingdon's BCF plan, the focus of this scheme will be people living with dementia, people susceptibility to falls and/or who are socially isolated and also people at risk of stroke as these long-term conditions are disproportionately represented in our non-elective admissions and admissions to long term residential care.

Initiatives under this scheme include:

- *Access to information and advice* - Access to good information and advice is fundamental to people being able to self-manage their own health and wellbeing. Over the last two years the Council has developed and promoted the online resident portal called Connect to Support. In 2017/18 platform supplier arrangements will be subject to competitive tender and service specification development will include accessibility through portable technology options. Partners will work on the links between the resident portal and the development of a directory of services to support the hospital discharge process referred to further in scheme 4: *Integrated Hospital Discharge*. A key objective here is to reflect synergies and avoid unnecessary duplication.

- *Risk stratification* - Much work has taken place over the last two years in applying risk stratification tools within primary care, e.g. Qadmissions, PAR30, the Electronic Frailty Index (EFI) and the Patient Activation Measure (PAM), as a means of early identification of people at risk of escalated needs. The development of fifteen Care Connection Teams (CCTs) across the Borough comprising of a guided care matron and care coordinator will support more proactive interventions to prevent or delay might otherwise be an inevitable trajectory towards escalated need. Proactive work between social care and, initially, CCTs in the north of the Borough to identify people receiving both social care and health support and explore opportunities for a more efficient and effective means of addressing need will be explored. Involvement of Adult Social Care in multi-disciplinary team (MDT) meetings or weekly *'huddles'* where appropriate will ensure a multi-agency approach to addressing the needs of people on the cusp of escalated needs. The allocation of social care resources to support CCTs that have extra care schemes and a concentration of care homes within their catchment area will be explored. See scheme: 5: *Improving care market management and development.*

- *Developing the preventative role of third sector* - 2016/17 has seen the successful implementation of the Wellbeing Service provided by the third sector consortium H4All. People referred to this service have benefitted from an assessment using the Patient Activation Measures (PAM). This assessment is intended to identify people needing support to engage more actively in the management of their own condition (s). During 2017/18 the model of investment in the third sector by both the Council and CCG will be reviewed with voluntary and community sector partners to see how the successes of the H4All Wellbeing Service can be built on to most effectively support Hillingdon's older residents, e.g. by improving access to information, addressing social isolation and keeping people active through the creation of a single point of access for older people. Any new model will be implemented in 2018/19, subject to approval through governance processes.

- *Keeping older people physically active* - Keeping people active is a contributory factor in preventing stroke and preventing or delaying the onset of dementia. During 2017/18 the Council and ACP partners will work together to develop a physical activity strategy and the Council's new Sport and Physical Activity Team will continue to deliver a range of activities to keep older people physically active and also prevent social isolation, e.g. tea dances, chair exercise classes and healthy walks.

- *Stroke prevention*: As set out in the 2016/17 plan, the key components of a stroke prevention strategy are: increasing physical activity, addressing excess weight issues and early detection. During 2017/19 the following initiatives will be undertaken:

  - *Increasing physical activity* - Alluded to above, an existing physical activity programme targeted at people aged 55 and over carrying excess weight will continue due to the beneficial outcomes for this group of people.

  - *Early detection* - Atrial fibrillation (AF), a disturbance of heart rhythm, is a major cause of stroke and is not tested as part of the health check programme. In late 2016/17 a pilot started using detection equipment in six community pharmacies in the Borough. The results from this will be used to inform possible expansion of screening programmes in 2017/18.

  - *Stroke risk and stroke prevention campaign* - During 2017/18 the Council's Communications Team will develop a proposal for a campaign intended to promote for people most at risk of stroke the uptake of the health checks programme and also signpost residents to physical activities and groups, social engagement activities, and facilities such as leisure centres, green spaces, and libraries.

- *Making best use of assistive technology* - The work of the CCTs referred to above, as well as the integrated approach to hospital discharge described in scheme 4: *Integrated Hospital Discharge,* provide opportunities to identify people who may benefit from assistive technology, e.g. telecare and telehealth, and to make referrals. This technology can help to provide the residents/patients and their families with greater confidence about them remaining in their own home.

