BETTER CARE FUND: PERFORMANCE REPORT (OCT - DEC 2017)

Relevant Board Member(s)	Councillor Philip Corthorne Dr Ian Goodman
Organisation	London Borough of Hillingdon
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Papers with report	Appendix 1) BCF Monitoring report - Month 7 - 9: Oct - December 2017 Appendix 2) BCF Metrics Scorecard

HEADLINE INFORMATION

Summary	This report provides the Board with the second 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 9 2017/18.
Ward(s) affected	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

a. notes the progress in delivering the plan during the Q3 review period;

b. supports the development of a Carers' Memorandum of Understanding containing the seven principles set out in the report (paragraph 9) as the basis for an updated Carers' Strategy for 2018/21; and

c. gives delegated authority to the Council's Corporate Director of Adult, Children and Young People's Services, in consultation with the Chairman of the Health and Wellbeing Board, the Chairman of Hillingdon Clinical Commissioning Group's Governing Body and the Interim Chairman of Healthwatch Hillingdon's Board, to agree revised Better Care Fund targets for 2018/19, subject to advice about deliverability from the Council's Corporate Director and Hillingdon Clinical Commissioning Group's Chief Operating Officer.

INFORMATION

1. This is the second 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 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 approved in December 2017.

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:* There were 2,869 emergency admissions of people aged 65 and over in Q3 compared to 2,514 during the same period in 2016/17. Projections based on April to December 2017 activity data suggest an outturn for 2017/18 of 11,088 against a ceiling of 9,428. 2017/18 has seen an increase in the number of admissions to Hillingdon Hospital across all age groups but predominantly amongst the 18 to 64 age group. Actual attendances at the Hospital has remained largely static during the April to December 2017 period and even fell during December and January 2018 in comparison with the same period in 2016/17.

- *Falls-related emergency admissions - Not on track:* In the period April to December 2017 there were 644 falls-related emergency admissions to hospital compared to 607 during the same period in 2016/17. This suggests a 2017/18 outturn of 858 admissions on a straight line projection against a ceiling of 787.

- *Emergency admissions from care homes - Not on track:* During the review period there were 609 emergency admissions of people aged 65 and over from care homes. On a straight line projection this would suggest a total of 812 admissions during 2017/18, which would represent a 3% increase on the 2016/17 outturn of 791 admissions. More detailed analysis that will now be undertaken by officers that will also consider London Ambulance Service (LAS) conveyances to Hillingdon Hospital, reasons for conveyance and length of stay post admission. The latter will help to shape conclusions about the appropriateness of admission. An update will be provided to the Board at its next meeting.

- *Permanent admissions to care homes - Not on track*: During the period 1st April to 31st December 2017 there were 134 permanent admissions to care homes. On a straightline projection this suggests an outturn for 2017/18 of 179 permanent admissions against a ceiling of 150 for the year.

- *Delayed transfers of care (DTOC)* - On *track:* At the end of Q3 there were 5,559 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*: The position to the end of December 2017 showed an average of 89% of people still at home 91 days after discharge against a target of 88%.

- *Disabled Facilities Grants* - 64 people aged 60 and over were assisted to stay in their own home through the provision of disabled facilities grants (DFGs), which represented 66% of the grants provided. This has prevented the need to identify alternative housing options at a time when housing in short supply.

4. The key milestones within the agreed plan for Q3 are as follows:

- *Approval of 2017/19 BCF plan by NHSE* - Confirmation was received on 30 October 2017 that Hillingdon's plan had been approved without conditions.

- *Section 75 agreement approved by Council's Cabinet and CCG Governing Body* - The agreement giving legal effect to the BCF plan was agreed by Cabinet and HCCG's Governing Body in December 2017.

- *Recruitment to posts within the Care Connection Teams completed* - This means that all fifteen Teams will be mobilised by the end of Q4, which will assist in the early detection of older people at risk of escalated needs (see paragraph 2.7, **Appendix 1**).

- *Introduction of monthly liaison meetings between Mental Health & Housing* - This started in October 2017 and has assisted in addressing issues at a much earlier stage (see paragraph 2.26, **Appendix 1**).

