BETTER CARE FUND: PERFORMANCE REPORT (APRIL - SEPTEMBER 2017)

Relevant Board Member(s)	Councillor Philip Corthorne Dr Ian Goodman
Organisation	London Borough of Hillingdon
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Papers with report	Appendix 1) BCF Monitoring report - Month 1 - 6: April - September 2017 Appendix 2) BCF Metrics Scorecard

HEADLINE INFORMATION

Summary	This report provides the Board with the first performance report on the delivery of the 2017/19 Better Care Fund plan.
Contribution to plans and strategies	The Better Care Fund is a key part of Hillingdon's Joint Health and Wellbeing Strategy and meets certain requirements of the Health and Social Care Act, 2012.
Financial Cost	This report sets out the budget monitoring position of the BCF pooled fund of £36,814k for 2017/19 as at month 6 2017/18.
Ward(s) affected	All

RECOMMENDATION

That the Health and Wellbeing Board notes the progress in delivering the plan during the Q1 and Q2 review period.

INFORMATION

1. This is the first performance report to the HWBB on the delivery of Hillingdon's Better Care Fund (BCF) Plan for 2017/19 and the management of the pooled budget hosted by the Council. The plan and its financial arrangements are set out in an agreement to be established under section 75 of the National Health Service Act, 2006 that both the Council's Cabinet and Hillingdon Clinical Commissioning Group's (HCCG) Governing Body will be asked to approve in December 2017. This follows formal notification on 31 October 2017 by NHSE that Hillingdon's plan had been approved without conditions.

2. **Appendix 1** of this report describes progress against the agreed plan, including expenditure. **Appendix 2** is the BCF performance dashboard which provides the Board with a summary update against the six key performance indicators (KPIs).

3. The key headlines from the monitoring report are:

- *Emergency admissions: Not on track* - In Q1 and Q2 there were 5,446 emergency admissions to hospitals of people aged 65 and over, which compares to 5,056 during the same period in 2016/17. This suggests an outturn for 2017/18 of 10,892 emergency admissions against a ceiling of 9,428.

- *Falls-related emergency admissions: Not on track* - In Q1 and Q2 there were 420 falls-related emergency admissions to hospital compared to 415 during the same period in 2016/17. This suggests a 2017/18 outturn of 840 admissions on a straight line projection against a ceiling of 787.

- *Emergency admissions from care homes: On track* - In Q1 and Q2 there were 382 emergency admissions to hospitals from care homes. On a straight line projection this would suggest a total of 764 admissions during 2017/18, which would represent a 3% reduction on the 2016/17 outturn of 787 admissions.

- *Permanent admissions to care homes*: *Not on track* - In Q1 and Q2 there were 92 permanent placements into care homes. On a straight line projection this would suggest a total of 184 permanent placements against a ceiling of 150. The highest number of placements (53) was in nursing homes, thus reflecting the high level of resident need that could not safely be met in the community.

- *Delayed transfers of care (DTOC): On track* - At the end of Q2 there were 4,301 delayed days, which would suggest a 2017/18 outturn of 8,612 delayed days against an NHSE imposed ceiling of 9,337 delayed days. On a straight line projection this would suggest an outturn 725 delayed days below the ceiling.

- *Still at home 91 days after discharge from hospital to Reablement: On track* - In Q1 and Q2 94% of people discharged from hospital to the Reablement Service were still at home 91 days after discharge against a target of 88%.

- *Disabled Facilities Grants* - 101 people aged 60 and over were assisted to stay in their own home through the provision of disabled facilities grants (DFG's), which represented 58% of the grants provided.

4. The key milestones within the agreed plan for Q1 and 2 are as follows:

Quarter 1

- *D2A pilot undertaken* - This was completed.

Quarter 2

- *Submission of 2017/19 BCF plan following approval by HWB and CCG Governing Body* - As shown in paragraph 1, this was completed with a positive outcome.

- *Tender for integrated homecare DPS model* - The tender process completed on the 6th October and the integrated model will go live in Q3.

- *Integrated brokerage pilot operational* - The pilot became operational in September with the co-location of Council and HCCG brokerage team staff.

- *Agreement on D2A model* - The Discharge to Assess (D2A) model has been agreed between health and care partners with the intention of expediting the return of people to their ordinary place of residence prior to admission.

- *Launch of new discharge letters for patients at The Hillingdon Hospitals* - The purpose of these letters is to help manage resident and Carer expectations by providing relevant information at a much earlier point following admission to hospital and they have started to be utilised across wards within Hillingdon Hospital.

- *Introduction of formal monthly liaison meetings between Mental Health and Housing* - This started in October and has helped to identify solutions to problems that would otherwise have led to prolonged delayed transfers of care. It has increased mental health awareness amongst the housing team and reduced the number of on the day homelessness applications from people who were previously in-patients in CNWL mental health wards.

- *Implementation of new mental health discharge planning tool* - The application of this tool has enabled earlier discharge planning to take place and this has contributed to a reduction in the number of mental health DTOCs, which is suggesting an outturn of 3,022 delayed days compared to 3,117 in 2016/17.

- *Completion of business case to develop a 'red bag' scheme* - This was completed with the intention of ensuring a consistent approach to the admission to hospital and discharge, of people living in care homes. The purpose is to introduce a consistent process and paperwork that follows the resident into and through the hospital and to enable the resident's belongings to be kept together. The main intended outcomes are an improved experience of care for the resident, improved communication between partners and the prevention of wasted staff time arising from lost forms, belongings, etc.