- *Flexible use of Disabled Facilities Grants* - A business case will be developed for a six month early intervention pilot to provide a non-means-tested grant to people aged 75 and over for installation of a level-access shower where they have disability/medical condition

that significantly restricts their mobility; they have reported difficulty with getting in and out of the bath; and they have no intention of leaving the property for at least 5 years. This is about proactively anticipating needs.

**c) Intended Outcomes/Success Measures**

This scheme will contribute to the following key BCF metric:

- Reduction in non-elective admissions.

The following measures that link to the Hillingdon outcomes framework for older people will also be used to identify whether the scheme is working:

- Increase in utilisation rates for Connect to Support (new and repeat users);
- Contributing towards a 5% reduction in falls-related non-elective admissions on 2016/17 outturn;
- % of users of Adult Social Care who have found it easy or difficult to access information and advice about services and/or benefits (test through the Adult Social Care Survey);
- Proportion of patients (among all those with a PAM score) whose PAM score has improved in the last 12 months.
- % of people aged 55 and over participating in screening programmes.

**d) Scheme Investment Requirements**

| Service | Provider | Funder 2017/18 | | | Funder 2018/19 | | | TOTAL 2017/19 £,000 |
|---|---|---|---|---|---|---|---|---|
| | | LBH £,000 | HCCG £,000 | TOTAL £,000 | LBH £,000 | CCG £,000 | TOTAL £,000 | |
| a) Connect to Support | Shop - 4-Support | 45 | 0 | *45* | 45 | 0 | *45* | *90* |
| b) Online Services Coordinator | LBH | 49 | 0 | *49* | 49 | 0 | *49* | *98* |
| c) Wellbeing Service | H4All | 543 | 334 | *877* | 543 | 334 | *877* | *1,754* |
| d) Information, Advice & Welfare Benefits Service | Age UK | 150 | 0 | *150* | 150 | 0 | *150* | *300* |
| e) Social Wellbeing Service | Age UK | 100 | 0 | *100* | 100 | 0 | *100* | *200* |
| f) Practical Support Service | Age UK | 76 | 0 | *76* | 76 | 0 | *76* | *152* |
| g) Falls Prevention Service | Age UK | 0 | 126 | *126* | 0 | 126 | *126* | *252* |
| h) Older People Wellbeing initiatives | LBH | 20 | 0 | *20* | 20 | 0 | *20* | *40* |
| i) Telecare | LBH | 262 | 0 | *262* | 262 | 0 | *262* | *524* |
| j) Disabled Facilities Grants | | 3,815 | 0 | *3,815* | 3,815 | 0 | *3,815* | *7,630* |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| k) Integrated Care Programme | HCCG | 0 | 759 | *759* | 0 | 759 | *759* | *1,518* |
| l) Care Connection Teams | HCCG | 0 | 1, 062 | *1, 062* | 0 | 1, 062 | *1, 062* | *2,124* |
| **TOTALS** | | **5,060** | **2,281** | ***7,341*** | **5,060** | **2,281** | ***7,341*** | ***14,682*** |

**Scheme 2: An integrated approach to supporting Carers.**

**a) Strategic Objectives**

This strategic objective of this scheme is to maximise the amount of time that Carers are willing and able to undertake a caring role as a result of them being able to say:
• "I am physically and mentally well and treated with dignity"
• "I am not forced into financial hardship by my caring role"
• "I enjoy a life outside of caring"
• "I am recognised, supported and listened to as an experienced carer"

**b) Scheme Overview**

This scheme continues the priority given in 2016/17 to support Carers and reflects the implementation of legal duties on local authorities under the Care Act, 2014 and the Children and Families Act, 2014 respectively to support Adult and Young Carers. It also reflects policy directives on NHS bodies as directed by NHSE. The health and wellbeing of Carers will be supported through the following actions:

- *Maintaining capacity to deliver Carer's assessments through the Carers in Hillingdon contract that provides a single point of access for Carers in the Borough* - Under this contract a triage assessment will continue to be promoted so that Carers can make informed decisions about whether to go through the full assessment process. In addition the online self-assessment facility through Connect to Support will be promoted and supported by Hillingdon Carers.

