Appendix 1

NHS
Hillingdon
Clinical Commissioning Group

Better Care Fund Plan 2017/19

HILLINGDON
LONDON

September 2017

Better Care Fund Plan 2017/19
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2016/17 Better Care Fund Plan

1. INTRODUCTION

1.1 Plan Summary

Local Authority	**London Borough of Hillingdon**
Clinical Commissioning Groups	**Hillingdon Clinical Commissioning Group (NHS Hillingdon)**
Boundary Differences	**Boundaries are co-terminus**
Date agreed at Health and Well-Being Board (HWB):	**26/09/17**
Date submitted:	
Total agreed value of pooled budget:	
2015/16	**£17,991,000**
2016/17	**£22,531,000**
2017/18	**£36,814,000**
2018/19	**£54,049,000**

1.2 Funding Contributions to the Plan

The contributions of the Council and Hillingdon Clinical Commissioning Group (HCCG) to the plan is summarised in table 1 below.

Table 1: Council and HCCG Financial Contributions Summary			
Organisation	**2016/17** *£,000s*	**2017/18** *£,000s*	**2018/19** *£,000s*
HCCG	11,965	17,158	26,770
LBH	10,566	19,656	27,279
TOTAL	**22,531**	**36,814**	**54,049**

1.3 Scheme Summary

Table 2 below shows the financial contribution to each scheme by both the Council and HCCG over the two years of the plan.

Table 2 Council and HCCG Financial Contribution by Scheme Summary					
		Funder 2017/18		**Funder 2018/19**	
	SCHEME	**LBH £000's**	**HCCG £000's**	**LBH £000's**	**HCCG £000's**
1	Early intervention and prevention	5,060	2,353	5,426	2,353
2	An integrated approach to supporting Carers	862	18	878	18

3	Better care at end of life	50	992	51	992
4	Integrated hospital discharge	4,607	11,406	4,643	11,406
5	Improving care market management and development	8,695	2,389	15,893	12,001
6	Living well with dementia	300	0	306	0
	Programme Management	82	0	82	0
	Total Partner Contributions	**19,656**	**17,158**	**27,279**	**26,770**
	TOTAL ANNUAL VALUE	**36,814**		**54,049**	

1.4 Signatories to the Plan, Authorisation and Sign-off

Signed on behalf of the Clinical Commissioning Group	Hillingdon CCG
By	Dr Ian Goodman
Position	Chair of Hillingdon CCG
Date	
Signed on behalf of the Council	London Borough of Hillingdon
By	Cllr Philip Corthorne
Position	Cabinet Member for Social Services, Housing, Health and Wellbeing/ Chairman, Health and Wellbeing Board
Date	
Signed on behalf of the Health and Wellbeing Board	Hillingdon Health and Wellbeing Board
By Chairman of Health and Wellbeing Board	Cllr Philip Corthorne
Date	

Signed on behalf of the Healthwatch Hillingdon	Healthwatch Hillingdon Board
By	Stephen Otter
Position	Chair of Healthwatch Hillingdon Board
Date	

1.5 Wider Partner Involvement

The 2017/19 BCF plan has been developed with the local acute trust, The Hillingdon Hospitals NHS Foundation Trust, the local community health and community mental health provider, the Central and North West London NHS Foundation Trust (CNWL) and the range of voluntary sector providers that comprise the third sector consortium H4All and these include Age UK Hillingdon, the Disablement Association Hillingdon (DASH), Harlington Hospice, Hillingdon Carers and Hillingdon Mind. All of these organisations will have a fundamental role to play in the delivery of the plan.

Partners have been consulted on the content of the plan through a range of fora. This includes the Hillingdon Transformation Board,the Clinical Design and Delivery Group, which includes representatives from the local accountable care partnership (ACP), known as Hillingdon Health and Care Partners. The multi-agency Carers' Strategy Group has also been consulted. Proposals contained within the draft plan were also taken to the Older People's Assembly in March 2017.

2. BACKGROUND AND CONTEXT

2.1 Hillingdon: The Place

Hillingdon is the second largest of London's 32 boroughs covering an area of 42 square miles (11571 hectares), over half of which is a mosaic of countryside including canals, rivers, parks and woodland. As the home of Heathrow Airport, Hillingdon is London's foremost gateway to the world, and is also home to the largest RAF airport at RAF Northolt. Hillingdon shares its borders with Hertfordshire, Buckinghamshire, Hounslow, Ealing, and Harrow.

There are 46 GP practices in Hillingdon with an average of registered patients per practice of 5,605. GP practice with the highest number of registered patients is located in Uxbridge and West Drayton with 14,276 patients. Only 4 GP practices in Hayes and Harlington locality have a registered population size above the Hillingdon average compared to 10 practices in Uxbridge and West Drayton and 8 practices in Ruislip and Northwood. Hillingdon CCG achieved full delegation of primary care commissioning on April 1st 2017.

The borough is divided into three localities that loosely correspond with the parliamentary constituencies. These are: Ruislip and Northwood, Uxbridge and West Drayton and Hayes and Harlington.

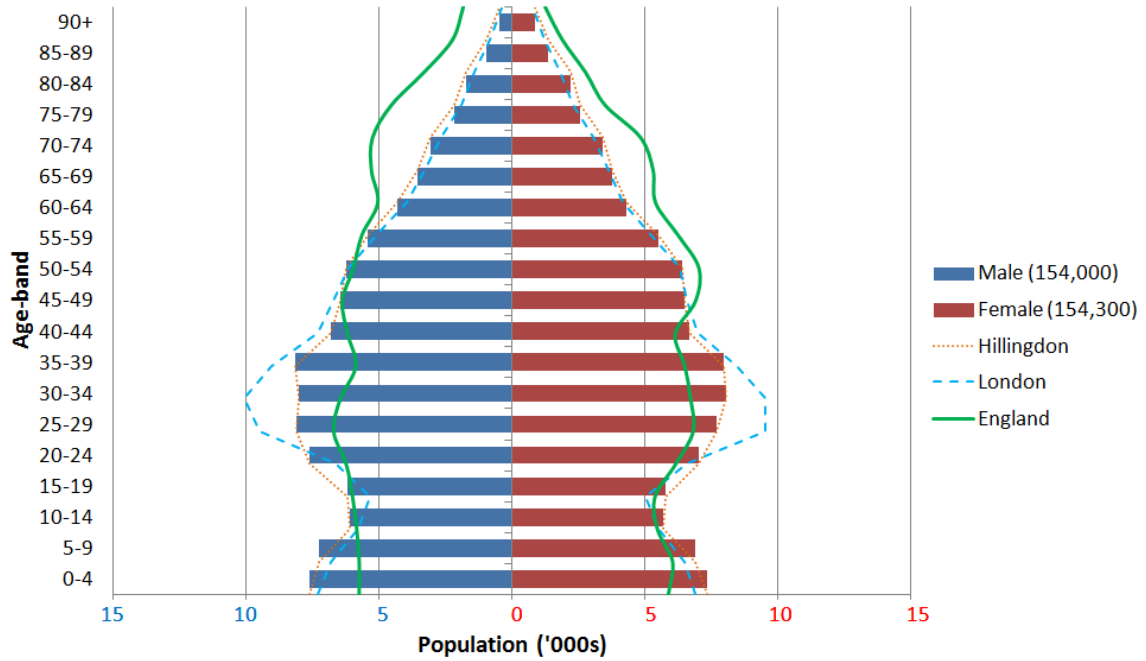
Hillingdon is ranked 153 out of 326 in the English index of multiple deprivation (IMD 2015) where the most deprived is ranked 1. It is ranked 25th most deprived out of London's 33 boroughs, hence it is seen as a relatively affluent area. Social segmentation of Hillingdon's neighbourhoods by dominant Acorn types also shows that a large proportion of Hillingdon's population is stable, home owning and 'fairly comfortable'. There are however major differences in deprivation between wards in the north and south of Hillingdon with small areas in the south the borough falling in the 20% most deprived wards nationally.

Hillingdon is a high employment area and official labour market data from NOMIS shows that 78.3% of the population aged between 16 and 64 are economically active. In June 2016 only 1.4% of the working age population were claiming out of work benefits, which compares to an average of 1.8% in both London and England.

2.2 Local demography, future demographic challenges and long-term health issues.

Hillingdon's Joint Strategic Needs Assessment (JSNA) shows that based on the Census-based sub-national population projections (SNPP) the population of the borough in 2017 is approximately 390,300. The diagram below shows the composition of Hillingdon's population by age and gender.

Chart 1. **Population Pyramid, Hillingdon 2017 (with distribution of other areas)**

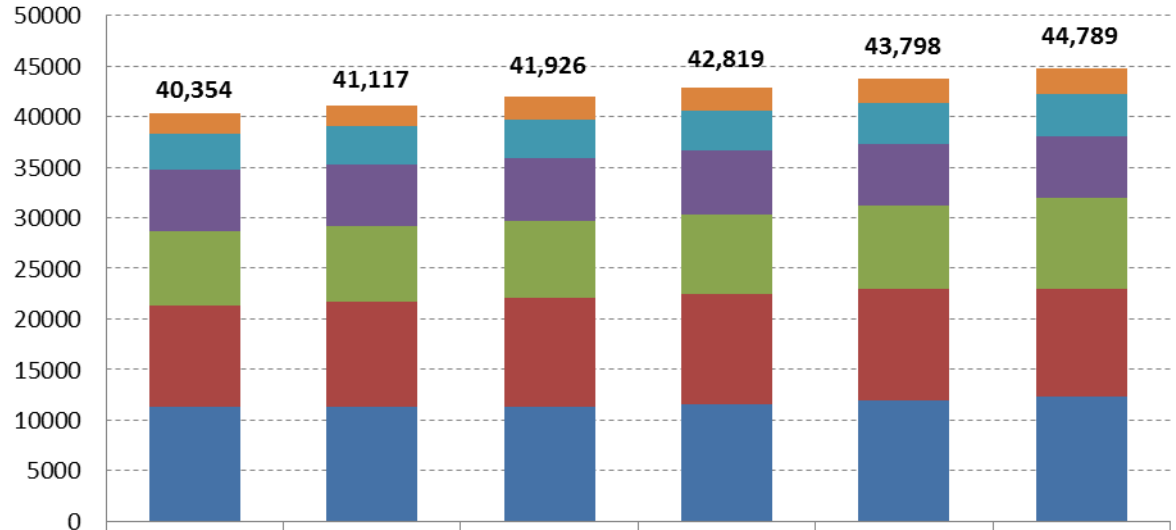


Source: National Statistics, 2014-based SNPP

The proportion of the population aged 0-9 is greater in Hillingdon than in England and also London. The proportion of the population aged 45+ is lower in Hillingdon than in England. The proportion of older people (age 65+ years) in Hillingdon is slightly higher than London, but lower than England. 40,354 people are aged 65 years or more and the table below illustrates the steady increase in the 65 and over population and particularly those people aged 80 and over during the period 2017 to 2022.

The focus of the 2017/19 BCF plan will continue to be on older people as the case for change as to why Hillingdon is focusing on this population group set out in the 2015/16 BCF plan continues to apply, e.g. largest population group with greatest demand on health and social care services. Chart 2 below demonstrates the steady increase in the 65 and over population between 2017 and 2022.

Chart 2

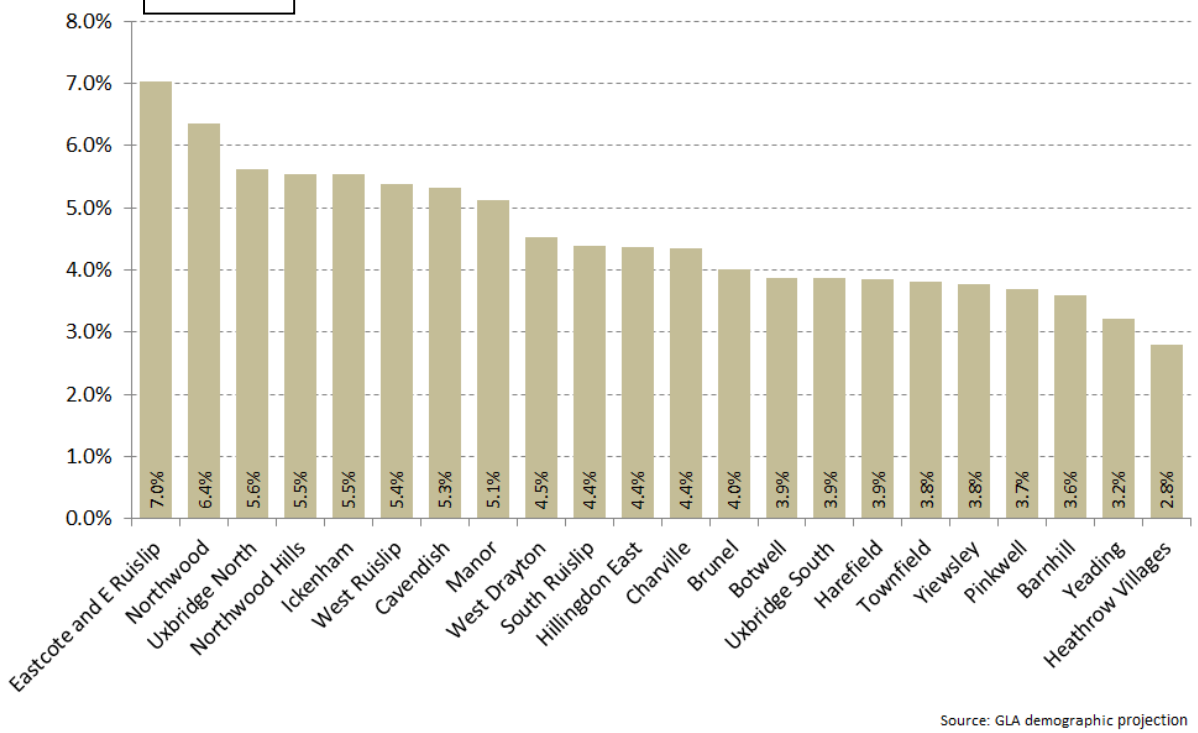


	2017	2018	2019	2020	2021	2022
90+	2063	2111	2182	2296	2396	2509
85-89	3552	3686	3797	3920	4072	4194
80-84	6020	6147	6215	6232	6067	6078
75-79	7353	7454	7652	7852	8303	9061
70-74	9999	10444	10717	10949	10969	10577
65-69	11367	11276	11363	11571	11992	12370

The demographic challenges and related health issues facing Hillingdon in respect of the older people population include:

- 40,354 older people live in Hillingdon in 2017, a figure that is likely to increase by nearly 6% (2,470) by 2020 and 10% (4,440) by 2022.
- The graph below shows the wards with the highest proportion of people aged 65 and over are in wards north of the A40.

