SOCIAL SERVICES, HOUSING AND PUBLIC HEALTH POLICY OVERVIEW COMMITTEE - 2017/19 BETTER CARE FUND PLAN

REASON FOR ITEM

To make the Committee aware of the content of the 2017/19 Better Care Plan and the implications for residents.

OPTIONS OPEN TO THE COMMITTEE

a) To question officers about the content of the plan.

b) To make suggestions or recommendations to inform the development of the plan from 2018/19.

c) To instruct officers about frequency of further updates required by the Committee.

INFORMATION

Introduction

1. The Better Care Fund (BCF) is a Government initiative introduced in 2014/15 that is intended to improve efficiency and effectiveness in the provision of health and care through closer integration between health and social care. The first BCF plan was for 2015/16.

2. The *2017/19 Integration and Better Care Fund Policy Framework* published in March 2017, required Hillingdon to develop a Better Care Fund Plan (BCF) for the 2017/19 period. This is Hillingdon's third BCF plan and, as with the two previous iterations, the focus of the 2017/19 plan will continue to be the 65 and over population.

3. Hillingdon's 2017/19 BCF plan was formally submitted on the 27 September. The formal submission comprised of the following documents:

- Supporting narrative plan
- Delayed transfers of care (DTOC) action plan (General and Mental Health)
- NHSE planning template.

4. These documents are available on the Council's website by using the following link http://www.hillingdon.gov.uk/28647. The updated Equality Impact and Health Impact Assessments can also be accessed by following this link.

Progress to Date

5. The eight schemes in the 2016/17 plan expanded on the activity undertaken in 2015/16 whilst maintaining a cautious approach to integrated working and the pooling of budgets. This approach minimised the risk to both the Council and HCCG. The key developments on the 2015/16 plan 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;
- Extending the scope of 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;

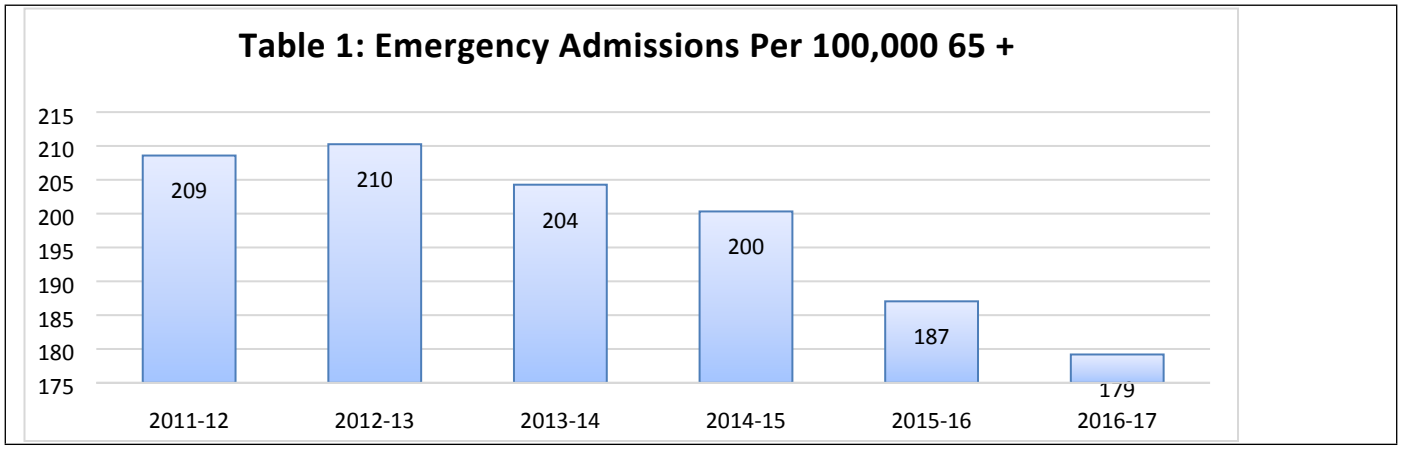
- Accelerating benefits through a greater ambition to integrate services across health and social care, building on progress made in 15/16, e.g. intermediate care; and
- Correcting anomalies from the 2015/16 plan, e.g. bringing the Council's budget for the community equipment contract into the pooled budget with that of the CCG so that the whole budget was under the same governance structure.