- *Implementation of NHS England's integrated approach to assessing Carer health and wellbeing* - This will entail the development of a Memorandum of Understanding (MoU) between the Council and Health partners, which will set out how partners will work together to support Carers.

- Identifying "hidden" and "young" Carers - This will entail using existing networks and materials e.g. Hillingdon People, local press, street champions newsletter, Public Health initiatives and voluntary sector promotional event, etc, to identify people who do not necessarily consider themselves to be Carers. It will also entail the development of a consistent mechanism for identifying and recording Carers in primary care.

- *Developing the remit of the Young Carers Strategy Group* - This group was launched in 2016/17 to embed Young Carer initiatives at a strategic level, e.g. Healthy Schools Strategy; developing an early intervention and prevention strategy. A key role for the group in 2017/18 will be to develop a Young Carers Plus programme for Young Carers affected by parental drug, alcohol or mental health issues;

- *Health checks and flu prevention* - GP Health Checks and Flu Jab programmes for Carers will be promoted;

- *Hospital admissions and discharge* - Partners will work together to ensure that Carers are supported throughout the hospital admission and discharge care planning processes;
- *Personalisation for Carers* - Awareness of and access to Carer Personal Budgets and Personal Health Budgets will be maximised;
- *Social activities for Young Carers* - A range of social activities for Young Carers will be developed;
- *Extending availability of services for Adult Carers* - Options to extend services for Adult Carers, particularly working Carers who cannot access weekday provision, will be explored;
- *Social Worker drop-in sessions* - Social Worker drop-in sessions at the Hillingdon Carers Partnership Carers' Centre will be delivered;

**c) Intended Outcomes/Success Measures**

This scheme will contribute to the following BCF national metrics:
- Reduction in non-elective admissions.
- Reduction in permanent admissions to care homes of 65 + population.

The following measures that link to the Hillingdon outcomes framework for older people will also be used to identify whether the scheme is working:

- Number of Carers' assessments completed.
- Number of Carers receiving respite or a carer specific service following an assessment.
- Through the National Carers' survey in 2018/19:
  - Proportion of Carers who have found it easy or difficult to find information and advice about support services or benefits
  - Carer quality of life questions about:
    - Getting enough sleep and eating well
    - Having sufficient social contact
    - Receiving encouragement and support.
- Increasing the number of Carers identified and registered on the Hillingdon Carers' Register.
- Number of Carers in receipt of a Direct Payment or a Personal Health Budget.

**d) Scheme Investment Requirements**

| Service | Provider | Funder 2017/18 | | | Funder 2018/19 | | | TOTAL 2017/19 £,000 |
|---|---|---|---|---|---|---|---|---|
| | | LBH £,000 | HCCG £,000 | TOTAL £,000 | LBH £,000 | CCG £,000 | TOTAL £,000 | |
| a) Carers' hub, assessments and review | Hillingdon Carers (lead) | 649 | 0 | *649* | 649 | 0 | *649* | *1,298* |
| b) Services to Carers (inc respite) | Various P & V | 213 | 0 | *213* | 213 | 0 | *213* | *426* |
| **TOTAL** | | **862** | **0** | ***862*** | **862** | **0** | ***862*** | ***1,724*** |