5. The key milestones that were not achieved were:

- *Agreement on advice, support and advocacy functions within discharge pathways* - This is subject to discussion by partners as the D2A model is embedded. Agreement on the delivery of these functions will be achieved in Q4 for implementation in 2018/19.

    - *Pilot for a GP with specialist interest support for care homes* - The purpose of the pilot is intended to identify the most appropriate model of GP support for care homes and this work was deferred to Q3 and a progress report will be provided to the Board in the Q3 performance update.

Accountable Care Partnership (ACP)

6. The 2017/19 BCF plan includes a commitment by the Council to explore membership of the ACP within the lifetime of the plan. Progress on the ACP has been reported via the Transformation Board and the Council's Corporate Director of Adults, Children and Young People's Services has been invited to a attend joint "board to board" meetings of the ACP and

Hillingdon Clinical Commissioning Group (HCCG). The outputs of this session will inform ACP development for 18/19 including the case for change for Council officers to consider.

7. The Council remains committed to the principles of what the ACP is seeking to achieve and, through the BCF and the supporting S75 agreement, is already demonstrating delivery of more integrated working and pooling of budgets. At this stage, however, the new operating model for the ACP is not yet fully developed and the financial modelling is not in place to demonstrate benefits which would formulate a feasible business case for the Council's membership.

8. The Council will continue to work with ACP members and HCCG through their joint board and at an operational level to shape the business plan and the financial modelling as well as to shape the model of care. Only when this is progressed can recommendations be made through the usual governance processes about formal Council membership. In the meantime, the benefits of integration between health and social care will still be progressed through the mechanism of the BCF section 75 agreement.

Conclusions

9. There is a considerable amount of activity in progress between health and care partners to improve the experience of care for residents and relieve pressure on the local care system. This is taking place within a context of increasing demand and complexity of demand, as well as resource constraints and high public expectations.

10. The impact of the work so far undertaken on key indicators is mixed, which reflects the complexity not only of resident need but also of the structure of the health and care system. It is also a reflection of the difficulties involved with delivering major change within large organisations and also within complex systems.

Financial Implications

11. The Quarter 2 performance report for the Better Care Fund shows a forecast net underspend for 2017/8 of £127k against the approved pooled BCF budget of £36,815k. This forecast underspend arises from staff vacancies in the Councils Reablement and Brokerage teams of £311k offset mainly by forecast overspends in the council provision of packages of care amounting to £184k. Expenditure commissioned by Hillingdon CCG is on target with their pooled budget share.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

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

Consultation Carried Out or Required

13. Hillingdon Hospital, CNWL and H4All have been consulted in the drafting of this report.

Policy Overview Committee Comments

14. None at this stage.

CORPORATE IMPLICATIONS

Corporate Finance Comments

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

Hillingdon Council Legal Comments

16. As is indicated in the body of the report, the statutory framework for Hillingdon's Better Care Fund is Section 75 of the National Health Service Act, 2006. This allows for the Fund to be put into a pooled budget and for joint governance arrangements between the Governing Body of Hillingdon's HCCG and the Council. A condition of accessing the money in the Fund is that the HCCG and the Council must jointly agree a plan for how the money will be spent. This report provides the Board with progress in relation to the plan.

BACKGROUND PAPERS

Appendix 1) BCF Monitoring report - Month 1 - 6: April - September 2017.
Appendix 2) BCF Metrics Scorecard.

Appendix 1

BCF Monitoring Report

Programme: Hillingdon Better Care Fund	
Date: December 2017	**Period covered:** April - Sept 2017 - Month 1 - 6
Core Group Sponsors: Caroline Morison/Tony Zaman /Paul Whaymand/Jonathan Tymms/ Kevin Byrne	
Finance Leads: Paul Whaymand/Jonathan Tymms	

Key: RAG Rating Definitions and Required Actions		
	Definitions	**Required Actions**
GREEN	The project is on target to succeed. The timeline/cost/objectives are within plan.	No action required.
AMBER	This project has a problem but remedial action is being taken to resolve it OR a potential problem has been identified and no action may be taken at this time but it is being carefully monitored. The timeline and/or cost and/or objectives are at risk. Cost may be an issue but can be addressed within existing resources.	Escalate to Core Officer Group, which will determine whether exception report required. Scheme lead to attend Core Officer Group.
RED	Remedial action has not been successful OR is not available. The timeline and/or cost and/or objectives are an issue.	Escalate to Health and Wellbeing Board and HCCG Governing Body. Explanation with proposed mitigation to be provided or recommendation for changes to timeline or scope. Any decision about resources to be referred to the Council's Cabinet/HCCG Governing Body.