- *Integrated homecare model operational* - The integrated homecare pilot became operational in November 2017 (see paragraph 2.35, **Appendix 1**).

- *Start of GP support for care homes pilot* - This started in December with one dedicated GP supporting four care homes. A further GP is due to be appointed in Q4 and the model evaluated in March 2018 (see paragraph 2.38, **Appendix 1**).

5. The key milestones that were not achieved were:

- *Launch of new discharge policy to support choice at The Hillingdon Hospitals* - This is delayed pending the outcome of further discussions about the integrated hospital discharge model (see paragraph 6 below).

- *Business case on use of DFG flexibilities under Regulatory Reform Order to support anticipatory care needs and early hospital discharge submitted* - This will be progressed in Q4.

- *Agreement on advice, support & advocacy functions within discharge pathways* - This is linked to the outcome of discussions on the integrated hospital discharge model in Q4.

Integrated Hospital Discharge Model

6. Q3 saw further work undertaken between the Council, Hillingdon Hospital, CNWL and the CCG to expedite the hospital discharge process. This included the Council establishing a block contract with a homecare provider for 120 hours care per week specifically to support hospital discharge. The cost of this was underwritten by the Hospital.

7. During Q3 a discharge executive group comprising of the Council's Corporate Director of Adult, Children and Young People's Services, Hillingdon Hospital and the CCG's Chief

Operating Officers and CNWL's Deputy Chief Operating Officer was formed with the specific intention of providing the leadership required to deliver a simplified and integrated hospital discharge process. Whilst there is still work in progress, the target is to have a new model in place by March 2017. Significant areas on which there is agreement between the partners include:

- *Single point of referral for hospital discharges*: Although the majority of Hillingdon Hospital in-patients are discharged without need of further assistance, for people who do require support it is proposed that wards refer into a single, multi-agency team using a single referral form. This team will be jointly managed by the Council and CNWL.

- *Hospital Discharge Homecare Service*: The Council commissioned this service for an initial pilot that started before Christmas and it has proved successful in expediting the discharge process. It is proposed to extend this for 2018/19 and Council officers will shortly be seeking approval from the Leader of the Council and the Cabinet Member for Social Services, Housing, Health and Wellbeing to award a contract to the incumbent provider under a new specification for one year. During this time it will be possible to review the hospital discharge model, the support arrangements required to sustain it and appropriate procurement options. Funding for this service in 2018/19 is being provided through additional hospital pressures funding made available by the Department of Health.

- *Step-down bed management*: NHS partners have commissioned 14 step-down beds in two care homes in the Borough and it is proposed that the Council manage the flow through these beds. Funding for the social care staff required to undertake this task is being made available through the additional hospital pressures money referred to above.

8. It is proposed to address the governance implications of the above through amendments to the BCF section 75 between the Council and the CCG. The Leader of the Council and the Cabinet Member for Social Services, Housing, Health and Wellbeing and HCCG's Governing Body will be asked to consider a report on the proposed amendments for 2018/19 in Q4. A memorandum of understanding will confirm operational arrangements between the Council and other health partners.

Supporting Carers

9. NHSE has developed a template for a local memorandum of understanding (MoU) between partners to co-operate with each other, to promote the wellbeing of individual Carers and to adopt a whole family approach in their work to support local Carers of all ages. This also includes seven principles which local partners are using to frame a proposed updated Carers' Strategy. The draft strategy will be submitted for consideration to the Council's Cabinet and HCCH Governing Body in Q1 2018/19. In the meantime, partners are being asked to sign-up to the MoU, which reflects a recognition by the Hillingdon health and care community of the importance of the role of Carers to the sustainability of the local health and care system and is consistent with BCF scheme 2: *An integrated approach to supporting Carers*. The MoU is a statement of intent and not a legal document.

10. The seven principles contained within the MoU are:
- *Principle 1* – We will support the identification, recognition and registration of Carers in primary care.
- *Principle 2* - Carers will have their support needs assessed and will receive an integrated package of support in order to maintain and/or improve their physical and mental health.