6. 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

7. **Measuring Success: Performance against National Metrics** - The following shows the 2016/17 outturn against the national metrics, including the locally determined user/patient experience indicators that we were required to report on:

- *Emergency admissions - Target missed*: During 2016/17 there were 10,252 emergency admissions (also known as non-elective admissions) of people aged 65 and over 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. As illustrated in table 1 there has been a steady decline in the number of emergency admissions per 100,000 of people aged 65 and over since 2014/15, i.e. demand has been managed and growth consumed within the context of an increasing older people population.



- *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. Table 2 below shows that Hillingdon's performance was above the average for London but below that for England.

Table 2: Number of Delayed Days Per 100,000 18 + Population, 2016/17 Compared			
	England	**London**	**Hillingdon**
NHS	2,990	1,611	2,402
Social Care	1,791	1,058	810
Both	405	148	417
Total	**5,186**	**2,818**	**3,630**

- *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. Table 3 shows that Hillingdon performed better than both London and England in 2016/17 in respect of the number of long-term admissions per 100,000 people aged 65 and over.

Table 3: Long-term Admissions to Care Homes per 100,000 65 + Population 2016/17 Compared		
England	**London**	**Hillingdon**
610.7	438.1	398.9

- *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%. The 2016/17 target was imposed by NHS England (NHSE). The factors that impact on target delivery are people who pass away during the 91 day period, as well as people who are readmitted to hospital or who have an updated care plan, e.g. due to escalated needs. Table 4 below shows that Hillingdon's performance was better than the average for both London and England.

Table 4: Percentage of People Still at Home 91 Days After Discharge 2016/17 Compared		
England	**London**	**Hillingdon**
82.47%	85.49%	86.1%

- *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. Table 5 below shows that Hillingdon's performance was higher than that of London and equal to the average for England.

Table 5: Adult Social Care Survey: Social Care-related Quality of Life 2016/17 Compared		
England	**London**	**Hillingdon**
19	18.6	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 outturn was 73.3%. Table 6 below shows that Hillingdon performed better than the average for both London and England.

Table 6: Adult Social Care Survey: Proportion of people who find it easy to find information 2016/17 Compared		
England	**London**	**Hillingdon**
70.3%	68.4%	73.3%

8. **Key Successes** - Despite missing a number of centrally given metrics, the plan has delivered a number of successful improvements:

- *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;

- *Step-down arrangements* - Partners worked together to establish bed-based step-down 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.

9. **Conclusions from 2016/17 plan** - 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 Sustainability and Transformation Plan (STP), secure better outcomes for residents from 2017/18 and address challenges across the health and care system.

10. 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, e.g. integrated brokerage and integrated homecare.

Sustainability and Transformation Plans (STPs) Explained

STPs are plans developed over footprints defined by the Government and including a range of clinical commissioning groups and local authorities with the intention of showing how a sustainable health and care system can be delivered by 2021. The footprint for Hillingdon is the North West London (NWL) CCGs and local authorities, e.g. Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster.

The Hillingdon aspect of the NWL STP is the local Health and Wellbeing Strategy, which we are required to have by law. This was approved by the Health and Wellbeing Board for public consultation on 26th September 2017.

2017/19 BCF Plan

11. The primary purpose of the 2017/19 plan is to deliver those aspects of the STP that require integration between health and social care and/or closer working between health and the Council for delivery.

12. The agreed BCF pooled fund for 2016/17 was £22,531k The HWB and HCCG Governing Body have agreed the total value of the 2017/18 expenditure plan as being £36,814k. The agreed expenditure plan for 2018/19 is £54,049k. Table 7 below provides the detailed total planned expenditure by organisation. The scheme descriptions attached as **Appendix 1** provide a detailed financial investment breakdown by scheme, but this is summarised in table 8 below.

Table 7: 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**

Table 8 Council and HCCG Financial Contribution by Scheme Summary

	SCHEME	Funder 2017/18		Funder 2018/19	
		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**	

13. The key developments under the 2017/19 plan are:

- ***Joint market management and development approach*** - This is the area that represents step-change for Hillingdon. It includes:
    - Development of an all-age joint brokerage service. This service will arrange homecare packages, short and long-term nursing home placements and Direct Payments and Personal Health Budgets on behalf of the Council and the CCG;
    - Commissioning of integrated, all-age homecare provision in 2017/18 on behalf of the Council and the CCG;
    - Commissioning of integrated end of life care at home provision in 2017/18 on behalf of the Council and the CCG;
    - Development of an integrated commissioning model for nursing home placements from 2019/20;
    - Supporting care homes - This is a combination of preventing emergency admissions that are avoidable and using different approaches to ensure sufficient supply of residential care homes and nursing care homes for people living with dementia as well as general nursing homes.