**Scheme 3: Better care at end of life**

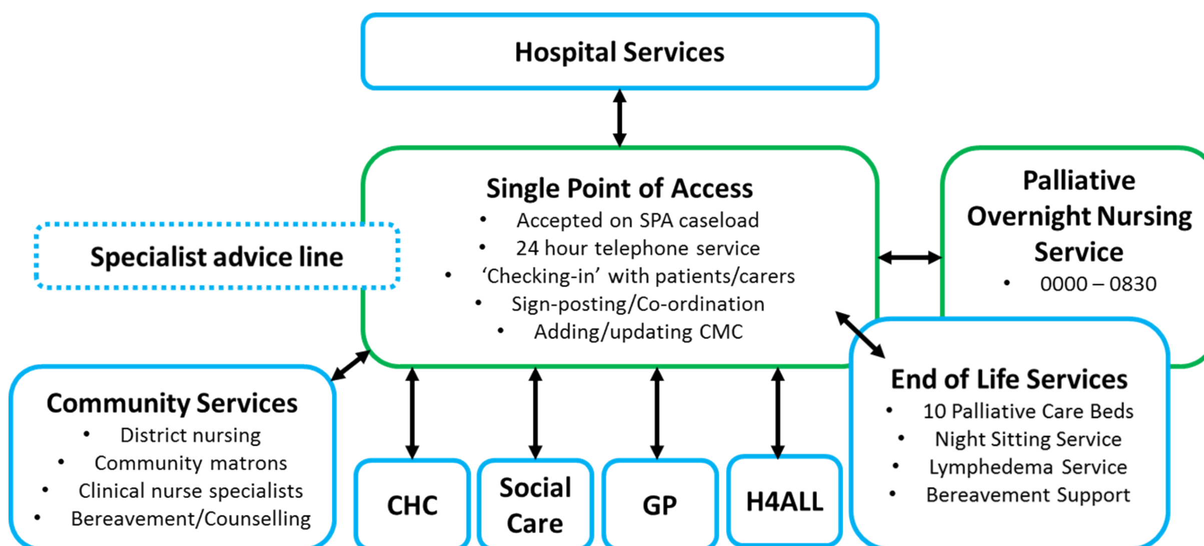
**a) Strategic Objectives**

This scheme seeks to realign and better integrate the services provided to support people towards the end of their life in order to deliver the ethos of a 'good death.' The main goals of the scheme are to:

- Ensure that people at end of life are able to be cared for and die in their preferred place of care; and
- To ensure that people at end of life are only admitted to hospital where this is clinically necessary or where a hospital is their preferred place of care or death.

**b) Scheme Overview**

Building on work undertaken during 2016/17, activity under this scheme will be aligned to the development of a new single point of access for people diagnosed as being within their last year of life.  The SPA will act as a central information and advice hub for end of life/palliative care patients and services, whilst providing a co-ordination on behalf of patients, Carers and staff and giving the wider generalist workforce 24/7 access to specialist palliative advice. This will be supported by the palliative overnight nursing function (PONS) which, in addition to telephone advice will be able to assess and provide hands on care and support at the patient's place of residence if required. The intended model is shown below.




The key initiatives under this scheme intended to deliver better outcomes for people at end of life are:

- *Facilitating seamless care provision between health and social care* - The specialist homecare needs of people at end of life will be reflected in the integrated homecare service model tender referred to in scheme 5: *Improving care market management and development.*  The intention behind this and a clear benefit of having the BCF pooled budget in place is to remove the possibility of disruption in care being caused by a transition in funding responsibility between health and social care, except in cases where the existing provider is unable to meet the escalating needs of the person at end of life.

- *Reviewing charges for Council funded services* - The Council will also explore the feasibility of removing the potential charge for people diagnosed as likely to have only having six months to live whose needs are primarily social care. This would help to avoid the complexities and potential disputes that can arise when trying to determine at what point a person's care should be health funded.

- *Utilisation of multi-disciplinary care and support planning* - In 2016/17 Adult Social Care gained read and write access to Coordinate My Care (CMC), an advanced care planning tool used in London primarily to support people at end of life. The intention and expectation is that there will be increased use of this tool by social care staff in line with the expected increase in use by other professionals and service providers across the Borough.

- *Reviewing hospice bed provision requirements* - This is linked into the bed-based services requirements review action contained outlined in scheme 5: *Improving care market management and development.* The intention would be to identify future requirements and provision options.

**c) Intended Outcomes/Success Measures**

This scheme will contribute to the following key BCF metric:

- Reduction in non-elective admissions.

The following measure that links to the Hillingdon outcomes framework for older people will also be used to identify whether the scheme is working:

- Proportion of people on an end of life pathway on CMC who achieved their preferred place of death.