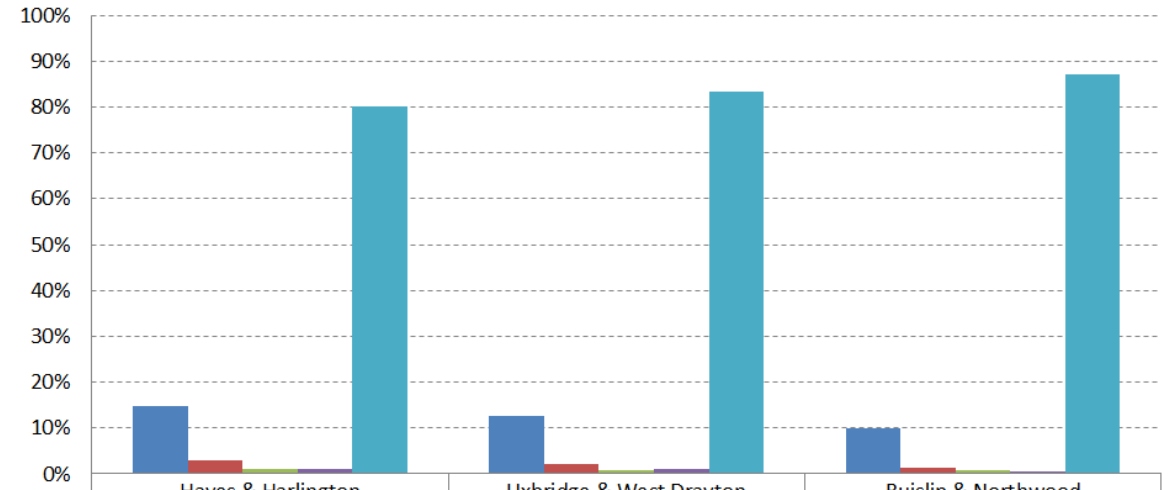
Chart 3. Hillingdon ward population for age 65+, 2016



Source: GLA demographic projection

- In 2016 79% of the 65 and over population was estimated by the GLA 2014 trend-based ethnic projections to be White. Each additional five year age group from 65 is projected to be less diverse. By 2020 the proportion of the 65 and over aged group that are White is projected to reduce to 75%. The highest proportion of Hillingdon's Black, Asian and Minority Ethnic (BAME) population is concentrated south of the A40, as illustrated in chart 4 below.

Chart 4. Census 2011
Over 65s Ethnicity: by locality

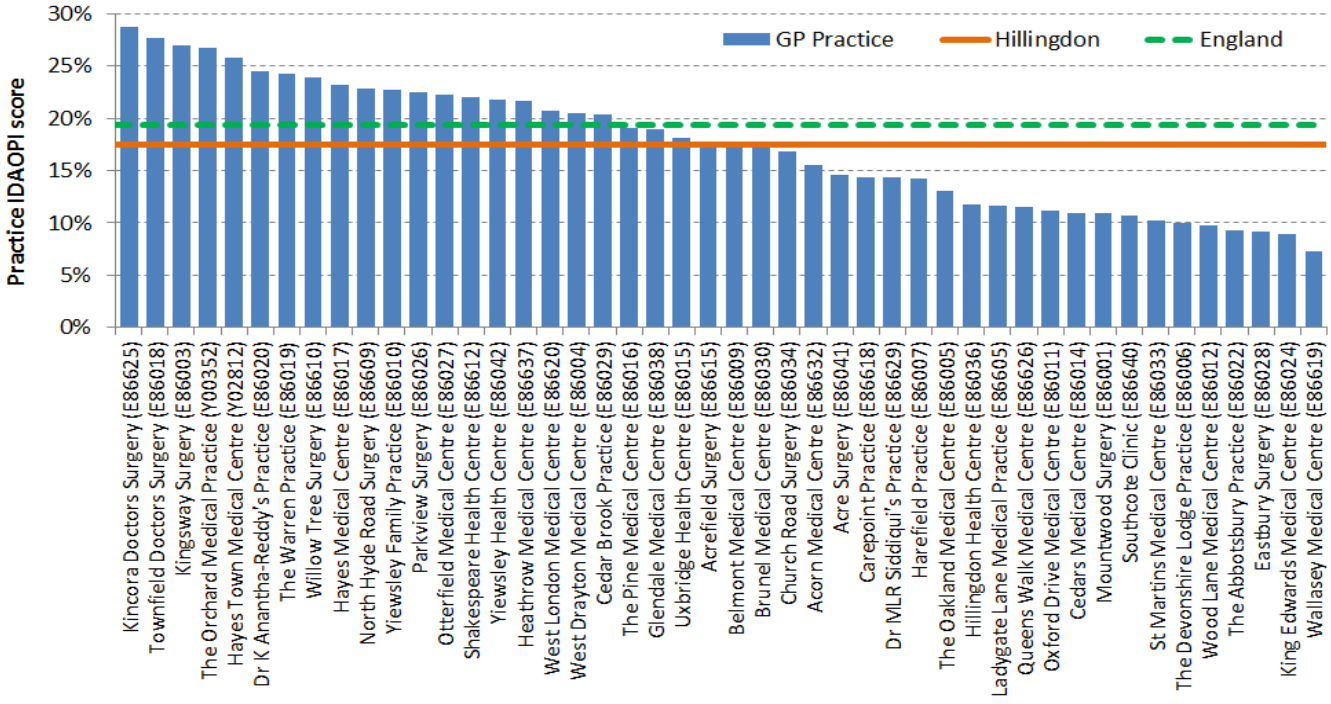


	Hayes & Harlington	Uxbridge & West Drayton	Ruislip & Northwood
Asian	14.8%	12.5%	10.1%
Black	2.9%	2.2%	1.4%
Mixed	1.0%	0.9%	0.8%
Other	1.1%	0.9%	0.5%
White	80.2%	83.5%	87.2%

- Income Deprivation Affecting Older People Index (IDAOPI) 2015 identified that the percentage of older people in Hillingdon experiencing deprivation was in line with the general level of deprivation in the borough and at 15.7% was relatively low in comparison with the average for England of 16.2%. However, the Chart 5 below showing older people deprivation by GP practice demonstrates that this population group is disproportionately concentrated in practices in the south of the borough.

- The Quality Outcomes Framework (QOF) recorded 1,813 people diagnosed with dementia on GP registers in 2015/16, which reflected a diagnosis rate of 54.23%, which was low for London (65.79%) and for England (60.78%). POPPI estimated the population of people living with dementia in 2015 at 2,880 and projected an 8% (240) increase to 3,120 in 2020. For the 85 and over population POPPI estimates suggest that the number living with dementia was 1,250 in 2015 and that this will rise by 17% (250) by 2020. The dementia diagnosis rate increased to 69.3% at the end of 2016/17 compared to 41% in 2014/15.

Chart 5. **Index of deprivation affecting older people index score, Hillingdon GP Practices**



Source: IDAOPI (Index of Deprivation 2015) applied to July 2016 Practice population (NHS Digital)

- The Quality Outcomes Framework (QOF) recorded 1,813 people diagnosed with dementia on GP registers in 2015/16, which reflected a diagnosis rate of 54.23%, which was low for London (65.79%) and for England (60.78%). POPPI estimated the population of people living with dementia in 2015 at 2,880 and projected an 8% (240) increase to 3,120 in 2020. For the 85 and over population POPPI estimates suggest that the number living with dementia was 1,250 in 2015 and that this will rise by 17% (250) by 2020. The dementia diagnosis rate increased to 69.3% at the end of 2016/17 compared to 41% in 2014/15.

- Table 1 below provides prevalence estimates for the number of older people living with long-term conditions. This shows the estimated prevalence of people living with stroke in Hillingdon. Atrial fibrillation is a known risk factor for stroke. The diagnosed prevalence in Hillingdon is 1.1% and the estimated prevalence is 2.0%. There could be an additional 2,500 people with undiagnosed atrial fibrillation in Hillingdon.

Table 3: Prevalence of Long-term Conditions within Older People Population						
Borough Estimate	**Stroke**	**Cardio Vascular Disease**	**Chronic Heart Disease**	**Hypertension**	**Disabetes**	**Mental Health Conditions**
2016	3,067	12,299	6,532	26,616	7,098	4,502
2021	3,312	13,271	7,047	28,688	7,662	4,816

- It is estimated that 2% of the most complex patients (all ages), e.g. people living with two or more long-term conditions, comprise 16.2% of CCG spend. 57% of these complex patients are people aged 65 and over; 35% are aged 75 and over and 14% aged 85 and over. In 2016/17 the local health spend on people aged 65 and over living with multiple health conditions was £9.1m.

- Quality Outcomes Framework (QOF) data shows that 6,741 people aged 65 and over registered with Hillingdon GPs on the 1st April 2017 had a diagnosis of diabetes.

- POPPI data estimates that approximately 4,200 older people are living with frailty. Frailty is a clinically recognised state of increased vulnerability which results from ageing associated with a decline in the body's physical and psychological reserves. Older people with frailty are at risk of unpredictable deterioration in their health resulting from minor stressor events.

- Although nearly 42% (10,049) of our non-elective activity in 2016/17 was attributed to the 65 and over population, this population group accounted for 58% (£27.3m) of the total health emergency admission spend in that year. In 2016/17 34% (£16.1m) of emergency admission spend was on the 80 and over population, which accounted for nearly 23% (5,495) of admissions in 2016/17. We estimate that some 28% (1.553) of emergency admission for the 80 and over population group were avoidable or deferrable, which is based on the proportion of admissions resulting in a length of stay of between 0 and 1 days.

- Nearly 46% of the Council's gross spend on care for older people in 2016/17 was on care homes (residential and nursing). This made Hillingdon the 15th lowest in London (18 boroughs have a higher proportion spend than Hillingdon). However, the desired trajectory would be towards the 40% level, focusing on people who can be better supported in their usual place of residence.

- At the time of the 2011 census 31% of all older people lived on their own and could be at risk of being socially isolated. Projections from the Projecting Older People Population Information System (POPPI) suggest that by 2020 36% (15,580) of the 65 and over population will be living on their own and 64% (9,980) of this number will comprise of people aged 75 and over.

- The 2011 census showed that 18% of unpaid carers were aged 65 and over. POPPI projections suggest that this number is likely to increase by 19% to 5,703 by 2020. The census also showed that approximately 10% of carers were aged under 25, which emphasies the continuing importance of supporting Carers of all ages.

2.3 Current state of the health and adult social care market.

NHS Provider Market

There are 46 GP practices in Hillingdon and 44 of these have formed into a confederation that gained legal staus from 1st April 2017.

Hillingdon has a single acute trust with The Hillingdon Hospitals Foundation Trust, which is based across two sites, with the main hospital being in Hillingdon and Mount Vernon being in Northwood in the north of the borough. Approximately 80% of Hillingdon Hospital's activity comes from residents of the borough.

Hillingdon also benefits from a single community health and community mental health provider, which is the Central and North West London Foundation Trust (CNWL).

The GP confederation, Hillingdon Hospital and CNWL have combined with a third sector consortium through an alliance agreement to form an accountable care partnership, which is called Hillingdon Health and Care Partners.

Harefield Hospital, which specialises in treating heart and lung conditions, is also based in the borough and is part of the Royal Brompton and Harefield Foundation Trust.

Care Homes

59% (4,953 delayed days) of delayed transfers of care in 2016/17 were attributed to issues with securing appropriate care home placements and 65% (3,243 delayed days) of these were nursing home related, primarily in respect of people with more challenging behaviours associated with dementia. This suggests that the current care home market is not suitable to meet current and future needs.