1. Summary and Overview		
	Plan RAG Rating	**Amber**
	a) Finance	**Amber**
	b) Scheme Delivery	**Amber**
	c) Impact	**Amber**

A. Financials

1.1 Table 1 below summarises the financial contribution to the BCF plan in 2017/18.

Table 1: BCF Financials Summary 2017/18			
Key components of BCF Pooled Fund 2017/18 (Revenue Funding unless classified as Capital)	**Approved Pooled Budget**	**Forecast Outturn**	**Variance as at Month 6**

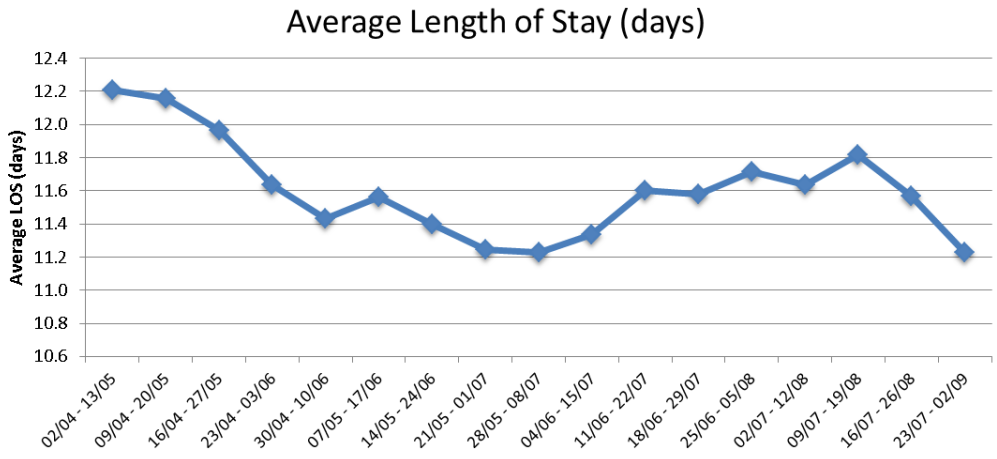
	£000's	£000's	£000's
HCCG Commissioned Services	17,158	17,158	0
LBH - Commissioned Services	15,842	15,715	(127)
LBH - Commissioned Capital Expenditure	3,815	3,815	0
Overall BCF Total funding	**36,814**	**36,688**	(127)

B. Outcomes for Residents: Performance Metrics

1.2 This section comments on those of the four national metrics that Hillingdon is required to report on where information is available. This information is summarised in the Better Care Fund Dashboard (**Appendix 2**). References throughout this document to the *'review period'* means Q1 and Q2 2017/18.

1.3 **Emergency admissions target (also known as non-elective admissions)** - *Not on track*: During the review period there were 5,446 emergency admissions to hospitals of people aged 65 and over, which compares to 5,056 during the same period in 2016/17. This suggests a total for 2017/18 of 10,892 on a straight line projection, which would be above the ceiling of 9,428. During the review period 75% (4,116) of emergency admissions of the 65 and over population were to Hillingdon Hospital. The remaining 25% of activity was primarily with the North West London Hospitals Trust, e.g. Northwick Park, and Watford General.

1.4 A report to the Board's September meeting showed that the length of stay across all age groups had reduced during 2017/18 thus suggesting that initiatives were having an effect. This is illustrated below.



1.5 **Delayed transfers of care (DTOCS)** - *On track*: Table 2 below suggests that on a straight line projection based on activity during the first half of the year the outturn for 2017/18 could be 725 delayed days below the ceiling set for Hillingdon by NHSE. Any projection at this time is subject to the severity of the winter period.

1.6 Table 2 shows that both NHS delays and those attributed to both the NHS and Social care are projected to be significantly below the NHSE-determined ceiling. It also suggests that Social Care delays will be above it. It should be noted that 73% (947) of Social Care delays

during the review period were in a non-acute setting, which is primarily mental health. Smaller numbers of people are involved than in acute settings such as Hillingdon Hospital but the needs are very complex. For example, one person who was delayed for over a year for whom over 70 care homes were contacted before a placement was eventually secured.

Table 2: Q1 - 2 DTOC Breakdown						
Delay Source	**Acute**	**Non-acute**	**Total**	**2017/18 Target**	**Projection 2017/18**	**Variance**
NHS	1,271	1,484	2,755	6,005	5,509	-496
Social Care	344	947	1,291	2,271	2,593	322
Both NHS & Social Care	33	222	255	1,062	510	-552
Total	**1,648**	**2,653**	**4,301**	**9,337**	**8,612**	**-725**

1.7 During the first half of 2017/18 nearly 18% (758) of all delays, e.g. health and social care, were attributed to issues with securing residential care placements and nearly 20% (849) to difficulties with securing nursing home placements. Nearly 70% (903) of all social care delays were related to issues in securing care homes placements. 45% (580) of the social care delays related to residential care home placements and 25% (322) to nursing homes.

1.8 It is important to note that the 166 delayed days reported by Hillingdon Hospital against social care in Q2 were attributed to 16 people.

1.9 Table 3 shows the breakdown of delayed days by the five NHS trusts that are hosting nearly 90% of the delays during the first half of 2017/18. CNWL accounted for 67% of the non-acute DTOCs during Q1 and 2, which reflects the position in 2016/17.

Table 3: Distribution of Delayed Days by NHS Trust	
Trust	**Number of Delayed Days (Q1 - 6)**
1. CNWL	1,775
2. The Hillingdon Hospitals	1,058
3. West London Mental Health Trust	552
4. North West London, e.g. Northwick Park	327
5. Bucks Healthcare	167
TOTAL	**3,879**

1.10 **Permanent admissions to care homes target** - *Not on track*: During Q1 and 2 there were 92 permanent placements into care homes (53 nursing homes and 39 residential homes). On a straight line projection this would suggest a total of 184 permanent placements against a ceiling of 150 in 2018/19. It should be noted that the high number of nursing placements is a reflection of the high level of resident need that it is unlikely could have been met safely in the community even if the new extra care schemes had been open.