**d) Scheme Investment Requirements**

| Service | Provider | Funder 2017/18 | | | Funder 2018/19 | | | TOTAL 2017/19 £,000 |
|---|---|---|---|---|---|---|---|---|
| | | LBH £,000 | HCCG £,000 | TOTAL £,000 | LBH £,000 | CCG £,000 | TOTAL £,000 | |
| a) Palliative home care. | Various P & V | 50 | 1,105 | *1,155* | 50 | 1,105 | *1,155* | *2,310* |
| b) Community Palliative Team. | CNWL | 0 | 108 | *108* | 0 | 108 | *108* | *216* |
| **TOTAL** | | **50** | **1,213** | ***1,263*** | **50** | **1,213** | ***1,263*** | ***2,526*** |

**Scheme 4: Integrated hospital discharge**

**a) Strategic Objectives**

This scheme seeks to prevent admission and readmission to acute care following an event or a health exacerbation and enabling recovery through intermediate care interventions with the aim of maximising the person's independence, ability to self-care and remain in their usual place of residence for as long as possible.

A further objective of this scheme is to support discharge from mental health community beds

in recognition of the impact of these delays on patient flow through Hillingdon Hospital.

**b) Scheme Overview**

This scheme seeks to consolidate the move to a discharge home to assess model that expedites the flow out of hospital of people whose medical needs no longer require them to be there. This assumes that most people will recover more quickly from the cause of their admission in their usual home environment. The scheme is also seeking to establish an integrated hospital discharge service with a single point of referral to eliminate the existing fragmentation that exists between services and organisations.

Under Hillingdon's Discharge to Assess model there are four pathways:

- *Pathway 0* - This is for people whose needs can safely be met at home and need no additional assessment. Patients are identified and discharges managed by ward staff. It is envisaged that the majority of patients will be discharged on this pathway.

- *Pathway 1* - This is for people whose needs can safely be met at home. At present needs are met either by the Council's Reablement Service for up to six weeks or Community Homesafe provided by CNWL for up to 10 days for people who have had a Comprehensive Geriatric Assessment (CGA). The intention is to get to a point where there is a community-based single point of referral and discharge coordinated by community-based staff, including arranging transport and community equipment. The assessment would then take place in the person's usual place of residence.

- *Pathway 2* - This is for people who are unable to return home as they require a period of further rehabilitation or their home needs preparation or adaptation. It is intended that people will be identified by ward staff and the Integrated Discharge Team (IDT). The onward route from hospital will either be to the 22 bed Hawthorne Intermediate Care Unit (HICU) for people who require rehabilitation, the 7 step-down beds in a private nursing home commissioned by the CCG for people who will be non-weight-bearing for more than 3 weeks. The Council also has a step-down flat available in an extra care scheme where a person's home is unsuitable to meet their immediate needs

- *Pathway 3* - This includes people who have been screened in the acute setting and require a full continuing healthcare (CHC) assessment. Patients will be identified by ward staff and the Integrated Discharge Team and their discharge managed by the IDT and this may be into step-down beds commissioned by the CCG in a local nursing home.

Improvements to hospital discharge processes, including early identification of people with complex needs likely to impact on timely discharge and transport and medication issues are captured within the A & E Recovery Action Plan and also the Delayed Transfers of Care (DTOC) action plan.

Other actions that will be taking place under this scheme include:

- *Reviewing the Integrated Discharge Team (IDT)* - Within the context of the Discharge to Assess model, the role and function of a multi-agency IDT will be undertaken by the Leadership Centre, an independent organisation that supports the public sector to address complex issues.

- *Emergency Care Improvement Programme (ECIP) undertaking a review of mental health discharges processes and causes of delay* - Delayed discharges of people with mental health needs represent the largest proportion of delayed transfers of care in Hillingdon.

- *Establishing regular liaison meetings between Mental Health and Housing* - Housing-related issues present one of key causes of delays in supporting the discharge from hospital of people with mental health needs. The Council and the community mental health provider, CNWL, will establish more structured referral routes and escalation pathways to ensure early identification of people with complex needs.

- *Developing a business case for establishing a Hospital Discharge Grant* - A business case will be developed to use flexibilities in the use of the Disabled Facilities Grant permitted under the Regulatory Reform Orders to establish a non-means tested grant of up to £4k to pay for the following in order to expedite a resident's discharge from hospital:
  - Home/garden clearance.
  - Home deep cleaning.
  - Home fumigation.
  - Furniture removals to establish a micro-environment.
  - Heating repairs, e.g. repairing or replacing boilers.
  - Repairs to, or replacement of, essential appliances, e.g. cooker, refrigerator/freezer.