- ***Getting hospital discharge right*** - The plan is proposing to bring together the various services involved in facilitating discharge from hospital into the community into a more integrated model.

- ***Developing the Accountable Care Partnership (ACP)*** - The Council will consider joining the ACP if the case for change demonstrates that this will result in better outcomes for residents.

Accountable Care Partnership (ACP) Explained

An ACP is a partnership of organisations which:

- Is commissioned to jointly deliver an agreed set of outcomes.
- Is accountable for end to end care of the population so that the resident receives a seamless offering across organisational boundaries.
- Is built around an identified registered population e.g. older people.
- Functions at a scale sufficient to hold clinical and financial accountability for this population group.
- Makes decisions on organisation and delivery of care within the partnership, sharing financial risks and benefits.

- Embeds service users/residents in decision making and governance.

The ACP in Hillingdon, known as the Hillingdon Health and Care Partners (HHCP), comprises of The Hillingdon Hospitals, CNWL, the Hillingdon GP Confederation and the H4All third sector consortium, i.e. Age UK, Disablement Association Hillingdon (DASH), Harlington Hospice, Hillingdon Carers and Hillingdon Mind.

- **Developing Care Connection Teams (CCTs) and care planning** - The development of CCTs will support anticipatory care planning in GP surgeries to prevent hospital attendances and admissions that are avoidable. Adult Social Care will work closely with the emerging CCTs and will identify specific staffing resources where extra care housing schemes are located.

Care Connection Teams Explained

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

a) *Practice GP lead* – They have oversight over the whole care pathway within primary care, with additional time spent with those patients at most risk of becoming unstable;

b) *Guided Care Matron (GCM)* – They are responsible for case management, daily monitoring of patients and referring to other services; in-reach support to care homes and supported housing and linking with Rapid Response for out of hours care.
c) *Care Coordinator (CC)* – They assist the Guided Care Matron in proactive care of patients, pulling practice and system intelligence on patients and updating care plans and communicating with other providers.

- ***Developing a single point of access for older people*** - The scope for developing a single point of access into third sector provided services for older people linked with the H4All Wellbeing Service will be explored.

- ***Exploring use of Disabled Facilities Grant flexibilities*** - A business case for using flexibilities to address anticipated needs and support hospital discharge, e.g. home/garden clearance, home deep cleaning, home fumigation, furniture removals to set up micro-environment, etc, will be developed;

- ***An integrated approach to supporting Carers*** - The intention is to consolidate the work that has taken place so far in supporting Carers to ensure a shared commitment across partners to the identification and referral of people who are Carers so that they can access timely support.

14. The integrated homecare and integrated care at home service for people at end of life are the two main areas where direct benefits for residents will be realised through the BCF pooled budget. The purpose of a pooled budget is to ensure that need is addressed irrespective of funding responsibility and this should be demonstrated in these two service areas. It should expedite access to services and prevent the need for residents to change service provider if their needs escalate, unless their service provider is no longer qualified to meet their needs.

Measuring Success

15. The success of the 2017/19 plan will be measured against a combination of nationally determined and some scheme specific metrics.

16. **Performance against national metrics** - The number of reportable national metrics has reduced from six in 2016/17 to four for the duration of the 2017/19 plan and these are:

a) ***Emergency (also known as non-elective) admissions*** - Hillingdon will be reporting on the component of the CCG's emergency admissions target associated with patients aged 65 and over. For 2017/18 a reduction target of 975 emergency admissions is proposed with scheme contributions as shown below:

- Intermediate care (see scheme 4: *Integrated hospital discharge*) - 49 (5%)
- Care of the Elderly Consultant (see scheme 1: *Early intervention and prevention*) - 78 (8%)
- 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 hospital discharge*) - 205 (21%)

b) ***Permanent admissions to care homes*** - This applies to permanent admissions to care homes by the Council of people aged 65 and over. The proposed target is 150 for 2017/18 and reducing to 145 in 2018/19 to reflect the opening of Grassy Meadow Court and Park View Court extra care sheltered housing in June and September 2018 respectively. The proposed target for 2018/19 reflects a reduction in permanent placements into residential care homes but recognises that permanent admissions to residential dementia, nursing and nursing dementia care homes will continue.

c) ***Delayed Transfers of Care 2017/18*** - In July 2017 NHSE issued Health and Wellbeing Board area targets for the NHS and for social care. Final clarification of NHSE requirements was received on 8th September and table 9 below shows the target for 2017/18 and its apportionment across the NHS, Social Care and both.