At the end of 2016/17 there were 48 care homes in Hillingdon and 29 of these were for older people. The bed base for older people was 1,247, which represented 91% of Hillingdon's total care home bed base. Table 2 below provides a breakdown of the older people's care homes in Hillingdon. Some homes are dual registered.

Table 4: Summary of Care Home Provision for Older People in Hillingdon

Category	Number of Care Homes	Number of Beds
All care homes for older people	29	1,247
Registered nursing homes	15	729
Residential homes without nursing	14	496
All care homes for people living with dementia	28	789
Registered dementia nursing homes	12	347
Registered dementia residential homes	16	442

Table 3 below shows that in 2016/17 the Council accounted for 35% of all placements of older people in the borough, which is comparable with London. It also demonstrates that 45% of all placements were of self-funders, which is a higher proportion than London. London figures are in brackets.

The CCG is paying Funded Nursing Care (FNC) on 47% (351) of the registered nursing beds in the borough.

Table 5: Placement Share of Older People Care Home Beds	
Placement Source	**Percentage**
LBH	35% (34%)
Other London councils	9% (14%)
London Continuing Healthcare	7% (6%)
Other public sector authorities	5% (5%)
Self-funders	45% (41%)

8 of Hillingdon's 29 care homes for older people are rated as *requires improvement* by CQC and 1 is rated as *outstanding.* The remaining homes are either rated *good* or have no rating because of a recent change of ownership.

Key issues for local providers include:

- **Debt** - The buy and lease financing model, particularly for the larger providers, leaves them with a considerable debt to service and this makes them vulnerable to market fluctuations.

- **National Living Wage** - Introduction of the NLW has increased staffing costs and this has filtered down into increased placement fees.

- **Staff recruitment and retention** - Hillingdon is a high employment area and most homes experience difficulties in recruiting and retaining staff for what continues to be low paid work. The issue is particularly pressing in nursing homes, where the national shortage of nurses is experienced at a local level. Providers are also competing with local NHS organisations that also face challenges with recruiting.

- **Quality** - Staff recruitment and retention issues, including turnover of home managers, and change of ownership arrangements, have resulted in instability in some homes that has contributed to quality issues. At 31st March 2017, 3 older people's care homes in Hillingdon with a combined capacity of 252 beds were identified by the Council's Provider Risk Panel as being *at risk*.

- **Impact of extra care** - The number of permanent placements in residential care homes by the Council is expected to reduce considerably from 2018/19 with the opening of two new extra care sheltered housing scheme comprising of an additional 148 self-contained flats with access to care and support 24/7.

Homecare

Homecare is traditionally low paid, low status work and providers experience a high turnover of staff, an issue particularly evident in areas with plentiful alternative sources of employment such as Hillingdon. There are 25 homecare agencies registered with the Care Quality Commission based in the borough and at least 3 only take referrals from self-funders. There is no legal requirement for homecare agencies operating in the borough to have a base situated within its geographic boundary.

The Council commissions approximately 15,000 hours per week of homecare for adults to support approximately 1,130 people a week. 50% of this activity is supported by three main providers and the other 50% is spread across 20 other providers. A further 1,000 hours a week are commissioned from 5 providers to support 33 children with homecare aweek. In addition, the CCG is commissioning packages of care week for approximately 200 people and this is primarily for people at end of life.

Many of the homecare agencies utilised by the Council also provide outreach support to assist service users to access community based daytime activities (approximately 30 agencies providing 3,850 hrs per week for 390 people).

A key issue for homecare providers is the ability to recruit and retain staff. Providers have also experienced increasing costs attributed to the National Living Wage, new pension requirements and legal judgements regarding travel time payment arrangements. Training requirements have also added to provider costs that fees from the public sector have not addressed. The effect of recruitment and retention issues has impacted on capacity, which has contributed to nearly 6% (468) of delayed days in Hillingdon during 2016/17 being attributed to issues with securing packages of care. These issues have also contributed to a decline in service quality with some providers and the Council's Quality Assurance Team works closely with CQC to support providers to address these when they arise. At 30th June 2017 5 homecare agencies were identified as presenting significant risks that impacted on the number and complexity of referrals they could receive.

Homecare contract financial viability issues contributed to the termination by mutual agreement of one of the Council's main contracts with a private provider in 2016. The agreement by the Council to increase fee rates helped to avoid another provider surrendering their contract. The Improved Better Care Fund (IBCF) grant has been essential to enable this to happen (see sections 5 and 6: *National Conditions* and *The Plan: Schemes and Spending*).

Third Sector

Hillingdon has a vibrant third sector comprising of hundreds of voluntary and community organisations. Five of Hillingdon's larger and established voluntary sector organisations, e.g. Age UK Hillingdon, the Disablement Association Hillingdon, Harlington Hospice, Hillingdon Carers and Hillingdon Mind, have collaborated to form a consortium called H4All that has been legally constituted as a community interest company. H4All is one of the constituent parts of the accountable care partnership known as Hillingdon Health and Care Partners (HHCP).

Workforce

NHS Digital data shows that on 31st March 2017 The Hillingdon Hospitals had a total workforce of 3,172 and this included 1,638 clinically qualified staff and of these 444 were doctors. There are 46 GP practices supported by 140 GPs and associated clinical and support staff. CNWL also has a local workforce of 888 to deliver its community health and community mental health services. It has a vacancy rate of 7.23% in community health and 19.3% in mental health.

The National Minimum Data Set for Social Care held by Skills for Care shows that in 2016 Hillingdon had an adult social care workforce of 5,200 people, 3,900 of which were involved in direct care. The average age of the workforce was 42 and 19% of the workforce was aged 55 and over. The turnover rate was 28%, adult social care workers in Hillingdon had on average 6.0 years experience in the sector and around 59% of the workforce had been working in the sector for at least three years.

2.4 Key financial challenges

Hillingdon's Sustainability and Transformation Plan (STP) submission showed that we know that if we do not transform our health and care system, by 2021 we will be facing a financial gap of around £120m. This is summarised in table 5 below.

Table 6: Hillingdon's Financial Gap 2016/21

Period 2016/2021	Hillingdon £m
CCG	(39)
Primary Care	(2)
Social Care	(34)
Acute and Community Care	(45)
Special Commissioning	0
Total	**(120)**

NHS

Our population segmentation shows that Hillingdon will see larger rises in the populations with increased health needs over the next five years than the wider population. This increased demand means that activity, and the cost of delivering services, will increase faster than our headline population growth would imply. NHS budgets, while increasing more than other public sector budgets, are constrained and significantly below both historical funding growth levels and the increase in demand. The most likely growth assumptions over the next five years in Hillingdon will see approximately 21% more activity that will need to be funded. Addressing this will require a shift in funding and resources in line with agreed STP priority areas, recognising funding pressures across the system and ensuring that human and financial resources shift to focus on delivering the things that will make the biggest difference to closing the funding gaps.

The total improvement resources across all NWL providers and commissioners, including the Academic Health Science Network (AHSN), to realign them around STP delivery areas in order to increase effectiveness and reduce duplication. This includes undertaking extensive system modelling of funding flows and savings through to 2020/21 to inform future funding models and sustain the transformation. The NWL CCG five year financial plan for the STP is currently being refreshed and this information will be added once this work has been completed, which is scheduled for the end of September 2017.

Local Authority

The Council's published Medium Term Financial Forecast to the financial year 2021/22 identifies an overall budget deficit of £70m over the 5 year period. The annual forecast net expenditure for the Council's General Fund Services (includes all services except Housing) is £228m. For 2017/18 savings of £15m have been identified and will be delivered for the current year to balance this year's budget. To date total savings of £107m have been delivered by the Council for the period 2010/11 to 2016/17. On average the Council has had to balance its budget year by year since 2010/11 by delivering savings of around £15m.

The key changes in the Council's budget over the next five years are a continuation in the reduction of government grants estimated to be £28m plus increased expenditure pressures caused by demographic and demand growth for Adult and Children's Social Care £13m, Payroll and Service provider inflation £26m and increased Waste Disposal Costs £4m.

For Adult Social Care the '*do nothing*' funding gap for the five years 2017/22 reflected in the development of the STP included increased demographic growth for services to Older People, People with Disabilities and Mental Health conditions, the impact of the increases of the National Living Wage on homecare and residential and nursing care home accommodation provider costs. As at October 2016, this has been estimated locally as £34m gap over the next 5 financial years. The 'do nothing' forecast funding gap for social care includes a corporate share of the financial savings set out above of £70m over the 5 year period that Adult Social Care Services will need to make to contribute to the Council's statutory requirement to set a balanced budget.

2.5 Key issues and challenges that the plan will aim to address.

The plan seeks to address some of the identified financial pressures associated with the increasing numbers of older people set out in section 2.4 through developing a more integrated model of care where people are supported to remain in their usual place of residence. It aims to embed the shift to planning for anticipated care needs and coordinating care around the person, their family and Carers and supporting self care rather than crisis management and reactive provision of services. Reducing fragmentation of service provision should help to improve patient flow through the Hospital and improve their experience of care, as well as alleviating the need for and cost of escalation beds. Finally, a more integrated approach to managing the private market, including supporting providers, through the development of integrated brokerage and integrated commissioning of homecare and nursing care home placements should help to improve capacity by making the public sector locally easier to do business with and thereby shape the market.

3. PROGRESS SO FAR

3.1 Existing approach to integration and the main points of the 2016/17 BCF plan.

Hillingdon's approach to integration has been to build the level of ambition incrementally, reflecting the developing relationship and appetite to manage risk by both the Council and the CCG. The eight schemes in the 2016/17 plan included some logical extensions of activity undertaken in 2015/16 whilst simultaneously maintaining the cautious and incremental approach to integrated working and the pooling of budgets that minimised the risk to both the Council and HCCG. They included:

- Extending the 2015/16 schemes where benefits could be achieved for other adult client groups, e.g. development and management of the supported living market that included all adults and extending the scheme on supporting Carers to all unpaid Carers;
- Adding funds to the pooled budget where this would have demonstrable benefits for residents/patients, e.g. specialist palliative personal care service for people at end of life;
- Extending the scope of the plan to include new types of activities, e.g. dementia;
- Accelerating benefits through a greater ambition to integrate services across health and social care, building on progress made in 15/16, e.g. intermediate care; and
- Correcting anomalies from the 2015/16 plan, e.g. bringing the Council's budget for the community equipment contract into the pooled budget with that of the CCG so that the whole budget was under the same governance structure.

The eight schemes in the 2016/17 plan were:

Scheme 1: Early identification of people with susceptibility to falls, dementia, stroke and/or social isolation.
Scheme 2: Better care for people at end of life
Scheme 3: Rapid Response and Integrated Intermediate Care
Scheme 4: Seven day working
Scheme 5: Integrated community-based care and support
Scheme 6: Care home and supported living market development
Scheme 7: Supporting Carers
Scheme 8: Living well with dementia

3.2 BCF progress to date

2016/17 has been a positional year that has enabled relationships to develop to create the opportunity for greater integration to deliver the objectives within the STP and better outcomes for residents from 2017/18.

Complexities of the local landscape and capacity within the health and care system meant that it was not possible to deliver some of the key actions within the 2016/17 plan in year. However, much of the developmental work has taken place that will facilitate delivery from 2017/18.

2016/17 has also seen significant progress on integrated working across health with voluntary sector partners through the development of the Accountable Care Partnership (ACP). They are working together to deliver integrated person centred care, primarily for people aged 65 and over. Discussions via the Health and Wellbeing Board have contributed to creating an environment that is contributing to a dialogue taking place about the Council joining the ACP.

3.3 Progress against national metrics

The following shows the 2016/17 outturn against the national metrics, including the locally determined user/patient experience indicators:

- *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.

- *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%.

3.4 Successes

The following are examples of key successes deriving from the 2016/17 plan:

- *Joint working across services, e.g. Homesafe, Rapid Response and Reablement* - This has had a significant impact on reducing the number of hospital admissions during a period that has seen a considerable rise in the number of attendances. It has also been possible to achieve shared benefits through more efficient management of the community equipment service;

- *H4All Wellbeing Service* - This innovative service, delivered by a local third sector consortium, is intended to prevent the needs of older people living with long-term conditions escalating which may otherwise result in a loss of independence and lead to an increased demand on health and care services. The service became operational in 2016/17 and is showing positive results;

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

- *Hospital discharge* - A new patient information booklet has been produced that should contribute to a reduction in the number of DTOCs attributed to the patient/family choice reason. Increased investment by the CCG has funded an additional consultant geriatrician post that will help to support community health teams to support discharge and prevent readmission. Hillingdon Hospital has established and recruited to nine Patient Flow Coordinator posts intended to help ensure a more consistent discharge process across wards;

- *Discharge to assess* - Partners worked together to establish bed-based discharge to assess arrangements in local care homes in order to relieve pressure on Hillingdon Hospital;

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

4. LOCAL VISION AND APPROACH TO HEALTH AND SOCIAL CARE INTEGRATION

4.1 Vision for 2020

Hillingdon's vision for care and support within the geographical boundary of the borough is set out within our STP submission and this is:

Health & Wellbeing	• Working collaboratively across health, social care and public health we will improve outcomes and reduce inequalities for our population with a focus on those with both traditional Long Term Conditions (including both physical and mental health LTCs) and emergent categories of LTCs such as pain, frailty and social isolation. • Our coordinated programme of work will bring together our existing plans for the BCF and our Health & Wellbeing Strategy (HWBB) and engage our whole community to create a resilient population and assist people to remain independent with better quality of life for longer.
Care & Quality	• We will provide care that is safe, effective and delivered by experienced practitioners through collaborative working across health and social care services. • We will be able to share information that improves the quality of health and social care services and that enables our population to make informed choices. • We will deliver the best and highest quality care possible within the constraints of our local economy and the growth in demand that we are predicting.