- *Principle 3* - Carers will be empowered to make choices about their caring role and access appropriate services and support for them and the person they look after.
- *Principle 4* – The staff of partners to this agreement will be aware of the needs of Carers and of their value to our communities.
- *Principle 5* - Carers will be supported by information sharing between health, social care, Carer support organisations and other partners to this agreement.
- *Principle 6* - Carers will be respected and listened to as expert care partners, and will be actively involved in care planning, shared decision- making and reviewing services.
- *Principle 7* - The support needs of Carers who are more vulnerable or at key transition points will be identified early.

11. The partners being asked to sign-up to the MoU include:
- The Council;
- Hillingdon Clinical Commissioning Group;
- The Hillingdon Hospitals NHS Foundation Trust;
- Central and North West London NHS Foundation Trust;
- Hillingdon GP Confederation;
- H4All; and
- The Hillingdon Carers' Partnership

2018/19 BCF Plan Requirements

12. From feedback received from the NHSE Better Care Support Team it is expected that a template will be received at some point during Q4 seeking details of any revisions to the metrics, progress in delivering the high impact change model to improve discharge from hospital and also changes in financial contributions to the pooled budget. The template is unlikely to be available until after the publication of the NHS Mandate, which is expected by the end of March. The Mandate will determine the approach that will also be taken about whether a DTOC target will be imposed on Hillingdon for 2018/19, which reflects the 2017/18 position.

Post-April 2019 Position

13. The current 2017/19 BCF plan ends on the 31st March 2019. At time of drafting no information was available about the Government's intentions after expiry of the current plan, although feedback from the NHSE Better Care Support Team suggests that this may be influenced by both the NHS Mandate and the social care green paper due to be published in the summer of 2018.

Conclusions

14. Performance against key indicators for the review period is so far showing a mixed picture regarding the impact of the considerable amount of work in progress on the health and care system. One area showing considerable improvement is in respect of DTOCs where the projected outturn for the year is suggesting that performance will be significantly below the nationally set ceiling. However, there some areas that require more intensive analysis in order to more fully understand the reasons behind the data, e.g. emergency admissions from care homes.

15. The review period has seen the implementation of the integrated homecare service pilot, which represents considerable progress in integration between health and social care. This has so far enabled the Social Care homecare capacity requirements to be met but it is as yet too

early to draw any conclusions about system impact at this stage. A full update will be included in the Q4 performance update.

16. The work in progress between the partners on the hospital discharge model should transform the way that the discharge process within Hillingdon Hospital is managed and improve the experience of care for patients.

Financial Implications

17. The Quarter 3 performance report for the Better Care Fund shows a forecast net underspend for 2017/8 of £169k against the approved pooled BCF budget of £36,815k. This forecast underspend arises from staff vacancies in the Council's Reablement team and reductions in the prescribing of Community Equipment offset mainly by forecast overspends in the Council's provision of packages of care and the Telecareline Service. 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?

18. *Performance report* - The monitoring of the BCF ensures effective governance of delivery via the Health and Wellbeing Board.

19. *Carers' memorandum of understanding* (MoU) - The existence of a specific scheme dedicated to supporting Carers in the BCF shows recognition by health and care partners of the critical role that they have in supporting the health and care system. The proposed MoU establishes a set of key principles that create an opportunity to deliver a consistent approach to supporting Carers across health and care partners in Hillingdon. Signing up to the MoU would demonstrate the commitment of the partner organisations to abide by the principles. A Carers' Strategy and delivery plan framed around the principles would then show how this would be done within the context of available resources.

20. *Delegated authority* - The recommendation is intended to give flexibility to allow targets to be agreed within nationally set timescales where there is local satisfaction that they are deliverable. The recommendation does not prevent the Chairman from directing that proposed targets should be discussed at a full Board meeting should he wish to do so.