**c) Intended Outcomes/Success Measures**

This scheme will impact on the following BCF metrics:
- Reduction in the number of non-elective admissions.
- Reduction in permanent admissions of older people aged 65 years and over to residential and nursing care homes, per 100,000 population.
- % of older people aged 65 years and over who are still at home 91 days after discharge from hospital into reablement
- % reduction in delayed transfers of care, including:
  - % reduction in delays attributed to the NHS
  - % reduction in delays attributed to Adult Social Care

**d) Scheme Investment Requirements**

| Service | Provider | Funder 2017/18 | | | Funder 2018/19 | | | TOTAL 2017/19 £,000 |
|---|---|---|---|---|---|---|---|---|
| | | LBH £,000 | HCCG £,000 | TOTAL £,000 | LBH £,000 | CCG £,000 | TOTAL £,000 | |
| a) Rapid Response | CNWL | 0 | 1,576 | *1,576* | 0 | 1,576 | *1,576* | *3,152* |
| b) Hawthorn Intermediate Care Unit | CNWL | 0 | 1,640 | *1,640* | 0 | 1,640 | *1,640* | *3,280* |
| c) Community Rehab | CNWL | 0 | 1,163 | *1,163* | 0 | 1,163 | *1,163* | *2,326* |
| d) Prevention of Admission/Readmission to Hospital (PATH) | Age UK | 29 | 91 | *120* | 29 | 91 | *120* | *240* |
| e) Take Home & Settle | Age UK | 0 | 63 | *63* | 0 | 63 | *63* | *126* |
| f) Reablement and Hospital | LBH | 2,689 | 0 | *2,689* | 2,689 | 0 | *2,689* | *5,276* |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Assessments | | | | | | | | |
| g) Reablement Physio | CNWL | 51 | 0 | *51* | 51 | 0 | *51* | *102* |
| h) Community equipment | Medequip | 756 | 715 | *1,471* | 756 | 715 | *1,471* | *2,942* |
| i) Community Homesafe | CNWL | 0 | 688 | *688* | 0 | 688 | *688* | *1,376* |
| j) Packages of care | Various P & V | 1,044 | 0 | *1,044* | 1,044 | 0 | *1,044* | *2,088* |
| k) Step-down beds (Franklin House) | Care UK | 0 | 198 | *198* | 0 | 198 | *198* | *396* |
| l) Support to step-down beds | CNWL | 0 | 53 | *53* | 0 | 53 | *53* | *106* |
| m) Cottesmore Reablement Flat | Paradigm Housing Group | 38 | 0 | *38* | 38 | 0 | *38* | *76* |
| n) Pressure mattresses | DHS | 0 | 206 | *206* | 0 | 206 | *206* | *412* |
| o) Continence Service | CNWL | 0 | 538 | *538* | 0 | 538 | *538* | *1,076* |
| p) Community matrons | CNWL | 0 | 687 | *687* | 0 | 687 | *687* | *1,374* |
| q) Mental Health Nurse in Rapid Response | CNWL | 40 | 0 | *40* | 0 | 0 | *0* | *40* |
| **TOTAL** | | **4,607** | **11,531** | ***16,138*** | **4,565** | **11,531** | ***16,096*** | ***32,234*** |

**Scheme 5: Improving care market management and development**

a) **Strategic Objectives**

This scheme is intended to contribute to the STP 2020/21 outcomes of achieving:

- A market capable of meeting the health and care needs of the local population within financial constraints; and
- A diverse market of quality providers maximising choice for local people.

b) **Scheme Overview**

The focus of this scheme is the following areas:

- Integrated brokerage;
- Integrated homecare for adults and young people;
- Care home market development; and
- Support for extra care sheltered housing.

The scheme represents both a logical progression from work undertaken in 2016/17 and also step-change in the integration between health and social care, which can be seen with the establishing of lead organisation/commissioner arrangements in respect of homecare and the potential to develop this further for nursing care home provision. By taking the step on the road to integration between health and social care this scheme seeks to address private provider market capacity and service quality issues that have a significant impact on Hillingdon's health and care system. This scheme is therefore also critical to the delivery of the objectives of several other schemes within the BCF plan, e.g. scheme 3: *Better care at end of life*, scheme 4: *Integrated hospital discharge* and scheme 6: *Living well with dementia*.