Finance & Efficiency	• It is simply not viable to continue trying to respond to increasing demand for services, particularly at the expense of preventative action. We are committed to finding financial savings and ways to achieve better outcomes for individuals and their families through the better integration of services and by reducing demand through an increased focus on prevention and patient activation.

4.2 Model for achieving fuller integration by 2020

The focus of the 2017/19 plan will continue to be on older people. Meeting the needs of 65 and over population 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. Key beneficiaries of the next iteration of the BCF plan will be:

- All of Hillingdon's residents aged 85 and over
- Frail older people aged 75 and over with one or more long-term conditions
- Older people who are at risk of dementia
- Older people who are at risk of falling for a first time.
- Older people who are socially isolated; and
- Carers of all ages.

The 2017/19 plan will see the delivery of the characteristics of full integration illustrated in table 6 below in respect of older people, e.g. joint commissioning and lead commissioning. Hillingdon CCG's preferred model of delivery for integrated care is through the Accountable Care Partnership, Hillingdon Health and Care Partners (HHCP). Whilst the Council is not formally a member of HHCP at this point, schemes within the 2017/19 plan provide an opportunity for closer alignment that can test the benefits and risks of formal participation, e.g. scheme 1: *Early intervention and prevention* and closer working with the Care Connection Teams and scheme 4: *Integrated hospital discharge* that is intended to see the development of a single intermediate care service.

Table 7: Characteristics of Full Integration

	Joint Commissioning	Lead Commissioning	Accountable Care Organisation (ACO)
Characteristics	Some or all LA/CCG commissioning decisions are made jointly. 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. The ACO decides what services to purchase to deliver those outcomes.

Source: 2017/19 Integration and Better Care Fund Policy Framework (DH March 2017)

4.3 Links to the Sustainability and Transformation Plan (STP)

Local government has been integral to the development of the North West London sector STP and is represented on the Joint Health and Care Transformation Group, the sector-wide governing group for the delivery of the plan, at both officer and elected member level. Hillingdon's elected member representative is the chairman of the Health and Wellbeing Board (HWB).

The Better Care Fund plan is key to the delivery of the aspects of Hillingdon's STP that are dependent on integration between health and social care or closer working between the NHS and the Council for delivery. The schemes have been devised to contribute to the implementation of relevant STP delivery areas and this is illustrated in section 6: *The Plan: Schemes and Spending*.

4.4 How BCF aligns to wider system transformation, complements the 5-Year Forward View and wider local government transformation

There is a wide range of system transformation programmes in progress in Hillingdon that are linked to the delivery of the Five-year Forward View and these include:

- Urgent and emergency care
- Primary care
- Personalisation
- Mental health
- Long-term conditions
- Children and young people

There are a range of schemes contained within the BCF plan that through their focus on on contributing to supporting timely discharge and preventing hospital admissions that are avoidable will contribute to the implementation of the urgent and emergency care plans. Actions within the Delayed Transfers of Care Action Plan (see Annex 1) will also contribute to the delivery of the Hillingdon Hospital Urgent and Emergency Care Work Plan and are also reflected within that document.

The BCF provides the mechanism through which social care can formally accede to the ACP, subject to the latter demonstrating that this is the most appropriate vehicle for delivering improved health and care outcomes for residents. The ACP is the key delivery vehicle identified by the CCG for the implementation of integrated care in line with the Five-year Forward View. The success of this model over the period of the plan would then enable it to be extended to other population groups from 2019, e.g. children and young people, and therefore see the scope of the BCF (or any successor initiative) extended from that date.

There is alignment with the long-term conditions programme in so far as schemes within the BCF contribute to the identification of older people living with conditions such as frailty, diabetes, obesity, etc. The mental health programme is supported by the BCF through the funding of mental health social workers in A & E, the specific scheme that is focused on addressing the needs of people living with dementia (scheme 6: *Living well with dementia*). The DTOC action plan also includes actions intended to address mental health delays.

There are also three key enablers that are essential to the delivery of integrated care in Hillingdon and these are ICT, estates and workforce. As part of the implementation process of the Five-year Forward View and in accordance with STP guidance, Hillingdon has developed a digital strategy that is aligned with a broader North West London Digital Strategy. This reflects the ambition for integration of Hillingdon's social care data for both direct care and improved commissioning purposes.

An estates strategy was also submitted as part of the broader North West London estates strategy component of the STP submission. A strategic estates group meets locally on a quarterly basis and involves senior representation from all statutory partners, including the Council. A standing item on the agenda of Health and Wellbeing Board meetings considers future developments and provides additional scope to explore best use of partner estates as well as other opportunities for addressing current and future need. A key outcome of this has been the development of the former Woodside Day Centre site to provide a health centre that is scheduled to open in 2019. This will eventually benefit the tenants at the nearby Grassy Meadow Court extra care sheltered housing scheme that is due to open in June 2018.

The scope of Hillingdon's BCF plan includes how the workforce in the independent sector, e.g. care homes, homecare, supported living schemes and voluntary sector providers. This is addressed within the scheme descriptions set out in section 6: *The Plan: Schemes and Spending*.

Local Government Transformation

As part of its devolution agenda the 2015/17 Government made a commitment to see further powers devolved to London. In December 2015, the government agreed the London Health and Care Devolution Agreement, which established five pilots as the first step towards improving health and care in London through integration and devolution. Hillingdon Council was also a signatory to the London Devolution Memorandum of Understanding. Five pilots were established under that agreement and none of these included Hillingdon. The next stage of devolution in London following the General Election remains unclear but the Council remains committed to considering the positive outcomes of the five pilots established under the 2015 agreement to identify scope for replication at a local level.

4.5 What will be different following delivery of the plan and the outcomes it will deliver.

By 2019/20 we expect to have in place a model of care and supporting enablers:

- Where residents have easy access to information and advice about services, including care and support services;

- That has a focus on improving health outcomes for residents with one or more health conditions or care needs, a personalisation of service provision and a collaborative approach between providers;

- Where there is systematic early identification of susceptibility to disease or exacerbation in the population, alongside integrated management of conditions and a consistent approach to care provision;

- Where better coordination of services are configured around Hillingdon's residents, including a much stronger focus on case management and prevention and integration of health and social care;

- Where residents and carers are actively involved in the planning of their care and recognised as expert partners in care;

- Enablement of self-care and preventative services and promotion of independence for as long as possible

- Where people are only admitted to Hillingdon Hospital when they are acutely ill;

- Where a hospital admission is necessary and unavoidable their lengths of stay are reduced;

- That enables people to be treated at or close to their home wherever possible;

- A reduction in the number of people living in residential care;

- The most effective use of health and care resources is made to achieve best value for the Hillingdon £ by allowing for a flexible use of collective resources and reduction in transaction costs; and

- Enablers such as IT interoperability, development of a sustainable workforce and a vibrant market offering residents/patients quality choices.

We will know that the plan has been successful if our older residents are able to say:

- 'I'm helped to take control of my own health and social care provision.'

- 'It doesn't matter what day of the week it is – as I get the support appropriate to my health and social care needs.'

- 'Social care and health services help me to be proactive. They anticipate my needs before I do and help me to prevent things getting so bad that I need a stay in hospital.'

- 'If I do need to go to hospital, they start to plan for my social and health care in the community from day one of my stay.'

- 'I only have to tell my story once and they pass my details on to others with an appropriate role in my care.'

- 'Systems are sustainable and what might once have been spent on hospital care for me is now spent to support me at home in my community.'

The Council, the CCG and other partners do expect that this will be an increasingly common experience as the benefits of closer integration and the roll out of an integrated model of care are experienced by more older people as we get closer to 2020, with the ability to measure residents' experience and the outcome of care across the whole health and care system. By 2019/20 we also expect to be able to roll out a new model of care to a wider population group.

5. NATIONAL CONDITIONS

a) National Condition 1: Jointly Agreed Plan

5.1 Confirmation of use of the Improved BCF Grant

It has been locally agreed that of the 3 conditions for applying the iBCF
- 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

The single biggest impact on maintaining the momentum of Hillingdon's strategies for addressing admission avoidance and timely discharge is having a stable care market. This is in order to ensure quality and capacity of care to address ongoing care needs when patients reach the end of their required interventions.

5.2 Disabled Facilities Grants - how this funding will support a strategic approach to health, care and housing.

The DFG funds will continue to be utilised to support older and disabled residents to remain in their own homes. During 2016/17 170 people were assisted with DFGs and of these 61% (113) were people aged 60 and over. 29% (32) of the older people receiving DFG's were owner occupiers, 66% (74) were social housing tenants, and 5% (5) were private tenants.

Schemes 1:*Early Intervention and Prevention* and 4: *Integrated Hospital Discharge* in section 6: *The Plan: Schemes and Spending* describe how during the lifetime of the plan it is intended to explore the scope for utilisation of the 2003 and 2008 Regulatory Reform Orders to enable DFGs to be used to fund adaptations to meet anticipatory needs, e.g. where a resident has a degenerative long-term condition, as well as establishing a Hospital Discharge Grant to fund house clearances, deep clean and a range of other home-based activities where difficulties in arranging help can lead to delay. Opportunities for using DFG funding to resource equipment for people requiring two or more care workers to transfer will also be explored.

5.3 Have councils with housing responsibility been involved in developing elements of the plan related to housing?

Hillingdon Council is a unitary authority and therefore incorporates housing responsibilities contained within the Housing Act, 1996 (homelessness and housing allocations) and the Housing Grants, Construction and Regeneration Act, 1996 (disabled facilities grants) within its sphere of responsibility. The relevant officers within the Council have been involved in the development of the plan. At elected member level, the chairman of Hillingdon's Health and Wellbeing Board is also the Cabinet Member for Social Care, Housing and Health and Wellbeing.

The development of the extra care sheltered housing programme is a result of the Council utilising its housing and planning responsibilities in an integrated way to deliver key outcomes within the plan. A supported living programme that has seen the delivery of three supported living schemes for people with learning disabilities over the last four years and will see another scheme being delivered in 2018 illustrates the strategic use by the Council of powers and resources available to it to meet the needs of Hillingdon's population. It should be noted that younger adults with learning disabilities are out of the scope of the 2017/19 BCF plan.

b) National Condition 2: Social Care Maintenance

5.4 Expected contributions from the CCG for 2017/18 and 2018/19.

The CCG will be passporting £6,146k for protecting adult social care, including £887k for Care Act implementation in 2017/18 and £6,263k in 2019/20, including a minimum of £887k for Care Act implementation.

5.5 Assurance that contributions to social care from the CCG does not destabilise the local health and care system as a whole.

Contributions from the CCG to social care is helping to stabilise the health and care system. This is achieved by preventing reductions in overall local authority funding resulting in social care spend being limited to meeting statutory requirements.

5.6 Confirmation that the contribution to be spent on social care services that have some health benefit and support overall aims of the plan.

The planning template shows that the main areas of expenditure of the CCG contribution to social care, including Care Act implementation, are:

- *Reablement and hospital assessments* - supports timely discharge and prevents admission
- *Physiotherapy support for Reablement* - supports the effectiveness of the Reablement Team.
- *Packages of care* - supports discharge and prevents increased demand on health services.
- *Supporting Carers* - enables Carers to continuing caring for longer thereby reducing demand on both health and social care.
- *Quality Assurance Team* - supports private providers, e.g. care homes, home care and supported living schemes, which helps to reduce demand on health services.
- *Adult Safeguarding* - ensures effective management of adult safeguarding in Hillingdon, including management of Deprivation of Liberty standards.
- *Wren Centre* - temporary dementia resource centre that will transfer to a purpose-built unit at the Grassy Meadow Court extra care sheltered housing scheme site in 2018.
- *Extra care social work post* - dedicated social work post to support new extra care schemes working closely with Care Connection Teams will help to manage avoidable demand on primary and secondary health care services.

c) ***National Condition 3*: NHS Commissioned Out of Hospital Services**

5.7 Allocation for out of hospital services.

For 2017/18 the BCF plan includes an investment by the CCG of £13,226k in out of hospital services that are included within the BCF. This includes:

- Early supported discharge (Community Homesafe)
- Rapid Response
- Community Rehabilitation
- District Nursing Service
- Community matrons
- Hawthorn Intermediate Care Service
- Franklin House Nursing Home step-down beds
- Community equipment (including pressure mattresses)
- Falls Services (Hillingdon Hospital, CNWL and Age UK)
- Prevention of Admission to Hospital (PATH) Service
- Integrated Care and Support Planning
- Care Connection Teams

The funding for these services is included within the capitated budget for the ACP. The level of investment will not be reduced in 2018/19, although there is an expectation that the ACP will use the opportunities presented by the capitated budget to remodel services to increase efficiency and effectiveness.