Consultation Carried Out or Required

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

Policy Overview Committee Comments

22. None at this stage.

CORPORATE IMPLICATIONS

Corporate Finance Comments

23. Corporate Finance has reviewed this report and notes that there are no direct financial implications associated with the recommendations therein. It is further noted that a net

underspend of £169k is projected against the Council managed elements of the pooled Better Care Fund Budget.

Hillingdon Council Legal Comments

24. 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 7 - 9: Oct - December 2017.
Appendix 2) BCF Metrics Scorecard.

Appendix 1

BCF Monitoring Report

Programme: Hillingdon Better Care Fund	
Date: March 2018	**Period covered:** Oct - Dec 2017 - Month 7 - 9
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**	
	a) Finance	
	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.

BCF Financial Summary 2017/18					
Key Components of BCF Pooled Funding (revenue unless classified as Capital)	**Approved Pooled Budget 2017/18**	**Forecast Outturn to March 2018**	**Variance as at Quarter 3**	**Variance as at Quarter 2**	**Movement from Quarter 2**
	£000's	£000's	£000's	£000's	£000's
Hillingdon CCG - Commissioned Services	17,158	17,158	0	0	0
LB Hillingdon - Commissioned Services	15,842	15,673	(169)	(126)	(42)
LB Hillingdon - Commissioned Capital Expenditure	3,815	3,815	0	0	0
Overall Totals	**36,815**	**36,646**	**(169)**	**(126)**	**(42)**

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'* mean Q3 2017/18 unless otherwise stated.

1.3 **Emergency admissions target (also known as non-elective admissions)** - *Not on track*: There were 2,869 emergency admissions of people aged 65 and over in Q3 compared to 2,514 during the same period in 2016/17. Projections based on April to December 2017 activity data suggest an outturn for 2017/18 of 11,088 against a ceiling of 9,428. The outturn for 2016/17 was 10,249, which is therefore suggesting a possible 8% increase in activity in 2017/18 on the previous year.

1.4 75% of emergency admissions for the 65 and over age group in the April to December 2017 period were to Hillingdon Hospital, which is showing a nearly 13% increase (from 4,821 admissions to 6,246) compared to the same period in 2016/17. The other 25% of admissions was to hospitals such as Northwick Park, Watford General, etc. During the period April to December 2017 there has been a 16.5% increase in emergency admissions to Hillingdon across all age groups but with the most significant increase in the 18 to 64 age group. There has also been an increase in the number of people being admitted with a single diagnosis and a length of stay of less than 48 hours. Overall during the review period there has been a reduction in length of stay for people admitted as a result of an emergency.

1.5 **Delayed transfers of care (DTOCS)** - *On track*: Table 1 below suggests that on a straight line projection based on activity during the period April to December 2017 could be -1,925 delayed days below the ceiling set for Hillingdon by NHSE. Table 1 also shows that the projections for delays attributed to the NHS, Social Care and both the NHS and Social Care are likely to be below the ceilings set for each.

Table 1: April - Dec 2017 DTOC Breakdown						
Delay Source	**Acute**	**Non-acute**	**Total**	**2017/18 Target**	**Projection 2017/18**	**Variance**
NHS	1,790	1,794	3,584	6,005	4,779	-1,226
Social Care	478	1,164	1,642	2,271	2,189	-82
Both NHS & Social Care	39	294	333	1,062	444	-618
Total	**2,307**	**3,252**	**5,559**	**9,337**	**7,412**	**-1,925**

1.6 During the period April to December 2017 nearly 17% (943) of all delays, e.g. health and social care, were attributed to issues with securing residential care placements and 20% (1,134) to difficulties with securing nursing home placements. Nearly 66% (233) of all social care delays in Q3 were related to issues in securing care homes placements. Nearly 51% (178) in Q3 of the social care delays related to residential care home placements and nearly 16% (55) to nursing homes. A combination of difficulties in securing placements for people with the more challenging behaviours as well as complex family dynamics are the main factors contributing to these delays.