Table 9: 2017/19 DTOC Targets

Attributed Responsibility	Number of Delayed Days		
	2016/17	2017/18	2018/19
NHS	5,536	6,005	6,095
Social Care	1,866	2,271	2,305
Both	962	1,062	1,078
TOTAL	**8,364**	**9,337**	**9,478**

17. A straightline projection based on activity from April to August 2017 would suggest an outturn for 2017/18 of 9,000 delayed days against a ceiling of 9,337, which means that this would appear to be achievable. However, it is susceptible to changes in local circumstances, e.g. a bad winter increasing demand at the Hospital and/or capacity issues within the local care market.

18. 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 in the Hospital 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 (D2A);
- Support to care homes, including the action by Adult Social Care to increase capacity by converting spot placements into block arrangements.

19. 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.

d) ***Delayed Transfers of Care 2018/19*** **-** The expectation is that a target for 2018/19 will be mandated and the target shown in table 3 above applies a 1.5% increase to the 2017/18 baseline to reflect demographic growth. The DTOC total and apportionment across NHS, Social Care and both is also shown in table 3 above.

e) ***Effectiveness of reablement*** - This is seeking to identify the proportion of people aged 65 and over who have been discharged home from hospital into reablement who are still at home 91 days after the discharge. The agreed target for 2017/18 is 88% with the provisional target for 2018/19 is also set at 88%, although this will be subject to the outcome of discussions about Hillingdon's intermediate care service model going forward.

20. **Performance against scheme specific metrics** - The schemes detailed in **Appendix 1** contain a further range of metrics that will not be reported to NHSE but will be reported to the HWB and HCCG's Governing Body as part of the quarterly performance reports. These additional metrics will give a broader understanding of the successful implementation of the plan than the national metrics and will also be supported by specific testing of the service user experience by services. The following are examples of the additional metrics that will be reported:

- Utilisation rates for Connect to Support, i.e. the Council's online information portal.
- Utilisation of self-assessment facilities on Connect to Support.
- % of users of Adult Social Care who have found it easy or difficult to access information and advice about services (tested through annual Adult Social Care Survey).
- Improvement in quality of life score for users of Adult Social Care services (tested through annual Adult Social Care Survey).
- Number of falls-related emergency admissions.
- Number of emergency admissions from care homes.
- Number of emergency admissions from extra sheltered housing schemes.
- Number of emergency admissions with a length of stay of between 0 and 1 days.
- Number of admissions a day avoided following a referral to Rapid Response by Hillingdon Hospital's Emergency Department.
- Number of referrals to Reablement per month.
- % of new users of the Reablement Service where there is no request for long-term support.

- Number of readmissions during a period of reablement.
- % of hospital discharges taking place before midday.
- % of Continuing Healthcare assessments taking place in an acute hospital trust setting
- Number of readmissions within 30 days.
- Number of Disabled Facilities Grants provided and value.
- Number of Carers' assessments completed.
- Number of Carers receiving respite or another Carer's service following an assessment.

Improved Better Care Fund Grant 2017/19

21. On 9 March, the Department of Communities and Local Government (DCLG) published funding allocations for the additional Improved Better Care Fund (IBCF); the Council's share of this increased funding is £4.1m available in 2017/18. The Council has committed the IBCF funding to stabilising the local social care provider market, e.g. care homes and homecare, which will have a direct impact on the health and care system's ability to support admission avoidance.

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

Governance

23. The delivery of the BCF schemes is overseen by the Transformation Group, which comprises of officers from the Council and the CCG, as well as representatives from the GP Confederation. This group has broader project management responsibilities for the delivery of STP programmes and is chaired by the chairman of the CCG's Governing Body.

24. The Core Officer Group comprising of the Council's Corporate Director of Finance , the CCG's Deputy Chief Finance Officer, the Corporate Director of Adults and Children and Young People's Services (a statutory member of the HWB), the CCG's Chief Operating Officer and the Council's Head of Health Integration and Voluntary Sector Partnerships that has overseen the delivery of plans over the last two years, will continue to have oversight and will also consider opportunities for integrated working and/or joint commissioning for recommendation to the HWB. Any decisions about the use of resources will have to be referred to the Council's Cabinet and the CCG Governing Body in accordance with constitutional arrangements and agreed delegations.