5.8 Additional target for non-elective admissions.

The non-elective admissions targets contained within the 2017/19 plan focus on the 65 and over population and will contribute to the overall CCG NEA target. Partners have agreed not to set an additional target over and above what is reflected in the CCG's Operating Plan.

5.9 Contingency funds.

See section 9: *Assessment of Risk and Risk Management*.

***d)* National Condition 4: Transfers of Care**

5.10 Implementation of High Impact Change Model for managing transfers of care.

Implementation Action Plan

Hillingdon's health and care partners are committed to the implementation of the High Impact Change Model (HICM). A detailed action plan (see **Annex 1**) for the delivery of the eight interventions has been developed that will assist in addressing Hillingdon's DTOC issues in acute settings. Nearly 70% of Hillingdon's acute delays are attributed to beds in The Hillingdon Hospitals Foundation Trust.

Many of the actions required to deliver the model are also reflected within BCF scheme 4: *Integrated Hospital Discharge*, unless otherwise stated below. This also includes funding for the relevant services.

- *Change 1: Early discharge planning* - Implementing the SAFER patient flow bundle and 'Red to green' to deliver a consistent approach to discharge planning across Hillingdon Hospitals.

'Red to Green Days' Explained

'Red and Green Bed Days' are a visual management system to assist in the identification of wasted time in a patient's journey.

A ***Red*** day is when a patient receives little or no value adding acute care. The following questions should be considered:

- Could the care or interventions the patient is receiving today be delivered in a non-acute setting?
- If I saw this patient in out-patients, would their current 'physiological status' require emergency admission?

A ***Green*** day is when a patient receives value adding acute care that progresses their progress towards discharge. It's when everything planned gets done.

- *Change 2: Systems to Monitor Patient Flow* - Developing a system-wide demand and capacity dashboard. Modelling system-wide care home requirements. See also BCF scheme 5: *Improving care market management and development*.

- *Change 3. Multi-disciplinary/Multi-agency Discharge teams* - Through the implementation of SAFER to ensure that MDMs are undertaken in a consistent way across all wards at Hillingdon Hospitals and reviewing the role and function of the Integrated Discharge Team within the context of the Home to Assess. See change 4 below.

SAFER Patient Flow Bundle Explained

S – **Senior** Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A – **All** patients will have an Expected Discharge Date and Clinical Criteria for Discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.

F – **Flow of patients** will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.

E – **Early discharge.** 33% of patients will be discharged from base inpatient wards before midday.

R – **Review**. A systematic MDT review of patients with extended lengths of stay (> 7 days – 'stranded patients') with a clear 'home first' mind set.

- *Change 4: Home first/Discharge to assess (D2A)* - Agreeing a D2A model, undertaking a pilot, reviewing the outcomes from the pilot, agreeing the model and implementing it.

- *Change 5: Seven day services* - Services and systems not currently in place to support seven day discharge. Reablement Team contracts to support seven day working in place but Hospital infrastructure not yet in place. This is being addressed through SAFER and implementation of Red to Green. Targets for discharges at weekends and before midday have been set by the Hospital but there has been limited progress so far in 2017/18.

- *Change 6: Trusted assessors* - Reviewing local trusted assessor arrangements in context of D2A model and new guidance.

- *Change 7: Focus on choice* - Producing a new in-patient information booklet. Finalising an agreed D2A model to inform the final version of the discharge policy based on patient choice and adapting a template provided by NHSE. Developing information, advice and advocacy arrangements to enable patients and/or their Carers and/or families to make informed choices.

- *Change 8: Enhancing health in care homes* - Developing business cases to extend the weekend GP care home advice and visiting service and care home pharmacy provision. Establishing a GP with specialist interest pilot to support care homes during the week and developing a 'red bag' scheme pilot. This impact area links into BCF scheme 5: *Improving care market management and development*.

Current Implementation Status

Hillingdon is in the process of implementing all of the eight high impact interventions and implementation is at varying stages. This section should be cross-referenced with section 6.4: *Key milestones associated with the delivery of the 2017/19 plan*. For example, a new patient information booklet about the hospital discharge process as well as a range of letters deriving from the NHSE *Supporting Patient Choice* template are now in operation, which should support a reduction in the number of DTOCs attributed to the patient/family choice reason. 'Red to Green' has been applied in ten wards at The Hillingdon Hospitals and plans are in progress to roll it out to all wards. A Discharge to Assess pilot has been completed and learning from this is being utilised to inform the next stage in its development (see section 6.4).

Trusted assessor arrangements are in place between health partners and between Rapid Response and Reablement. Long standing trusted assessor arrangements are in place between health and social care partners in respect of community equipment. Further extension of trusted assessor arrangements is under development.

Funding

The majority of the funding for implementation of the HICM, which includes services set out in section 5.7 above: *Allocation for out of hospital services*, is mainly split between schemes 4: *Integrated hospital discharge* and 5: *Improving care market management and development*. This includes funding for pathways 1 and 2 of Hillingdon's D2A model. There is a risk that that additional demand of people with greater acuity is placed on the care market that is not funded through the release of funding from closure of escalation beds and that there is insufficient capacity within the market to meet the demand. This is captured within the risk log. See section 9: *Assessment of risk and risk management*.

5.11 Action plan to reduce DTOCs.

Hillingdon's DTOC action plan is appended as **Annex 1** and **Annex 1A**. The focus of **Annex 1** is acute DTOCs at the The Hillingdon Hospitals, which accounts for nearly 70% of Hillingdon's acute DTOCs in 2016/17 and Q1 2017/18. **Annex 1A** utilises an NHSI template to specifically address mental health DTOCs attributed to beds provided by CNWL, which accounted for nearly 90% of Hillingdon's non-acute DTOCs in 2016/17 and nearly 70% in Q1 207/18.

The actions contained within the DTOC action plan are intended to contribute to reducing the numbers of DTOCs in both acute and non-acute settings as well as facilitating the flow of medically optimised patients into the community. For acute care, this is achieved through the implementation of the High Impact Change Model and the Emergency Care Improvement Programme (ECIP) plan agreed at the A & E Delivery Board.

5.12 Relationship between DTOC reduction target and A & E Delivery Plan.

The agreed DTOC reduction targets for 2017/18 and provisional targets for 2018/19 set out in section 10: *National Metrics* reflect the specific targets set by NHSE/I for The Hillingdon Hospitals and the Central and North West London Foundation Trust for 2017/18.

The DTOC action plan that is intended to deliver the DTOC reduction targets is reflected in Hillingdon's whole system Urgent and Emergency Care Work Plan and the direct correlation is identified in the tasks set out in **Annex 1** and **Annex 1A**. Strategic accountability for the delivery of the over-arching plan sits with the A & E Delivery Board, which meets on a monthly basis and is chaired by the chief executive of The Hillingdon Hospitals.

Operational delivery of the Urgent and Emergency Care Work Plan, including the DTOC action plan, sits with five workstream groups of which discharge is one. Each workstream group has an executive sponsor and for the Discharge Workstream Group this is the Director of Adult, Children and Young People's Social Care. This group is chaired by CNWL's Deputy Chief Operating Officer. Delivery blockages that this group is unable to address are escalated directly to the A & E Delivery Board and via that route to HCCG's Governing Body, the HWB and/or the Council's Cabinet where a decision about use of resources is required.

5.13 How progress will be continued with the following former national conditions:

a) **Seven day services to support discharge**
b) **Data sharing**
c) **Joint assessment and accountable lead professional for high risk populations.**

a) <u>Seven day community services to support discharge</u>

Actions to support the development of seven day community services to facilitate discharge from hospital seven days a week are reflected in the DTOC action plan referred to section 5.10 above.

The Hillingdon Hospitals has set targets for increasing the percentage of patients discharged at weekends from its medical wards of 65% in 2017/18 from a baseline of 15.5% in 2016/17 and also 65% from its surgery wards from a baseline of 19% in 2016/17. The Hospital's Urgent and Emergency Care Work Plan includes actions to deliver the four priority seven day standards that will also support the delivery of the out of hospital standard.

b) Data sharing

As at 30th June 2017 just over 94% of all adult social care records had a confirmed NHS number and a robust system is in place with NHS Digital to enable verification to be undertaken. Whilst the NHS number is not used routinely on Adult Social Care correspondence the system functionality to be able to do this is now in place and its application will be explored during 2017/18.

The Council is committed to adopting systems that have APIs and Open Standards. The Council has now signed the North West London Information Sharing Agreement that provides information governance authorisation for participation in the Care Information Exchange (CIE). If successful this will see direct links being established between the Council's case management database, Protocol, and that of the CIE provider. The intention is that Adult Social Care care plans will initially be uploaded which will enable GPs and other healthcare partners to see these plans for the first time.

Work is also in progress to enable electronic transfer of assessment and discharge notices between Hillingdon Hospital and the Council that will improve efficiency as well as contribute towards reducing the demand on paper.

During the period of the 2017/19 plan Hillingdon's health and social care partners will be contributing anonymised data to the North West London data warehouse to assist in mapping spend across health and social care within the borough by condition. This information will help to inform future commissioning decisions.

c) Joint assessment and accountable lead professional for high risk populations.

There is agreement across health and social care that GPs will be the accountable professional for high risk populations. 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 and with the Continuing Healthcare Team.
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 and the Continuing Healthcare Team.

The CCTs currently in place are linked to Adult Social Care to ensure appropriate local authority involvement to address eligible social care needs. Further alignment of adult social care staff with the CCTs will be explored further during 2017/18 and allocation of specific Adult Social Care resources to CCTs supporting extra care schemes and high densities of care homes implemented in 2018/19.

There will be further development and definition of the Frailty Pathway across care settings, with the implementation of the Rockwood Frailty score and additional care of the elderly consultant capacity in the community, with recruitment to an existing vacant post underway. Successful recruitment to this post, hopefully by October 2017, will provide additional specialist community based resource to support GPs and community staff.

6. THE PLAN: SCHEMES AND SPENDING

6.1 Schemes, outcomes and spending

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 susceptible 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

working alongside GPs, will support more proactive interventions to prevent or delay what 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: the 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 enhancements to the 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, ensuring integration with existing services 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 the uptake of the health checks programme for people most at risk of stroke 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			
		LBH £000's	HCCG £000's	Total £000's	LBH £000's	HCCG £000's	Total £000's	Total 2017/19 £000's
a) Connect to Support	Shop-4-Support	45	-	45	46	-	46	91
b) Online Service Co-ordinator	LBH	49	-	49	50	-	50	99
c) Wellbeing Service	H4All	543	334	877	543	334	877	1,754
d) Information	Age Uk	150	-	150	150	-	150	300

Advice Welfare and Benefits Service								
e)Social Wellbeing Service	Age Uk	100	-	100	100	-	100	200
f) Practical Support Service	Age Uk	76	-	76	76	-	76	152
g) Falls Prevention Service	Age Uk	-	143	143	-	143	143	285
h) Older People Wellbeing Initiatives	LBH	20	-	20	20	-	20	40
i) Telecare	LBH	262	-	262	267	-	267	529
j) Disabled Facilities Grant	LBH	3,815	-	3,815	4,174	-	4,174	7,989
k) Integrated Care Programme	CCG	-	1,062	1,062	-	1,062	1,062	2,124
l) Care Connection Team	CCG	-	759	759	-	759	759	1,518
j) Primary Care		-	56	56	-	56	56	112
	Total	**5,060**	**2,353**	**7,413**	**5,426**	**2,353**	**7,779**	**15,193**

Scheme 2: An integrated approach to supporting Carers.

a) Strategic Objectives

The strategic objective of this scheme is to maximise the amount of time that Carers are willing and able to undertake a caring role. This will be contributed to by Carers 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 Familes 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, social media, 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 the individual's 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' self-assessment 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' Carers' Register.
- Number of Carers in receipt of a Direct Payment or an individual with Personal Health Budget to contribute to the local trajectory by 2021 (303 to 607).