1.11 It should be noted that the new permanent admissions figure in paragraph 1.8 above is a gross figure that does not reflect the fact that there were 96 people who were in permanent care home placements also left during the period 1st April 2017 to 30th September 2017. As a result, at the end of Q2 there were 458 older people permanently living in care homes (211 in residential care and 247 in nursing care). This figure also includes people who reached their sixty-fifth birthday in Q1 and 2 and were, therefore, counted as older people.

1.12 **Percentage of people aged 65 and over still at home 91 days after discharge from hospital to reablement** - *On track*: Performance during Q1 and 2 is that 94% of people discharged from hospital are still at home after a period of Reablement, which exceeds the target of 88%. However, it should be noted that the review period for the purposes of this national metric is Q3 and the results will not be available until Q1 2018/19. The outturn is affected by people who pass away within the 91 day period and also those who are readmitted to hospital either for a reason related to the original cause of admission or for a different reason. People who are the subject to a care plan review during the 91 day period as a result of an escalation of need are also excluded.

2. Scheme Delivery

Scheme 1: Early intervention and prevention.	**Scheme RAG Rating**	**Green**
	a) Finance	**Green**
	b) Scheme Delivery	**Green**

Scheme 1 Funding	Approved Pooled Budget	Forecast Outturn	Variance as at Month 6
	£000's	£000's	£000's
HCCG - Commissioned Services	2,353	2,353	0
LBH - Commissioned Services	1,245	1,245	0
LBH - Commissioned Capital Expenditure	3,815	3,815	0
Total Scheme 1	**7,413**	**7,413**	**0**

Scheme Financials

2.1 HCCG and LBH expenditure is in line with the pooled budget.

Scheme Delivery

2.2 *Connect to Support* - From 1st April to 30th September 2017, 7,350 individuals accessed Connect to Support and completed 11,247sessions reviewing the information & advice pages and/or details of available services and support. This represents an increase of 4,863 people and 7,158 sessions on the same period in 2016/17.

2.3 During Q1 and 2, 51 people completed online social care assessments and 16 were by people completing it for themselves and 35 by Carers or professionals completing on behalf of another person. 32 self-assessments have been submitted to the Council to progress and the remainder have been sent to residents at their request in order for them to decide in their own time how they wish to proceed. There have been 11 self-assessments undertaken by Carers during the first half of 2017/18.

2.4 *H4All Wellbeing Service* - The service provides older residents in Hillingdon with:

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

2.5 The Wellbeing Service uses three measures to evidence in improvements as a result of the intervention of the service and these are:

- *The Patient Activation Measure (PAM) tool* - People referred to the service are supported to complete a questionnaire comprising of 13 questions both before and after H4All all interventions. This provides a PAM Level between 1 and 4 and PAM Score between 0 to 100, which is representative of the person's ability and motivation to self-manage their own health and wellbeing. The lower the level and score the lower the person's ability/motivation to self-manage. During the review period 135 showed an improvement in their PAM scoring.

- *B. The Campaign to End Loneliness Measure* - The tool has been developed by the Campaign to End Loneliness in Later Life presents people with three statements and these are:
    - I am content with my friendship and relationships;
    - I have enough people I feel comfortable asking for help at any time; and
    - My friendships are as satisfying as I would want them to be.

- To each of these statements respondents are asked to give one of the following answers which results in a score shown in brackets: Strongly agree (4), Disagree (3), Neutral (2) and Strongly Disagree (0). These are added together and the lower the score the least lonely the person is identified to be. The tool has been used for the first time during the first half of 2017/18 and out the 30 people that it has been used with improvements resulting from H4All interventions has been shown.

- *C. Service User Experience Satisfaction Questionnaires* - During Q1 and 2 there were 118 respondents to satisfaction questionnaires and the results are shown in table 4 below.

Table 4: H4All Wellbeing Services Satisfaction Survey Results

Nature of Enquiry	Satisfied with Outcome			Unknown/ NA
	Yes	No	Partially	
Improved Health & Wellbeing	29	39	45	5

Reduced Social Isolation	47	43	21	8
Less Contact with Health Services	20	55	31	13
Help to Manage Long-term Condition	20	1	12	86
Appropriate Service Received	104	3	10	2
Additional Support Required	13	98	6	2
Would Use the Service Again	111	-	1	6
Effective Signposting/Referral	9	3	4	96

- *Care Connection Teams* - The role of the Care Connection Teams is explained below. Following a pilot with two CCTs in the north of the borough, posts in all 15 of the intended CCTs were recruited to during the review period. This means that all of them will be fully operational by the end of 2017/18 once all appointees are in post.

Care Connection Teams (CCTs) Explained

The CCTs 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.

2.6 At the end of September the operational CCTs were carrying a caseload of 575 people and CCT are reporting 334 hospital admissions were avoided in the reporting period. Admissions avoided included cases where people with a urinary tract infection (UTI) or respiratory tract infection (LRTI) were supported with appropriate medication or helped to manage their symptoms. It also included patients being supported by another service such as Rapid Response, District Nursing or having their medication reviewed or receiving care at home instead of in hospital if they were on the palliative care pathway and wanted to die at home.