The key objectives of this scheme will be achieved through the following initiatives:

***Integrated Brokerage***

- Expanding utilisation of e-brokerage facility in Connect to Support to include nursing care home and homecare placements for Continuing Healthcare patients.
- Co-locating both Council and CCG brokerage teams.
- Developing affordable options for Council and CCG approval to expand scope of joint brokerage to include self-funders.
- Expanding take-up of Personal Health Budgets (PHBs) and integrated budgets, e.g. combination of Direct Payments (DPs) and PHBS.
- Reviewing the impact of closer alignment to inform a decision about structural integration in 2018/19.

***Integrated homecare for adults and young people***

- The Council will lead for itself and the CCG in the tendering for an integrated, tiered service model of homecare through a Dynamic Purchasing System (DPS), e.g. a type of framework agreement that allows new providers to the market place to enter at any time if certain specified criteria are met. The DPS will become operational in October 2017 for two years. For the Council the tender will provide coverage for a part of the Borough where a contract is currently not in place; it will also provide additional capacity in other parts of the Borough. The model is intended to address NHS capacity requirements in all parts of the Borough.
- Homecare placements will be made through the integrated brokerage team through an electronic process.
- A review of the impact of the model in 2018/19 will inform the approach taken by both the Council and the CCG to respond to the expiry of the Council's other homecare contracts at the end of 2019.

***Care home market development***

- Developing and launching a market position statement following a joint health and social care bed based services demand exercise to advise the market of Council and NHS supply requirements over the next 10 years.
- Exploring with providers increasing local capacity for residential dementia and nursing (inc dementia) care home capacity through conversion of spot purchases to block arrangements and seeking approval for other affordable options to meet supply needs.
- Developing an integrated nursing care home specification, e.g. to meet social care and CHC requirements.
- Determining the agreed procurement route for delivery in 2019/20.
- Commissioning a GP advice and visiting service in an integrated way with existing and planned services in community/primary care through the ACP to support care homes.

- Developing and implementing a model of support for care homes to be delivered through the ACP to better enable them to manage people with more challenging behaviours, including people who are living with dementia.
- Exploring the development of a career pathway for nursing care home staff through the ACP to contribute to addressing shortage of qualified nurses in this setting.

***Support for extra care sheltered housing schemes***

- Developing a model of in-reach health and social care support for extra care schemes linked to Care Connection Teams. This will include dedicated social work support and it is proposed will entail the reallocation of Protecting Adult Social funding from contributing to the mental health nurse in Rapid Response to resourcing a dedicated social work post to support extra care.
- Delivering a new care and wellbeing service at Cottesmore House and Triscott House in 2017/18 and at two new schemes called Grassy Meadow Court and Park View Court in 2018.
- Delivering a model of primary care, e.g. GP, support for extra care schemes. This links into the proposed service for care homes referred to above.

c) **Intended Outcomes/Success Measures**

This scheme will contribute to the following national BCF metrics:

- Reduction in non-elective admissions
- Reduction in permanent admissions to care homes of 65 + population.
- Reduction in delayed transfers of care and specifically for those attributed to the lack of care home placement or package of care reasons.

The following measures that link to the Hillingdon outcomes framework for older people will also be used to identify whether the scheme is working:

- Reduction in non-elective admissions from care homes.
- Reduction in inappropriate non-elective admissions from extra care sheltered housing schemes.
- Proportion of people on an end of life pathway on CMC who achieved their preferred place of death.