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*	661	0	*661*	*1,310*
b) Services to Carers (inc respite)	Various P & V	213	0	*213*	217	0	*217*	*430*
c) Carer Support Worker		0	18	*18*	0	18	*18*	*36*
TOTAL		**862**	**18**	***880***	**878**	**18**	***896***	***1,776***

Scheme 3: Better care at end of life

a) Strategic Objectives

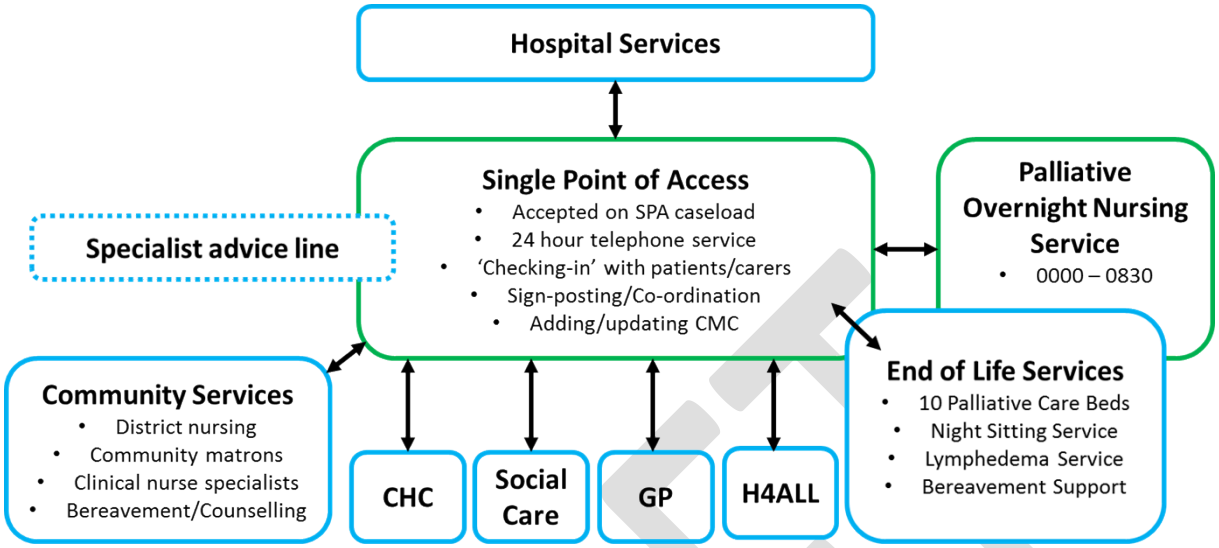
This scheme seeks to realign and better integrate the services provided to support people towards the end of their life in order to deliver the ethos of a 'good death.' The main goals of the scheme are to:

- 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) <u>Scheme Overview</u>

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 six months to live and 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	884	*934*	51	884	*935*	*1,869*
b) Community Palliative Team.	CNWL	0	108	*108*	0	108	*108*	*216*
TOTAL		**50**	**992**	***1,042***	**51**	**992**	***1,043***	***2,085***

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 three pathways:

- *Pathway 0 (Simple Discharges)* - This is for people whose needs can safely be met at home and need no additional assessment. The patient is functionally fit or at functional baseline when they are declared medically optimised. The patient can go directly home either without care or with a care package restart. The patients for this pathway are identified and their discharges managed by ward staff. It is envisaged that the majority of patients will be discharged on this pathway.

- *Pathway 1 (Home to Assess)* - This is for people who are not at their functional baseline when they are declared medically optimised. Following a risk assessment, their needs can be safely met at home (including a residential or nursing care home), where an assessment will be undertaken. Any care, equipment or rehabilitation will be provided at home, including a Continuing Healthcare assessment where appropriate. The discharge will be managed by the Discharge Coordinators or the Integrated Discharge Team (IDT) when required. 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 to determine ongoing care needs would then take place in the person's usual place of residence.

- *Pathway 2 (Cannot return home)* - This is for people who are unable to return home as they require a period of further rehabilitation, their care needs are not able to be safely met in their usual place of residence or their home needs preparation or adaptation. It is intended that people will be identified by ward staff and the discharge managed by the Discharge Coordinators or the IDT. The onward route from hospital will either be to the 22 bed Hawthorne Intermediate Care Unit (HICU) for people who require rehabilitation, the 5 step-down beds in a private nursing home commissioned by the CCG for people who require a bed based service on discharge and will be non-weight-bearing for more than 3 weeks or require a full continuing healthcare (CHC) assessment. 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.

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 Urgent and Emergency Care Work Plan and 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.
- 88% 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 (delayed days), including:
  - % reduction in delays attributed to the NHS
  - % reduction in delays attributed to Adult Social Care

The following measure will also be used:
- 85% of new clients who received reablement where no further request was made for ongoing long term support;
- Less than 15% of Continuing Healthcare assessments completed in a hospital.

d) Scheme Investment Requirements

Service	Provider	Funder 2017/18			Funder 2018/19			
		LBH £000's	HCCG £000's	Total £000's	LBH £000's	HCCG £000's	Total £000's	Total 2017/19 £000's
a) Rapid Response	CNWL	-	1,669	1,669	-	1,669	1,669	3,338
b) Hawthorn Intermediate care Unit	CNWL	-	1,603	1,603	-	1,603	1,603	3,206
c) Community Rehab	CNWL	-	1,198	1,198	-	1,198	1,198	2,396
d) Prevention of Admissions and Readmission (pATh)	Age UK	29	74	103	29	74	103	206
e) Take Home and Settle	Age UK	-	63	63	-	63	63	126
f) Reablement and Hospital Assessments	LBH	2,638	-	2,638	2,689	-	2,689	5,327
g) Reablement Physio	CNWL	51	-	51	51	-	51	102

h) Community Equipment	Medequip	756	715	1,471	761	715	1,476	2,947
i) Community Homesafe	CNWL	0	688	688	0	688	688	1,376
j) Packages of care	Various P&V	1,044	0	1,044	1,064	0	1,064	2,108
k) Step Down beds (Franklin House)	Care UK	0	198	198	0	198	198	396
l) Pressure Mattresses	CCG	0	206	206	0	206	206	412
m) Continence Service	CNWL	0	582	582	0	582	582	1,164
n) Community Matrons	CNWL	0	599	599	0	599	599	1,198
o) District Nursing	CNWL	0	3,346	3,346	0	3,346	3,346	6,692
p)Twilight Service	CNWL	0	124	124	0	124	124	248
q) Tissue Viability	CNWL	0	288	288	0	288	288	576
r) Support to step down Beds	CNWL	0	53	53	0	53	53	106
s) Cottesmore Reablement Flat	Paradigm Housing group	49	0	49	50	0	50	99
t) Mental Health Nurse in rapid response	CNWL	40	0	40	0	0	-0	40
	Total	**4,607**	**11,406**	**16,013**	**4,643**	**11,406**	**16,049**	**32,062**

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:

- Pilot of an 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 to tendering 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.

- Trial of co-locating both Council and CCG brokerage teams from September 2017.

- 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 in order to achieve the defined trajectory by 2021.

- Reviewing the impact of the brokerage pilot and consequent closer alignment of teams to inform a decision about any structural integration in 2018/19.

Integrated homecare for adults, children 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 piloted integrated brokerage team through an electronic process.

- The integrated homecare model will include specialist palliative provision for people whose final preferred place of care is at home. The investment element for this provision is reflected in scheme 3: *Better care at end of life*, although delivery will be through work undertaken as part of this scheme 5.

- 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, including the possibility of the Council being included within the NHS Any Qualified Provider (AQP) contract.

- Expanding the existing weekend GP advice and visiting service across the Borough and establish a Monday to Friday GP with specialist interest pilot to provide an emergency response, e.g. advice and/or visits as appropriate, for a defined number of care homes from October 2017 to March 2018.

- Based on the outcomes of the pilot, commission 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 a range of training opportunities for care home staff supported through the ACP and Council, e.g. falls prevention, deprivation of liberty and mental capacity assessments, prevention of pressure ulcers, continence care, palliative care and respiratory conditions.

- Developing a business case for additional community dietician to specifically work with care homes.

- 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.

- Developing a '*Red Bag'* scheme pilot scheme with local care homes. The '*Red Bag*' keeps important information about a care home resident's health in one place, easily accessible to ambulance and hospital staff. contains standardised information about the resident's general health, any existing medical conditions they have, medication they are taking, as well as highlighting the current health concern. This means that ambulance and hospital staff can determine the treatment a resident needs more effectively.

- Developing a care home dashboard to be shared with care home managers that shows the number of hospital attendances and admissions from care homes and also London Ambulance call outs to care homes and conveyances to hospital.

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.

The following targets will be set for people in receipt of a combination of PHBs, integrated health and social care budgets, e.g. a combination of PHBs and Direct Payments, and people with a managed Personal Health Budget, which is where the actual sum of money allocated is identified but it is managed on behalf of the individual by the CCG:

PHB Target by Quarter 2017/19 (Cumulative)				
	Q1	**Q2**	**Q3**	**Q4**
2017/18	38	58	83	113
2018/19	148	183	223	263

d) **Scheme Investment Requirements**

Service	Provider	Funder 2017/18			Funder 2018/19			Total 2017/19 £000's
		LBH £000's	HCCG £000's	Total £000's	LBH £000's	HCCG £000's	Total £000's	
a) Quality Assurance team	LBH	168	-	168	171	-	171	339
b) Adult Safeguarding	LBH	260	-	260	265	-	265	525
c) Brokerage Team	LBH	315	62	377	315	62	377	754
d) Home Care	Various P&V	7,952	251	8,203	7,952	251	8,203	16,406
e) Care Home Prescriber	HCCG	0	32	32	0	32	32	64
f) Older peoples care Home	Various P&V	0	1,968	1,968	7,149	1,968	9,117	11,085
g) EMI over 65 Residential	Various P&V	0	0	-	0	2,913	2,913	2,913
h) EMI over 65 Domicillary	Various P&V	0	0	-	0	199	199	199
i) Physical Disability (Under65)	Various P&V	0	0	-	0	2,370	2,370	2,370
j) Pallative Care - Residential	Various P&V	0	0	-	0	509	509	509
k) Pallative Care - Domicilliary	Various P&V	0	0	-	0	596	596	596
l)Funded Nursing Care	Various P&V	0	0	-	0	3,025	3,025	3,025
m) Extra Care Social Work Post		0	0	-	41	0	41	41
n) Medication Admin		0	24	24	0	24	24	48
o) Community Matron		0	52	52	0	52	52	103
	Total	**8,695**	**2,389**	**11,084**	**15,893**	**12,001**	**27,893**	**38,977**

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	306	0	306	606
TOTAL		**300**	**0**	**300**	**306**	**0**	**306**	**606**

6.2 How the 2017/19 plan builds on key successes and challenges from 2016/17.

The 2016/17 plan has provided a foundation on which the Council and the CCG are able to work more collaboratively to better manage the care market, thereby supporting primary and secondary care. Work in 2016/17 has also created an environment in which the Council is actively exploring the possible advantages of it joining the ACP.

6.3 Changes from 2016/17 and rationale.

The key changes from the 2016/17 plan:

- *Developing the Accountable Care Partnership (ACP)* and the Council giving full consideration to its involvement - The ACP currently comprises of 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 contribute to the development of a business case that will enable the Council to fully evaluate the merits and benefits of formally joining the ACP.

- *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, , Reablement, the Night Carer 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. 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 trial alignment of joint brokerage arrangements for homecare, short and long-term nursing home placements using existing contractual arrangements and Direct Payments and Personal Health Budgets. Also included is the development of integrated homecare via a dynamic purchasing system (DPS) that will meet the homecare needs of adults and children referred by either the Council or the CCG. 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.

6.4 Key milestones associated with the delivery of the 2017/19 plan

This section sets out some of the key milestones for the delivery of the 2017/19 plan.

1. Key milestones 2017/18

Quarter 1

- D2A pilot undertaken.

Quarter 2

- Submission of 2017/19 BCF plan following approval by HWB and CCG Governing Body.
- Tender for integrated homecare DPS model.
- Integrated brokerage pilot operational.
- Agreement on D2A model.

- Launch of new discharge letters for patients at The Hillingdon Hospitals.
- Submission of pilot GP with specialist interest support for care homes and 'red bag' pilot business case.
- Introduction of formal monthly liaison meetings between Mental Health and Housing.
- Implementation of new mental health discharge planning tool.
- Agreement on advice, support and advocacy functions within discharge pathways.

Quarter 3

- Approval of 2017/19 BCF plan by NHSE.
- Section 75 agreement approved by Council's Cabinet and CCG Governing Body.
- Launch of new discharge policy to support choice at The Hillingdon Hospitals.
- Integrated homecare model operational.
- Implementation of agreed D2A model.
- Business case on use of DFG flexibilities under Regulatory Reform Order to support anticipatory care needs and early hospital discharge submitted.
- *'Red to Green*' extended to all wards at The Hillingdon Hospitals.
- Start of GP support for care homes pilot.
- Q2 STP delivery update report to HWB and CCG GB.

Quarter 4

- DTOC escalation protocol established between North West London CCGs and Health and Wellbeing Boards.
- Memorandum of understanding supporting an integrated approach to the identification and assessment of Carers' health and wellbeing needs signed by partners.
- Launch of End of Life Single Point of Access.
- Agreement on an integrated commissioning model for nursing care home placements.
- Single point of access in place for out of hospital services operational.
- Development of business case to determine the case for the Council joining the ACP.
- Evaluation of GP in care homes pilot and agreement of model of care and service specification Launch of care home market position statement.
- Launch of 'Red Bag' scheme in all care homes in Hillingdon
- Q3 STP delivery update report to HWB and CCG GB.
- Review outcome of Brokerage pilot.

2. Key milestones 2018/19

Quarter 1

- Grassy Meadow Court extra care scheme opens.
- Q4 STP delivery update report to HWB and CCG GB.

Quarter 2

- Park View Court extra care scheme opens.
- Implementation of GP with specialist interest service to support care homes and extra care housing schemes based on outcomes of pilot.
- Q1 STP delivery update report to HWB and CCG GB.

Quarter 3

- Q2 STP delivery update report to HWB and CCG GB.

Quarter 4

- Single, integrated intermediate care service operational.
- Q3 STP delivery update report to HWB and CCG GB.

6.5 Assessment of impact on patients.

Partners will continue to use the Adult Social Care Survey quality of life measure the percentage of patients scoring 14 or above (out of 24) for self-reported quality of life question. This survey is undertaken in quarter 4 of each financial year. The provisional baseline for 2017/18 is 58%.