2.7 *Falls-related Admissions: Not on track* - During the review period there were 420 falls related emergency admissions to hospital compared to 415 during the same time in 2016/17. A straight line projection would give an outturn of 840 admissions against a ceiling of 787.

2.8 *Keeping older people active* - Examples of activities undertaken to support older residents include:

- *Moves Programme* - This includes ten chair based exercise sessions available across the borough in libraries, two in community centres and one at the Wren Centre in Ruislip. Attendance at these sessions ranges from 30 people attending weekly in Uxbridge to 12 in Hayes End. Zumba sessions and gentle aerobics sessions also take place at West Drayton Community Centre and Yeading Library

- *Tea dances - These are h*eld monthly at the Civic Centre (attendance around 120 per dance) and one at Winston Churchill hall (attendance on average 60 per dance). These are now being extended and will include a tea dance and a line dance at West Drayton Community Centre and a Bollywood Dance (Desi) at Botwell Community Centre.

2.9 *Atrial fibrillation (AF) pilot* - AF is one of the major causes of stroke, which is one of the main causes of disability in the older people population. At the end of 2016/17 10 AF detectors were distributed to community pharmacies across the borough. During the review period 251 residents were screened for AF and one person was identified with the condition. This person would then have been referred to their GP for advice about treatment and lifestyle choices that in order to reduce the likelihood of them having a stroke. The review of the delivery of health checks in Hillingdon is currently the subject of a review. The inclusion of AF as part of these checks will be considered as part of this review.

Scheme 2: An integrated approach to supporting Carers.	**Scheme RAG Rating**	**Amber**
	a) Finance	**Amber**
	b) Scheme Delivery	**Green**

Scheme 2 Funding	**Approved Pooled Budget**	**Forecast Outturn**	**Variance as at Month 6**
	£000's	**£000's**	**£000's**
HCCG - Commissioned Services	18	18	0
LBH - Commissioned Services	862	883	21
Total Scheme 2	**880**	**901**	**21**

Scheme Financials

2.10 There is currently a forecast overspend of £21k on the cost of Carers Assessments by the Council. Expenditure commissioned by Hillingdon CCG is on target with the pooled budget share.

Scheme Delivery

2.11 379 Carer's assessments were completed during the first half of 2017/18. This is made up of 143 sole assessments completed by Hillingdon Carers, 19 sole assessments completed by the Council and 217 joint assessments, e.g. Carer and cared for person completed by the Council. The projected outturn for 2017/18 on a straight line projection is 758 assessments against a target of 569. The assessment figures reflect full assessments and triage assessments (known as Type 1 assessments) that have been undertaken by Hillingdon Carers that have not proceeded to full assessments. Since June 2017 all new Carers' assessments have been completed on Connect to Support.

2.12 During the first half of 2017/18, 275 Carers were provided with respite or another carer service at a cost of £822k. This compares to 237 Carers being supported at a cost of £796k during the same period in 2016/17. This includes bed-based respite and home-based replacement care as well as voluntary sector provided services and services directly purchased via Direct Payments.

2.13 *Identification of Carers* - In the twelve months since the start of the Hillingdon Carers' Partnership contract in September 2016 959 new Adult Carers have been identified against a target of 500. 464 Young Carers have also been identified against a target of 143. As a result, at the end of September 2017 the Hillingdon Carers' Partnership was supporting 24.8% of Carers compared to the 18% supported by Hillingdon Carers in 2014. Percentages are based on the 26,000 Carer population as identified in the 2011 census.

2.14 *Young Carers* - The review period has seen the development of the Young Carers' strategy Group, which has been instrumental in increasing the number of referrals of Young Carers, e.g. there were 304 new referrals from schools. Significant sums of external funding have been secured during the review period to support Young Carers and this includes:

- *Supported Transition Programme:* A three-year investment of £111k was secured from the Henry Smith Foundation to help young adult Carers with the transition from school to further education, employment or apprenticeships.

- *Family Support Service:* Additional three-year funding of £99.9k was awarded by Children in Need to provide short-term but intensive and holistic support to families affected by multiple caring situations.

- *Trips and activities:* £14k was acquired through a range of small grants to funds a range of trips and activities and also to establish a hardship fund to ensure Young Carers have access to items they need for their education and to pursue hobbies and sports. This fund contributed to the achievement of 3,213 short break opportunities that were delivered for Young Carers during the review period.

2.15 *Supporting working Carers* - A total of 63 working Carers have accessed new services such as 1:1 personal training sessions offered at a venue of a Carer's choice and a programme of 14 Wellbeing Workshops was provided during the day and repeated in the evenings at the new Carers' Centre in order to improve access for working Carers.

2.16 *External funding* - In its first year of operation (Sept 2016 to Sept 2017) the Hillingdon Carers' Partnership has attracted £417.8k additional investment to support Carers in the borough.

Issues/Risks

2.17 This scheme is identified as amber due to the £21k overspend on the Council's contribution to the pooled budget. However, this will be funded from underspends in other aspects of the Council's contribution.

Scheme 3: Better care at end of life.	**Scheme RAG Rating**	**Green**
	a) Finance	**Green**
	b) Scheme Delivery	**Green**

Scheme 3 Funding	Approved Pooled Budget	Forecast Outturn	Variance as at Month 6
	£000's	£000's	£000's
HCCG - Commissioned Services	992	992	0
LBH - Commissioned Services	50	50	0
Total Scheme 3	**1,042**	**1,042**	**0**

Scheme Financials

2.18 HCCG and LBH expenditure is in line with the pooled budget.

Scheme Delivery

2.19 A tender was undertaken for the integrated homecare services under a dynamic purchasing scheme (DPS) model that also included the provision of care at home to people at end of life. The new service will enable need to be addressed irrespective of whether funding responsibility sits with the Council or the NHS.