1.7 **Permanent admissions to care homes target** - *Not on track*: During the period 1st April to 31st December 2017 there were 134 permanent admissions to care homes. On a straight line projection this suggests an outturn for 2017/18 of 179 permanent admissions against a ceiling of 150 for the year. The issue has been entering care homes as a short-term measure converting to permanent placements, which is attributed to the speed with which people become institutionalised. The aim is to avoid people going into care homes at all and the opening of the new extra care sheltered housing schemes will provide an alternative care setting. This will also include step-up provision that will enable people to have a short respite from their own home where a period of convalescence is required. Some clarity about the definition is also being sought from NHSE that may impact positively on the outturn.

1.8 **Percentage of people aged 65 and over still at home 91 days after discharge from hospital to reablement** - *On track*: The position to the end of December 2017 showed an average of 89% of people still at home 91 days after discharge against a target of 88%. However, it should be noted that the review period for the purposes of the national metric is Q3 and that verified results will not be available until May 2018.

2. Scheme Delivery

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

Scheme 1 Funding	Approved Pooled Budget 2017/18	Forecast Outturn to March 2018	Variance as at Quarter 3	Variance as at Quarter 2	Movement from Quarter 2
	£000's	£000's	£000's	£000's	£000's
Hillingdon CCG - Commissioned Services	2,353	2,353	0	0	0
LB Hillingdon - Commissioned Services	1,245	1,270	25	(0)	25
LB Hillingdon - Commissioned Capital Expenditure	3,815	3,815	0	0	0
Overall Totals	**7,413**	**7,438**	**25**	**(0)**	**25**

Scheme Financials

2.1 There is currently a forecast £25k pressure on the Telecareline service provided by the Council. Expenditure commissioned by Hillingdon CCG is on target with their pooled budget share.

Scheme Delivery

2.2 *Connect to Support* - From 1st October to 31st December 2017, 3,251 individuals accessed Connect to Support and completed 4,883 sessions reviewing the information & advice pages and/or details of available services and support. The volume of activity is consistent with the same period in 2016/17.

2.3 During Q3, 24 people completed online social care assessments and 11 were by people completing it for themselves and 13 by Carers or professionals completing on behalf of another person. 24 self-assessments were 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 were 7 self-assessments undertaken by Carers during the first half of 2017/18.

2.4 A refresh of Connect to Support will be undertaken during Q4 and a programme to promote the system delivered in 2018/19. The Council and NHS partners will also be working together to establish an interface with NHS information systems.

2.5 *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.

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

- *A. 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 72 people showed an improvement in their PAM scoring. 11 people showed a decrease in their score. Research by the University of Oregon in 2013 suggests that just 1 point improvement in a person's PAM score can result in an equivalent to £400 a year saving to the NHS.

- *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.

- A full report on the outcomes of the use of this tool will be reflected in the Q4 performance update.

- *C. Service User Experience Satisfaction Questionnaires* - During Q3 there were 148 respondents to satisfaction questionnaires and the results are shown in table 2 below.

Table 2: H4All Wellbeing Services Satisfaction Survey Results

Nature of Enquiry	Satisfied with Outcome			Unknown/ NA
	Yes	No	Partially	
Improved Health & Wellbeing	45	45	53	5
Reduced Social Isolation	71	48	22	8
Less Contact with Health Services	33	66	37	13
Help to Manage Long-term Condition	34	2	3	82
Appropriate Service Received	132	5	10	2
Additional Support Required	18	9	8	4
Would Use the Service Again	139	-	1	8
Effective Signposting/Referral	22	3	4	113

2.7 *Care Connection Teams* - At the end of December 14 out of the intended 15 CCTs were operational and carrying a caseload of 706 people. In the period between April and December 2017 was 2,016 people were referred to the CCTs. The methodology to assess the impact for the individual on their emergency activity before and after the interventions by the CCTs is

currently being finalised, but clinicians working in the service estimate that just under 2,000 hospital admissions were avoided. Admissions avoided included cases where people with a urinary tract infection (UTI) or respiratory tract infection (LRTI) and they 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.