d) **Scheme Investment Requirements**

| Service | Provider | Funder 2017/18 | | | Funder 2018/19 | | | TOTAL 2017/19 £,000 |
|---|---|---|---|---|---|---|---|---|
| | | LBH £,000 | HCCG £,000 | TOTAL £,000 | LBH £,000 | CCG £,000 | TOTAL £,000 | |
| Quality Assurance Team | LBH | 168 | 0 | *168* | 168 | 0 | *168* | *336* |
| Adult Safeguarding | LBH | 260 | 0 | *260* | 260 | 0 | *260* | *520* |
| Brokerage Team | LBH | 315 | 0 | *315* | 315 | 0 | *315* | *630* |
| Home Care | Various P & V | 7,854 | 1,110 | *8,964* | 7,977 | 1,110 | *9,087* | *18,174* |
| Care Home Prescriber | HCCG | 0 | 32 | *32* | 0 | 32 | *32* | *64* |
| Older People's Care | Various | | 1,110 | | | 1,110 | | |

| Home | P & V | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Extra Care Social Work Support | LBH | 0 | 0 | *0* | 40 | 0 | *40* | *40* |
| **TOTAL** | | **8,597** | **2,251** | ***10,848*** | **16,725** | **2,251** | ***18,976*** | ***29,656*** |

**Scheme 6: Living well with dementia**

a) **Strategic Objective**

The objective of this scheme is that people with dementia and their family carers are enabled to live well with dementia and are able to say:

- *I was diagnosed in a timely way.*
- *I know what I can do to help myself and who else can help me.*
- *Those around me and looking after me are well supported.*
- *I get the treatment and support, best for my dementia, and for my life.*
- *I feel included as part of society.*
- *I understand so I am able to make decisions.*
- *I am treated with dignity and respect.*
- *I am confident my end of life wishes will be respected. I can expect a good death.*

b) **Scheme Overview**

Dementia is primarily a condition associated with old age and as Hillingdon's population ages the numbers of people living with this condition is likely to increase significantly, with a consequential impact on the local health and social care economy. This scheme represents a continuation of work undertaken in 2016/17 and many of the key actions required to support people living with dementia and their families are addressed within other schemes in the plan. These include the following actions:

- *Preventing or delaying the onset of dementia* - This action links in with the work being undertaken under scheme 1: *Early intervention and prevention*, as the actions intended to prevent stroke will also assist in preventing or delaying the onset of dementia, e.g. promoting physical activity, nutrition guidance, smoking cessation and early detection of conditions such as hypertension and high cholesterol.

- *Securing care home provision for people living with dementia with challenging behaviours* – The current limited availability of this provision is the cause of people with dementia staying in inappropriate care settings for longer than is desirable and can contribute to delayed transfers of care. The work being undertaken under scheme 5: *Improving care market management and development is* intended to address this gap in provision.

- *Securing care provision for people living with dementia at end of life* – The work being undertaken under scheme 5: *Improving care market management and development* will ensure that appropriate service provision is available to address need at this particularly sensitive time.

- *Developing dementia-friendly alternatives to care home settings* - Linked to scheme 5: *Improving care market management and development,* two extra care sheltered housing schemes that have been built to the University of Stirling's Gold Standard, an internationally renowned design standard for dementia-friendly environments, will open in 2018. These are

Grassy Meadow Court with 88 self-contained flats and Park View Court with 60 flats. Both schemes are intended as a realistic alternative to residential care for older residents and tenants will have access to 24/7 on site care and support provision.

The following action is specific to this scheme:

- *Developing a local dementia resource centre model* - A dementia resource centre will be included in the Grassy Meadow Court extra care scheme referred to above that is due to open in early 2018. This resource is primarily intended to meet the social care needs of people living with dementia in the community with family carers, but during 2017/18 health and social care partners will work together to identify how the maximum benefit can be obtained from this facility.

c) **Intended Outcomes/Success Measures**

This scheme will impact on the following BCF metrics:

- Reduction in permanent admissions to care homes.

d) **Scheme Investment Requirements**

| Service | Provider | Funder 2017/18 | | | Funder 2018/19 | | | TOTAL 2017/19 £,000 |
|---|---|---|---|---|---|---|---|---|
| | | LBH £,000 | HCCG £,000 | TOTAL £,000 | LBH £,000 | CCG £,000 | TOTAL £,000 | |
| Wren Centre (dementia resource centre) | LBH | 300 | 0 | 300 | 300 | 0 | 300 | 600 |
| **TOTAL** | | **300** | **0** | **300** | **300** | **0** | **300** | **600** |