The biennial national Carers' Survey will be used to test the quality of life of Carers. The measure will be the percentage of Carers scoring 7 or above (out of 12) for self-reported quality of life. The next survey will be undertaken in 2018/19 and the provisional baseline is 64.6%.

An outcomes framework and scorecard has been developed for the ACP that will test resident experience of integration. The scheme descriptions set out in section 6: *The Plan: Schemes and Spending*, identifies the measures that the BCF plan will make a contribution towards.

6.6 Evidence that plans are deliverable.

Delivery of the 2017/19 plan will be challenging but implementation timescales have been set reflecting priorities and available capacity. The deliverability of the plan has been subject to scrutiny through the governance process set out in section 8: *Programme Governance*.

7. OVERVIEW OF FUNDING CONTRIBUTIONS

7.1 Care Act, 2014 - how funding for implementation is being used.

The Care Act implementation element of the Protecting Social Care funding passported to the Council from the CCG, which is £887k in 2017/18 is being used to fund:

- the online resident portal called Connect to Support;
- capacity to Carers undertake assessments and reviews, including within the Carers in Hillingdon contract; and
- services to Carers, e.g. respite and replacement care services.

7.2 Funding dedicated to Carer-specific support

Hillingdon's plan includes a specific scheme dedicated to supporting Carers. In 2017/18 the total resource dedicated to supporting Carers by the Council is £862k and the amount in 2018/19 will be subject to the allocation of the CCG uplift of £178k. Aligned to this funding is an additional £18k in 2017/19 invested by the CCG for support provided by the third sector Hillingdon Carers' Partnership, which is led by Hillingdon Carers. Carers of

people in receipt of Continuing Healthcare funding will receive funding to provide respite in order to support them in their caring role where required.

7.3 Reablement

The Protecting Adult Social Care funding from the CCG includes £2,302k in 2017/18 for reablement and hospital assessments. The allocation for 2018/19 is subject to the outcome of discussions about the D2A model and its delivery.

7.4 Social care

The CCG has agreed to passport £6,085k to the Council to protect adult social care in 2017/18 and £6,263k in 2018/19. This includes the element for reablement and hospital assessments referred to in section 7.3 above.

7.5 Improved Better Care Fund Grant - How this funding will be used.

The IBCF grant is being used to stabilise the care home, homecare and supported living markets. There are three components to the work that the IBCF will support and these are:

- *Market Stabilisation* - Review of prices for existing providers for which a provision of £4.9m has been set aside. The aim is to agree sustainable prices for providers to enable care workers to receive an increased rate of pay.

- *Dynamic Purchasing System (DPS) for Homecare* - Tendering of Homecare spot provision via a Dynamic Purchasing System in a joint approach with Hillingdon CCG and across Adults and Children's Social Care.

- *Care Home Placements* - Reviewing placement purchasing model and working with providers to block purchase a number of beds thereby securing placements when clients move on from the placements.

The IBCF is intended to contribute to a reduction in delayed transfers of care :

- *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.

- *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.

8. PROGRAMME GOVERNANCE

8.1 Description of Governance Arrangements

The governance arrangements for the 2016/17 plan have evolved to reflect the approach taken by Hillingdon partners that the BCF is a delivery tool for those aspects of the STP that require integration between health and social care or closer working between health and other Council services. This means that there is a single governance structure for the BCF and the STP. This is summarised in Chart 6 on page 56.

The legal agreement between the Council and the CCG established under Section 75 (s.75) of the National Health Service Act, 2006, for the 2016/17 plan will be updated to reflect new financial arrangements and the modified governance arrangements. The terms of the updated agreement will be agreed during October 2017 before formal agreement by the Council's Cabinet and CCG's Governing Body in November 2017.

8.2 Description of how the programme will be delivered.

Each of the six schemes are led by an identified lead who is a senior manager within one of the partner organisations. They are supported by multi-agency task and finish groups created either to deliver service transformation or to deliver the specific requirements of the schemes set out in the plan.

The delivery of STP programmes, including BCF schemes, is overseen by the **Transformation Group**. This group undertakes a programme management office function and therefore monitors the delivery of key milestones within project plans for STP programmes. It is chaired by the chair of the CCG's Governing Body and its membership comprises of key officers across the CCG and Council and representatives from the GP confederation. It also has representation from Healthwatch Hillingdon.

The Tranformation Group is accountable to the **Transformation Board** which has executive level representation from health and care partners across Hillingdon, including elected member representation from the Council in the person of the chairman of the Health and Wellbeing Board. The Board is chaired by the chair of the CCG's Governing Body and meets six weekly . It has responsibility for the delivery of key transformation programmes and alignment of approaches to ensure delivery of the CCG's QIPP and Council's mid-term financial forecast (MTFF) efficiencies:

- Joint Health and Wellbeing Strategy /Sustainability and Transformation Plan
- Shaping a Healthier Future
- Whole System Integrated Care (including the early adopter project)
- Better Care Fund
- Primary Care Transformation
- System-wide Urgent and Emergency Care Transformation
- 7 day working

Partner representatives on the Transformation Board are accountable to the Boards of their respective organisations. The Board reports into the **Hillingdon Health and Wellbeing Board** (HHWBB). The HHWBB provides leadership in developing a strategic approach for health and wellbeing in Hillingdon and is responsible for holding partner agencies to account for performance on agreed priorities. It is also responsible for collaborative working to develop social care and health related commissioning plans to improve the health and wellbeing of residents of the Borough and monitor implementation and performance. The Board therefore takes strategic oversight for health and care systems in the Borough and has been involved from the outset in the planning for 2017/19 BCF plan. It is responsible for final sign off of plans and reports on behalf of partners and is the overarching leadership and governing body but does not, however, have authority to take investment decisions on behalf of its members. Individual partners, therefore, need to be satisfied with the proposals going to the Board and, as necessary, to agree them in advance. This applies to the **HCCG Governing Body** and to **Hillingdon Council's Cabinet**.

Healthwatch Hillingdon, as the local "consumer champion" and full member of the Board needs to be satisfied that plans reflect its understanding of what residents and patients say they need.

A **Core Officer Group** comprising of senior officers from the CCG, Adult Social Care, LBH and CCG Finance and the LBH Corporate Policy team was established as part of the governance arrangements for the 2015/16 plan to have operational responsibility for the management of the s.75 pooled budget and it is intended that this group will continue for the duration of the 2017/19 plan. This group meets monthly and is jointly chaired by the Director of Adult Social Care and the CCG's Chief Operating Officer. It provides oversight of the programme and also considers opportunities for integrated working and/or joint commissioning for recommendation to the Transformation Board and the Health and Wellbeing Board. Any decisions about the use of resources that are required are referred to the Council's Cabinet and CCG Governing Body in accordance with constitutional arrangements and agreed delegations.

8.3 Description of how the plan will contribute to reducing health inequalities as per section 4 of the 2012 Health and Social Care Act and reduce inequalities for people with protected characteristics under the 2010 Equality Act.

Health Inequalities

A health impact assessment has been completed that will support the decision by HCCG's Governing Body and the HWB to approve the draft plan.

The BCF Plan seeks to address health inequalities faced by Hillingdon's more vulnerable older population. However, given the disparity in social and economic wellbeing between older people in the north of the borough and those in the relatively more deprived, more culturally diverse wards in the south, particular consideration will have to be given as to how different communities will be engaged. The development of the CCTs with use of risk assessment tools, as referred to in scheme 1: *Early intervention and prevention,* will assist in the identification of residents in need, as will their links with the H4All Wellbeing Service. The Wellbeing Service will be proactively establishing relationships with local faith and other community-based groups to both identify residents in need and to enable them to access existing community-based support arrangements.

The provision of Personal Health Budgets for people meeting Continuing Health Care (CHC) thresholds and Personal Budgets for people meeting the National Adult Social Care eligibility criteria provides opportunities for a more personalised approach to addressing need that would reflect cultural and religious diversity. Promotion of Personal Health Budgets as well as integrated budgets, e.g. a combination of PHBs and Direct Payments, is addressed in *scheme 5: Improving care market management and development* of the plan.

Equality Act Protected Characteristics

An equality impact assessment has been completed that will support the decision by HCCG's Governing Body and the HWB to approve the draft plan. No inequalities were identified as a result of the assessment. The impact of the six schemes was neutral on three of the protected characteristics and these were gender identify, pregnancy and maternity and marriage and civil partnership. The assessment showed that the impact of the schemes was positive for all other characteristics. It should be noted that Hillingdon

includes Carers as a protected characteristic and therefore considers their needs in any impact assessment.

The assessment showed that particular attention will need to be given to how schemes develop to address the greater diversity in the south of the borough. During the lifetime of the plan there are also areas for development that may require specific assessments to support decisions made by either HCCG's Governing Body and/or the Council's Cabinet.

It is recognised that during the 2017/19 period the plan will develop in response to changing circumstances (including new opportunities) and the need for further health and equality impact assessments will be kept under review in light of these.

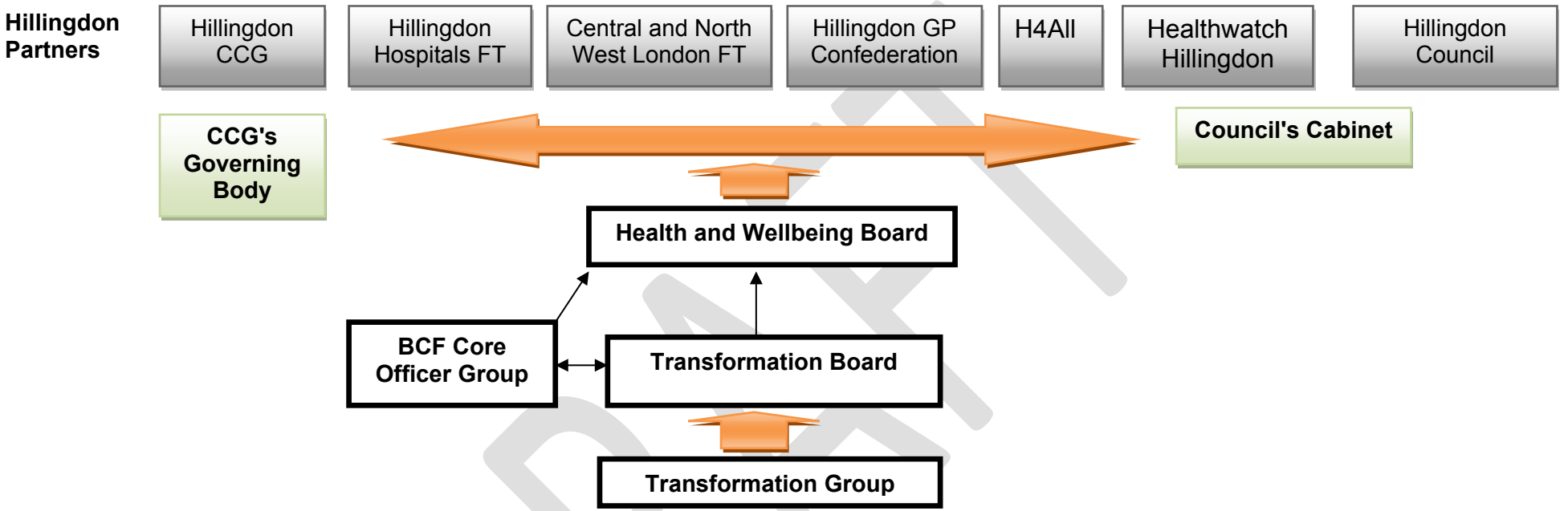
8.4 Description of how learning and insight will be utilised and timely corrective and preventative action taken when needed.

Good practice from vanguard sites as well as other health and care providers across the country and local intelligence about what works and what does not will be fed through the governance structure described above. There are a variety of sources for this intelligence, including the Better Care Exchange and the London Better Care Leads Network.

The BCF schemes are supported by a programme manager who will liaise with scheme leads. The practice during 2016/17 has been to work with key operational leads across partner organisations, e.g. through the ACP Clinical Design and Delivery Group (see chart 6: *Summary of Governance Arrangements*) about proposed changes to the model of care or other operational changes to reflect local learning or good practice elsewhere. This will be replicated in 2017/19.

The governance structure for the STP and BCF described above builds in enough safeguards to ensure that issues can be identified early and appropriate corrective action taken. Quarterly performance reports to the HHWB and CCG's Governing Body also provide opportunities to identify progress blockers that require high level consideration by strategic leaders across the partnership.

Chart 6: Summary of Governance Arrangements



STP Delivery Areas	DA1 Prevention & Wellbeing				DA2 Long-term Conditions		DA3 Older People		DA4 Mental Health	DA5 Sustainable Acute Services		Enablers
Supporting Groups & Scheme Delivery Responsibility (BCF Scheme Number)	Prevention Group (1)	Primary Care	Children & Young People Mothers & Babies	Carers Strategy Group (2)	Long-Term Conditions	Cancer	Clinical Design & Delivery Group	End of Life Forum (3)	Mental Health & Learning Disabilities	Planned Care	A & E Delivery Board	• Digital. • Estates. • Workforce. • Provider market (5). • Medicines. • Statutory targets.
							Dementia Working Group (6)			Integrated Discharge Workstream Group (4)		

Key to Summary of Governance Arrangements	
	*Use of resources decision authority*
	*Line of accountability*
	*Reporting line*

9. ASSESSMENT OF RISK AND RISK MANAGEMENT

9.1 Assessment of main delivery risks and current market position.

The overarching risks for the 2017/19 plan are set out in table 8 below. The risk assessment methodology is described in **Appendix 1**.