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.

2.20 Recruitment to a single point of access (SPA) and overnight nursing service to be provided by CNWL that will improve access to the right end of life care and support started. The SPA will be delivered by five members of staff and it is not expected to be operational until February 2018 once the staffing complement is in place.

Scheme 4: Integrated Hospital Discharge.	Scheme RAG Rating	Amber
	a) Finance	Amber
	b) Scheme Delivery	Amber

Scheme 4 Funding	Approved Pooled Budget	Forecast Outturn	Variance as at Month 6
	£000's	£000's	£000's
HCCG Commissioned Services funding	11,406	11,406	0
LBH - Protecting Social Care funding	4,607	4,377	(230)
Total Scheme 4	**16,013**	**15,783**	**(230)**

Scheme Financials

2.21 There is currently a forecast underspend of £230k mainly arising from staffing vacancies in the Council's Reablement Service. Expenditure commissioned by Hillingdon CCG is on target with the pooled budget share.

Scheme Delivery

2.22 *Criteria-led discharge pilot* - A pilot was run on Beaconsfield East Ward at Hillingdon Hospital under which a multi-disciplinary team comprising of occupational therapists, physiotherapist, nurses, speech and language team and medical staff agreed criteria under which nurses and therapists could agree the discharge of patients without the requirement of a further review by the medical team. The pilot proved successful and has been rolled out to other wards within the Hospital. This helps to expedite the discharge process.

2.23 *SAFER patient bundle* - This is explained below and has been rolled out across wards within Hillingdon Hospital but the extent of its implementation is at different stages across the hospital.

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.

2.24 *Red2Green* - This links to SAFER and is a method of ensuring that the care that is planned to take place for a person on any given day actually happens. The basic principle of Red2Green is that a day on which everything which should happen for a person is a Green day. This approach enables processes and systems that are not working to be identified and resources directed to address blockages. Once again, this approach has now been rolled out to all wards within the Hospital.

2.25 *Discharge to Assess (D2A)* - The evolution of a Discharge to Assess (D2A) model has been a key development during the first half of 2017/18. The impetus for this initiative has been nationally driven and is based on the premise that people will recover more quickly from an incident that led them to be admitted to hospital in their own home. Three discharge pathways have been agreed and these are:

- *Pathway 0 (Simple Discharges)* - This is for people whose needs can safely be met at home and need no additional assessment. The person can go directly home either without care or with a care package restart. It is envisaged that the majority of patients will be discharged on this pathway.

- *Pathway 1 (Discharge to Assess)* - This is for people who are medically optimised who have needs that can safely be met at home (including a residential or nursing care home) with additional assistance. Any care, equipment or rehabilitation will be provided at home, including a Continuing Healthcare assessment where appropriate. The discharge will be managed by the ward with input from the Discharge Coordinators or the Integrated Discharge Team (IDT) when required.

- *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 cannot be safely met in their usual place of residence or their home needs preparation or adaptation.

2.26 Q1 and 2 has seen the testing phase of the D2A model and during this period there has been 228 referrals and 165 supported discharges from Hillingdon Hospital.

2.27 *Seven day working* - Table 5 illustrates performance against seven day metrics.

Table 5: Hillingdon Hospital Discharges before Midday and at Weekends

Item	2017/18 Target	2016/17 Baseline	Q2 2017/18 Outturn
Medicine Directorate, inc A & E			
Discharges before midday	33%	21.3%	20.3%
Weekend discharges	65%	16.2%	16.2%
Surgery Directorate			
Discharges before midday	33%	19.2%	18.6%
Weekend discharges	65%	20.9%	13.7%

2.28 *Reablement Team activity* - During Q1 and 2 the Reablement Team received 383 referrals and of these 298 were from hospitals, primarily Hillingdon Hospital and the other 85 were from the community. The community referrals represented potential hospital attendances and admissions that were consequently avoided. During the first half of 2017/18, there were 218 new referrals to the service and of these 91% (199) completed their period of reablement with no on-going social care needs, which is above the target of 85%.

2.29 *Rapid Response Team activity* - In Q1 and 2 the Rapid Response Team received 2,190 referrals, 63% (1,386) of which came from Hillingdon Hospital, 19% (401) from GPs, 9% (203) from community services such as District Nursing and the remaining 9% (200) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 1,386 referrals received from Hillingdon Hospital, 64**%** (1,189**)** came from A&E and Homesafe, 14% (197) from Discharge to Assess, of which 1,093 (79%) were discharged with Rapid Response input, 257(18%) following assessment were not medically cleared for discharge and **36** (**3**%) were either out of area or inappropriate referrals. All 80**4** people referred from the community source received input from the Rapid Response Team. As with the Reablement Service activity described above, the community referrals represented potential hospital attendances and admissions that were consequently avoided thus helping to reduce avoidable demand.