25. An equality impact assessment of the plan was undertaken that did not identify any inequalities arising from the proposed schemes. However, it was recognised that particular attention will need to be given to how schemes develop to address the greater diversity in the south of the borough and during the lifetime of the plan there are areas for development that may require specific assessments to support decisions made by the Health and Wellbeing Board and either the Council's Cabinet and/or HCCG's Governing Body.

Post-April 2019 Position

26. It is as yet unclear what the Government's intentions are in respect of the integration agenda at the end of the current plan. Officers will advise the Committee in due course once further information is known. In the meantime it is proposed that officers provide an update on progress in Q4 2017/18, including details of any revisions to the plan for 2018/19.

2017/19 BCF Plan Scheme Descriptions

Scheme 1: Early Intervention and Prevention

a) Strategic Objectives

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

b) Scheme Overview

As with previous iterations of the Hillingdon's BCF plan, the focus of this scheme will be people living with dementia, people 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 Advice Welfare and Benefits Service	Age UK	150	-	150	150	-	150	300
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	CCG	-	1,062			1,062		2,124

Programme				1,062	-		1,062	
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

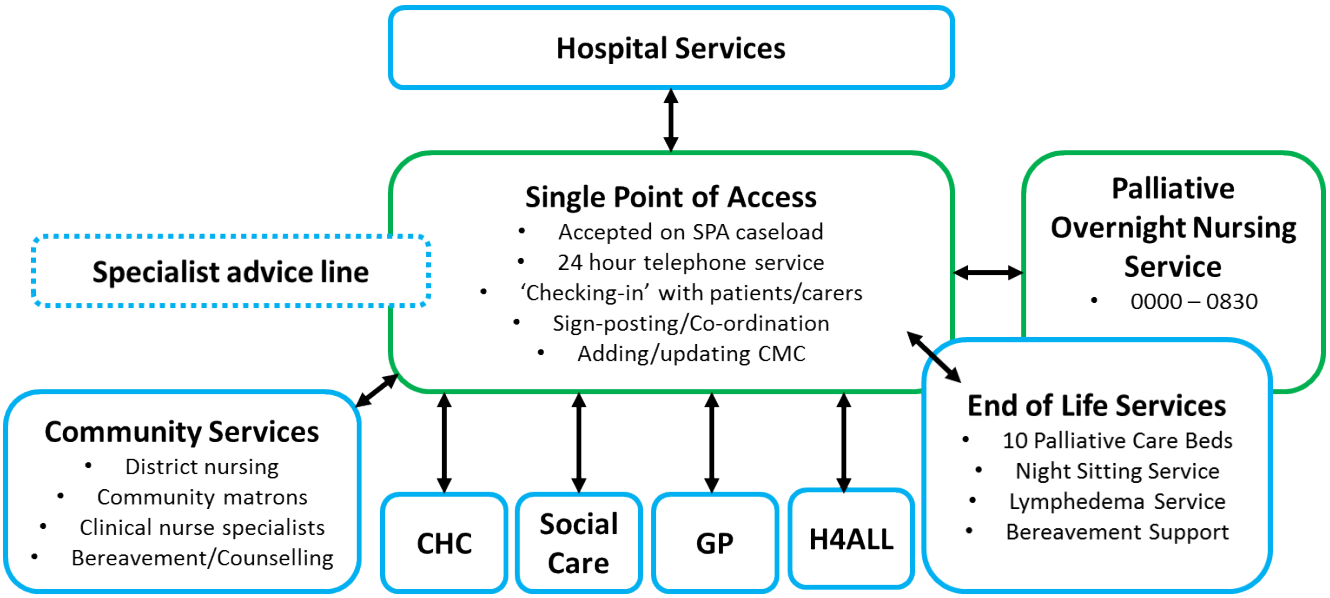
a) Strategic Objectives

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:

- *<u>Facilitating seamless care provision between health and social care</u>* - 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.

- *<u>Reviewing charges for Council funded services</u>* - 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.

- *<u>Utilisation of multi-disciplinary care and support planning</u>* - 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	Various	0	0		0	2,913		2,913

Residential	P&V			-			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	LBH	0	0	-	41	0	41	41
n) Medication Admin	HCCG	0	24	24	0	24	24	48
o) Community Matron	CNWL	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**