Table 8: 2017/19 BCF Plan Risk Log					
Risk No	**Risk Description**	**Likelihood rated on a scale of A-F with A being very likely and F being very unlikely**	**Impact rated on a scale of 1-4 with 1 being a major impact and 4 being a small impact**	**Risk Score**	**Actions in Place**
A. Service Delivery Risks					
R001	Admissions and DTOC targets are not met as a result of schemes failing to deliver system wide solutions.	C	2	C2	Monthly reporting to A & E Delivery Group and quarterly reporting to HWB.
R002	Inability to shift resources from acute into a community setting as a result of acute flows.	D	3	D3	Plans have focused on alignment and integration of investment and service changes with subsequent reduction in demand on secondary care.
R003	Insufficient capacity within partner organisations to deliver scheme actions.	C	3	C3	Capacity to deliver key pieces of work is kept under review by partners through the A & E Delivery and Transformation Boards.
R004	There is insufficient capacity within the private care market to meet demand.	B	1	B1	Embedding strong commissioner-provider relationships and establishing single commissioner arrangements to improve market intelligence. Quarterly updates to HWB/CCG Governing Body on market

					performance issues.
R005	D2A will impact on the local homecare market leading to insufficient capacity to meet demand (links to R004 above).	B	1	B1	Embedding strong commissioner-provider relationships and establishing single commissioner arrangements to improve market intelligence. Developing metrics to enable monitoring of impact on market capacity which will be monitored through Discharge Workstream Group and quarterly updates to HWB/CCG Governing Body on market performance issues.
R006	Lack of engagement from frontline/clinical staff resulting in no changes in frontline service.	D	3	D3	An engagement plan for fontline staff will be developed to share agreed key messages and information during the lifetime of the plan.
R007	Achieving interoperability between health and social care systems cannot proceed for technical reasons or related to excessive supplier charges.	D	3	D3	Participation in IT initiatives as part of the implementation of the local digital strategy. Representations through the LGA to central government about supplier costs is on going.
R008	Confusion amongst staff and the public about services available to support residents and access points.	D	3	D3	fontline staff will be developed to share agreed key messages and information during the lifetime of the plan.
B. Financial Risks					
R009	There is insufficient capacity within community services (including mental health), which means that the Hospital is unable to decommission escalation beds.	C	3	C3	A hospital discharge dashboard will enable the Transformation Group to monitor on a monthly basis. Escalation route will be through A & E Delivery Board, HWB and CCG Governing Body as appropriate.
R010	Financial challenges faced by the constituent organisations within the ACP could conflict with the overall objectives of the ACP and inhibit its ability to deliver system changes.	D	3	D3	There is a joint protocol in place to manage this. Regular meetings between the ACP Board and CCG Governing Body will help to manage this.
R011	Increased costs arising related to issues faced by private providers in recruiting staff and/or statutory requirements.	C	2	C2	See R004.

9.2 Financial risks, including deficits or risks relating to provider or care market financial positions.

Financial risks, including those experienced as well as posed to the whole system by the care market are identified in the risk log in table 8 above. More detail is provided about the current state of the health and social care market in section 2.3.

9.3 Approach to mitigation of risks, including risk shares and contingency arrangements.

Risk Sharing

The CCG is currently in discussion with the ACP regarding risk share arrangements from 2018/19. For 2017/18 any risk share arrangements between the CCG and the Council will be linked to specific services, e.g. community equipment and homecare, and both organisations with otherwise manage their own risks. This reflects the practice in 2016/17.

Contingency Arrangements

As the partners have not agreed an NEA target over and above that in the CCG's Operating Plan no specific contingency arrangements have been put in place. Risk management arrangements are as described above.

10. NATIONAL METRICS

10.1 Non-elective admissions (General and Acute)

a) Explanation for how the target has been reached.

An all age non-elective (also known as emergency) admissions ceiling for Hillingdon has been set by NHSE at 24,494 admissions. Section 2 of this document (*Background and Context)* shows that nearly 42% (10,049) of non-elective admissions in 2016/17 were attributed to the 65 and over population and Hillingdon's BCF is seeking to reduce the number of admissions by 9% (975) in 2017/18.

b) Analysis of previous performance and assessment of impact of 2017/19 plan.

The activity in 2016/17 exceeded the ceiling for the year of 9,700 but was similar to the activity in 2015/16. In 2017/18 the contribution to delivering the 975 target is intended to be as follows:

- Intermediate care (see scheme 4: *Integrated hospital discharge*) - 49 (5%)
- Care of the Elderly Consultant - 78 (8%)
- Health and Wellbeing Gateway (see scheme 1: *Early intervention and prevention*) - 127 (13%)
- Care Connection Teams (see scheme 1: *Early intervention and prevention)* - 517 (53%)
- Homesafe (see scheme 4: *Integrated* - 205 (21%)

hospital discharge)

10.2 Permanent admissions to residential and nursing care homes.

a) Explanation for how the target has been reached.

The target of 150 permanent admissions in 2017/18 reflects the demographics of the borough and the lack of realistic alternatives to residential care pending the delivery of two extra care schemes comprising of 148 self-contained flats in 2018. The target of 145 permanent admissions for 2018/19 reflects the fact that Grassy Meadow Court extra care scheme will open in June 2018 and Park View Court scheme in September and that both schemes will take up to a year to achieve full occupancy due to the complexity of the needs of the population group. It is assumed that there will be no change in the number of permanent placements into residential dementia, nursing and nursing dementia care homes during 2018/19. Any reduction in the number of placements will be attributed to lower numbers of permanent placements into residential care homes and also a lower number of short-term residential care placements converting into permanent placements. This can happen where people admitted to care homes as a temporary measure may experience an escalation of need leading to their temporary placement being converted to permanent. Built into the target assumptions for 2018/19 is 1.5% demographic growth. This reflects the increase in the 65 and over population as illustrated in section 2.2 of this document: *Local demography, future demographic challenges and long-term health issues.*

b) Analysis of previous performance and assessment of impact of 2017/19 plan.

161 permanent placements were made during 2016/17 against a ceiling of 150. Nearly 56% (90) of placements were to nursing homes and 44% (71) into residential and of these 92% (65) were residential dementia. The key impact of the 2017/19 plan will be the opening of the two new extra care sheltered housing schemes in 2018/19 as well as improvements in the capacity and quality of provision of homecare.

10.3 Effectiveness of reablement

a) Explanation for how the target has been reached.

The review period is people being discharged from hospitals in Q3. The target referrals into the Reablement Service in 2017/18 is 70 a month and 71% (50) of these are expected to be from hospitals, primarily from Hillingdon Hospital. This would mean a total of 150 discharges from hospitals in Q3 being supported by Reablement. The target assumes that 88% (132) of patients will still be at home after the 91 day period. The key reasons during 2016/17 why people were not home were deaths, readmissions and new reablement plans arising from changes of circumstances, e.g. escalation of need. Of the people readmitted approximately 50% were related to the original cause of admission and the proposed target is predicated on joint working between partners being able to reduce the number of readmissions relating to the original cause of admission by at least 3 people. The number of deaths could only really be affected by restricting the levels of acuity of people accepted into the service, which would be contrary to the purpose of the service.

The provisional target for 2018/19 is dependent on the outcome of discussions about the D2A model, including the development of an integrated intermediate care service.

b) Analysis of previous performance and assessment of impact of 2017/19 plan.

The focus of the Reablement Service is to support people with reablement potential rather than accepting all new referrals from hospitals and the community. This ensures that the service is able to assist in maximising the independence of residents and reduce on going demands on the local health and care system. Recruitment issues during 2016/17 impacted on the number and complexity of referrals that the service was able to accept but this has been addressed for 2017/18. It is not intended to reduce the level of community referrals accepted into the service as this has a major benefit for Hillingdon Hospital in helping to avoid admissions.

The following additional measures will be used to assess the impact of Reablement during 2017/18:

- 85% of new people referred to the Reablement Service require no further long-term support.
- <30% of people supported by the Reablement Service from hospitals are readmitted during the 91 day period following hospital discharge.

10.4 Delayed transfers of care

a) Explanation for how the target has been reached.

The information contained in table 9 below summarises the 2017/18 target outturn position for Hillingdon in accordance with targets set by NHSE. The trajectory for 2017/18 and that for the provisional 2018/19 target is set out in tab 4: *HWB Metrics* of the planning template supporting this narrative document.

Table 9: 2017/19 DTOC Targets

Attributed Responsibility	Number of Delayed Days	
	2017/18	2018/19
NHS	6,005	6,095
Social Care	2,271	2,305
Both	1,062	1,078
TOTAL	**9,337**	**9,478**

Quarter 1 2017/18 activity would, on a straightline projection, suggest an outturn for the year of 9,736 delayed days, reducing the number of DTOCs by 399 delayed days (9,736 - 9,337) is achievable. Taking into consideration that in 2016/17 67% (Q1 2017/18 position was 69%) of acute delayed days were attributed to Hillingdon Hospital patients and 86% (Q1 2017/18 position was 67%) of non-acute delays to CNWL patients, addressing issues with and for these two trusts will have a significant impact on Hillingdon's position.

The range of key initiatives included within the Urgent and Emergency Care Plan and the DTOC action plan that will support the reduction of DTOCs at Hillingdon Hospital include:

- Stronger processes to ensure that delays being reported reflect the correct definition;
- Improved information available for patients and family members to help manage; expectations and address the main cause of delays for the Hospital;
- Implementation of the SAFER patient flow bundle;
- Implementation of discharge to assess.

- Support to care homes, including the action by Adult Social Care to increase capacity by converting spot placements into block arrangements.

The key initiatives that will contribute to the reduction in the number of DTOCs attributed to patients of CNWL with mental health needs include:

- Stronger processes to ensure that delays being reported reflect the correct definition;
- Implementation of a discharge planning tool;
- Reviewing the training and guidance provided to staff presenting cases to the joint funding panel for mental health patients that includes membership from Adult Social Care, the CCG and Mental Health; and
- Establishing regular meetings with the Council's Housing Team to address accommodation issues at an early stage.

The provisional target for 2018/19 uses the projected 2017/18 outturn as the baseline and applies a 1.5% increase to it to reflect demographic growth as identified in the JSNA.

94% of people registered with a Hillingdon GP are residents of the borough and nearly 90% of inpatient activity comes from people registered with a GP in the borough. To address issues with delays involving people either with GPs out of the area and/or who are resident in another part of the region, a joint protocol with clear escalation routes is in the process of development between CCGs and local authorities in North West London. The intention is to have this in place by December 2017.

b) Assessment of impact of 2017/19 plan.

Delivery against plan DTOC targets will be monitored via the Hospital Discharge Workstream Group, the A & E Delivery Board, the HWB and the CCG's Governing Body as described in section 5.12: *Relationship between DTOC reduction target and A & E Delivery Plan.*

Appendix 1

Risk Scoring Methodology

Attributes:

		LIKELIHOOD		Risk rating	Risk rating	Risk rating	Risk rating
Greater than 90%	This week		**Very High (A)**	**A4**	**A3**	**A2**	**A1**
70% to 90%	Next week / this month		**High (B)**	**B4**	**B3**	**B2**	**B1**
50% to 70%	This year		**Significant (C)**	**C4**	**C3**	**C2**	**C1**
30% to 50%	Next year		**Medium (D)**	**D4**	**D3**	**D2**	**D1**
10% to 30%	Next year to five years		**Low (E)**	**E4**	**E3**	**E2**	**E1**
Less than 10%	Next ten years		**Very Low (F)**	**F4**	**F3**	**F2**	**F1**

THREATS:

Attributes	**Small (4)**	**Medium (3)**	**Large (2)**	**Very Large (1)**
	IMPACT			
Financial	up to £250K	£250k - £1million	£1million - £5million	Over £5million
Service Provision	Slightly reduced	Service suspended short term/ reduced	Service suspended long term/ statutory duties not delivered	
Health & Safety	Sticking plaster/ first aider	Broken bones/ Illness	Loss of life/ major illness	Major loss of life/ large scale major illness
Objectives	Objectives of several teams not met	Group objectives not met	Corporate objectives not met	
Morale	Negative attitude	Some hostility/ minor non co-operation	Industrial action	Mass staff leaving/ unable to attract staff

Reputation	No media attention/ minor letters	Adverse local media	Adverse national publicity	Remembered for years
Government Relations		Poor assessment(s)	Service taken over temporarily	Service taken over permanently

OPPORTUNITIES:

Attributes:	**Minor (4)**	**Moderate (3)**	**Major (2)**	**Outstanding (1)**
Financial	Some financial gain	High financial gain	Major financial gain	Huge financial gain
Reputation	Minor improvements to image	Some enhancement to reputation	Enhanced reputation	Significantly enhanced reputation