2.30 *Hospital Discharge Team activity* - The Council's Hospital Discharge Team supported the early discharge of 189 people from Hillingdon Hospital and Mount Vernon Hospital during Q1 and 2 and also 70 people from other, out of Hillingdon hospitals. *'Early discharge*' means that people were identified and supported into alternative care settings before the Estimated Date of Discharge (EDD). The early discharge from the Hillingdon Hospitals amounted to 395 bed days avoided, thereby assisting the Hospital with patient flow.

2.31 During the review period 101 people aged 60 and over were assisted to stay in their own home through the provision of disabled facilities grants (DFG's), which represented 58% of the grants provided.

2.32 21% (21) of the people receiving DFG's were owner occupiers, 75% (76) were social housing tenants, and 4% (4) were private tenants.

Issues/Risks

2.33 During the review period 47% of discharge notices served on the Council by Hillingdon Hospital in accordance with the Care Act were withdrawn. This impacts on market capacity where there is late notification and packages of care have already been put in place. In these circumstances the care also has to be funded which has resource implications. There is also a further impact on officer time in terms of follow up, updating support plans with new dates, resending to providers, confirming new discharge dates and then contacting the relevant ward to ensure that the discharge is definitely taking place.

2.34 *Risk - D2A model*: By its nature this model results in people leaving hospital at a much earlier stage than would traditionally have been the case. This has the potential to increase demand on the homecare market, e.g. by increasing the number of people requiring two care workers four times a day. In view of the limited number of care workers within the market, this has the potential to have a detrimental impact on the supply of care workers to support residents with on-going care needs. Health and care partners are aware of this risk and it will continue to be monitored. In addition, the plan includes initiatives to support the care market and these are reported on later in this delivery update.

2.35 *Risk - Bed-based step down*: An objective during 2017/18 has been to avoid the creation of additional bed-based step-down provision. However, the award of additional funding to the NHS in the budget combined with understandable concerns about the pressure on the Hospital over the winter pressure could well lead to the regulators asking for a temporary increase in short-term bed provision within care homes. The concern with such an approach is the potential impact that it could have on the availability of long-term beds, which could ultimately lead to prolonged delays. It is a case of solving one problem only to create another. The proposed way forward is that any proposal to increase short-term bed provision within care homes should take the form of a business case to the Transformation Board.

2.36 This scheme is identified as amber because of the forecast underspend on the Council's contribution which will offset overspends in the Council's contribution to other schemes within the pooled budget. It is also identified as amber because some actions within the DTOC action plan have not been delivered within the agreed timeframe. These include:

- Agreement on D2A model and implementation of pathways - This was agreed by partners in Q3.
- Introduction of monthly liaison meetings between Mental Health and Housing - This started in Q3.
- Agreement on advice, support and advocacy functions within discharge pathways - This will be completed in Q4.

Scheme 5: Care market management and development	**Scheme RAG Rating**	**Amber**
	a) Finance	**Amber**
	b) Scheme Delivery	**Amber**

Scheme 5 Funding	**Approved Pooled Budget**	**Forecast Outturn**	**Variance as at Month 6**
	£000's	**£000's**	**£000's**
HCCG - Commissioned Services	2,389	2,389	0
LBH - Commissioned Services	8,695	8,779	84
Total Scheme 5	**11,084**	**11,168**	**84**

Scheme Financials

2.37 There is currently a forecast overspend of £84k mainly arising from the forecast increased costs of Homecare packages. Expenditure commissioned by HCCG is in line with the pooled budget share.

Scheme Delivery

2.38 *Integrated brokerage* - The co-location of the CCG's brokerage team with the social care team started in September. The purpose of this is to develop a more integrated approach to managing the market that will help to improve quality of service provision and value for money. It is also intended to make it easier for providers to work with statutory agencies by creating a single point of contact, although the delivery of this is a future ambition.

2.39 *Integrated homecare* - A tender for an integrated, all-age homecare service under a dynamic purchasing system (DPS) model (see below) that will be led by the Council was completed. This is a pilot for two years to test the concept. Officers from the Council and CCG will then be able to review outcomes to coincide with the expiry of existing Council homecare contracts and then make recommendations about the shape of the future model for Cabinet and the CCG's Governing Body to consider. The integrated homecare model also includes care at home for people at end of life as referred to in paragraph 2.19.

2.40 *Emergency admissions from care homes: On track* - During the review period there were 382 emergency admissions from care homes. On a straight line projection this would suggest a total of 764 admissions during 2017/18, which would represent a 3% reduction on the 2016/17 outturn of 787 admissions. However, it should be noted that these figures do not reflect emergency admissions to Hillingdon Hospital of people living in care homes who do not have a Hillingdon GP, which will primarily homes outside of the borough.

2.41 The review period has seen a range of measures put in place that should result in an improvement in service quality within care homes in Hillingdon and a reduction in A & E attendances and admissions that are avoidable. These measures include:

- *Project Team* - The establishment of a multi-agency project team to develop and implement the measures to support quality care provision in care homes. This task and finish group includes consultant geriatrician, GP and care home representatives.
- *Pharmacy support* - The recruitment of a full-time pharmacist employed as part of a care home pharmacy support service to support better medicines management.
- *Managing falls in care homes* - Falls prevention and management training that has been attended by 58 members of staff from 28 care homes.
- *Mental capacity training* - A rolling programme of training on the Mental Capacity Act and Deprivation of Liberty Standards.
- *GP support for care homes* - Funding agreed by the CCG for two GPs with special interest to support care homes.
- *Development of a 'Red Bag' scheme* - Funding was agreed by the CCG for two part-time project managers provided by the Council to support Hillingdon's care homes in implementing the scheme, which is explained below. Both project managers have experience of managing care homes themselves. Funding for the red bags was also agreed. All of Hillingdon's care homes for adults have agreed to participate in the schemes, which will be fully implemented by the end of March 2018.

The *Red Bag* Scheme Explained

The '*Red Bag*' keeps important information about a care home resident's health in one place, easily accessible to ambulance and hospital staff. It 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.

2.42 *Support for extra care sheltered housing schemes* - The tender took place for the care and wellbeing service at Cottesmore House and Triscott House and also the new schemes that will be opening in 2018, e.g. Grassy Meadow Court and Park View Court. The contract was awarded to Carewatch, a company with experience of delivering care in an extra care setting in both London and other parts of the country. This contract started on 1st November 2017.

Issues/Risks

2.43 This scheme is identified as amber because of the forecast overspend on the Council's contribution which will be offset by underspends in the Council's contribution to other schemes within the pooled budget. It is also identified as amber because some actions within the DTOC action plan have not been delivered within the agreed timeframe. An example includes:

- *Pilot for a GP with specialist interest support for care homes* - This pilot is intended to identify the most appropriate model of GP support for care homes and this work was deferred to Q3

Scheme 6: Living well with dementia	**Scheme RAG Rating**	**Green**
	a) Finance	**Green**
	b) Scheme Delivery	**Green**

Scheme 6 Funding	**Approved Pooled Budget**	**Forecast Outturn**	**Variance as at Month 6**
	£000's	**£000's**	**£000's**
HCCG - Commissioned Services	0	0	0
LBH - Commissioned Services	300	300	0
Total Scheme 6	**300**	**300**	**0**

Scheme Financials

2.43 Expenditure in line with the pooled budget plan.

Scheme Delivery

2.44 A simplified process for care homes to make referrals to the Older People's Mental Health Team at the Woodlands Centre on the Hillingdon Hospital site was introduced following issues raised at the Older People's Care Home Managers' Forum.

2.45 Work on equipping the new Dementia Resource Centre (DRC) that will be based at Grassy meadow Court was undertaken. This was in compliance with the Stirling University Design Gold Standard. In Q3 meetings with partners will take place to identify how the resources within the DRC and also within Grassy Meadow Court and the other extra care schemes can be put to best use by partners to support the residents of the schemes and older people in the local community. This will include third sector organisations like the Alzheimer's Society and also health partners such as GPs, consultant geriatricians at Hillingdon Hospital and community health and community mental teams provided by CNWL.

2.46 Linking in with Scheme 1: *Prevention and early intervention*, a range of activities continue to be in place to support people living with dementia and these include:

- *Weekly dementia coffee mornings* - In Uxbridge up to 25 people attend these sessions on a weekly basis. Activities vary from singing, reminiscence, art, reading aloud and seated football. In Botwell a new group started in March 2017 that also meets on a weekly basis and includes activities such as singing, drummunity, reminiscence, arts and crafts and reading aloud.

- *Art sessions for dementia* - Arts sessions are held once a month at the coffee mornings referred to above where an artist runs a workshop. Art sessions were held during dementia awareness week (14 - 20th May 2017) with participants from the dementia coffee mornings and the Wren Centre, i.e. the current Dementia Resource Centre. This culminated in an exhibition in Uxbridge Library.

- *Dementia Friendly Walk* - In April 2017 a new monthly dementia friendly walk was established at Norman Leddy Memorial Gardens. These gardens were chosen as they are enclosed and have plenty of seating. Attendance has varied from 2-8 people.

- *Tovertafel* - This is a new project that is being developed in libraries to promote social interaction and meaningful activities for people living with dementia. There are currently 8 people meeting every Friday to use the Tovertafel in Uxbridge library. The Tovertafel is a little box that can be mounted on the ceiling above the dining room table of a care home or a table in a library. Inside the box is a high-quality projector, infrared sensors, speaker, and processor that work together to project the games onto the table. Because the colourful objects respond to hand and arm movements, residents get to play with the light itself.

BCF Programme Management Costs

Programme Management	Approved Pooled Budget	Forecast Outturn	Variance as at Month 6
	£000's	**£000's**	**£000's**
BCF Programme Management	82	82	0
Total	**82**	**82**	**0**

3. Issues/Risks

3.1 Non-scheme specific issues and risks include:

- **IT Interoperability** - Developing interoperable systems between the NHS and Adult Social Care continues to present challenges in the delivery. The Care Information Exchange (CIE), which was intended to provide the opportunity for professionals to view the details of the interventions of partner organisations in meeting the care needs of residents, as well as allowing residents themselves to view their records on line, has not delivered what it was hoped it would. The charitable funds that have supported the development of this project cease at the end of 2017/18 and post April 2018 funding options are currently being explored by partners across North West London.

- **Local Care Market Fragility** - Workforce capacity and capability issues continue in Hillingdon and manifest themselves in the difficulties of homecare providers in the south of the borough in particular to accept packages of care and also in care home providers being willing to accept people with the more complex needs. The care market in Hillingdon is particularly affected by the borough being a high employment area with alternative options to working in the care industry available to people. It should also be noted that the decision by the supermarket chain Lidl to pay its workforce the London Living Wage of £10.20 per hour also attracts people from generally lower paid work in the care industry.