2.8 *Falls-related Admissions* - In the period April to December 2017 there were 644 falls-related emergency admissions to hospital compared to 607 during the same period in 2016/17. This suggests a 2017/18 outturn of 858 admissions on a straight line projection against a ceiling of 787. Further analysis is required in order to understand the reasons behind these figures, e.g. the extent to which it is attributable to increasing frailty and/or the number of persistent fallers. Possible linkages between the increase in admissions from care homes and the increase in number of admissions attributable to falls will also be explored and the outcome reported to in the next performance update.

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

Scheme 2 Funding	**Approved Pooled Budget 2017/18**	**Forecast Outturn to March 2018**	**Variance as at Quarter 3**	**Variance as at Quarter 2**	**Movement from Quarter 2**
	£000's	£000's	£000's	£000's	£000's
Hillingdon CCG - Commissioned Services	18	18	0	0	0
LB Hillingdon - Commissioned Services	862	863	1	21	(20)
Overall Totals	**880**	**881**	**1**	**21**	**-20**

Scheme Financials

2.9 Expenditure on target with Pooled Budget.

Scheme Delivery

2.10 269 Carer's assessments were completed during the review period. The projected outturn for 2017/18 on a straight line projection is 890 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.

2.11 During the review period 240 Carers were provided with respite or another carer service at a cost of £377k. This compares to 178 Carers being supported at a cost of £376k 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.

The reason for the apparent reduction in unit cost of support to Carers is that the financial figures do not include those circumstances where respite is included against the cared for person's support plan. This means that it is not possible to accurately cost the support being provided to Carers.

2.12 *Identification of Carers* - At 31st December 2017 there were 6,641 Adult Carers and 804 Young Carers registered with the Hillingdon Carers' Partnership (HCP). Q3 saw 228 new Adult Carers and 30 new Young Carers register. Newly-registering Carers are now offered a Carer's Assessment as part of the registration process.

2.13 *Young Carers* - Following a six-month pilot funded via the Council's Carers in Hillingdon contract with the Hillingdon Carers' Partnership, Hillingdon Carers started a new Family Support Service with a three-year grant from Children In Need. The service offers short-term but intensive support to 'complex' families with Young Carers. By addressing the wider social issues of the whole family, the child(ren) can be better supported. Families supported under this programme usually involve mental health or drug and alcohol issues.

2.14 A new Cognitive Behavioural Therapy (CBT) programme for Young Carers called 'Headquarters' started in Q3. This is a four-session programme of emotional support workshops with seven young carers (10-14 years). It was developed by a member of the Hillingdon Carers' staff team who has a degree in Psychology and is studying for an MSc in Clinical Psychology.

Cognitive Behavioural Therapy Explained
CBT is a talking therapy that can help a person to manage their problems by changing the way they think and behave. It's most common use is to treat anxiety and depression.

2.15 Referrals to HCP from schools in the Borough have risen by 47% in Q2 and Q3. This has largely been as a result of a) outreach activity and new Schools Guide to Supporting Young Carers; and b) the strategic links available through the new Young Carers Strategy Group e.g. access to central meetings of school governors.

2.16 *Supporting working Carers* - The Working for Carers programme – a pan-London initiative funded through Big Lottery and the European Social Fund is now well-established. Activity in Hillingdon in Q3 is as follows:

- 3 Hillingdon workshops
- Weekly drop-in Employment Advice sessions
- 3 Hillingdon carers supported back into employment
- 2 carers into volunteering

2.17 Working carers have access to the Healthier Carers Hillingdon programme and during Q3 12 working carers received 6 x 1:1 personal training sessions at a time and venue to suit their working patterns and 15 accessed a series of evening health and wellbeing workshops.

2.18 *External funding* - During Q3 an additional £111k was secured from the Henry Smith Foundation to support young adult Carers in transition from school into whatever comes next for them. The grant is for the period 1st November 2017 to 31st July 2018.

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

Scheme 3 Financials	Approved Pooled Budget 2017/18	Forecast Outturn to March 2018	Variance as at Quarter 3	Variance as at Quarter 2	Movement from Quarter 2
	£000's	£000's	£000's	£000's	£000's
Hillingdon CCG - Commissioned Services	992	992	0	0	0
LB Hillingdon - Commissioned Services	50	50	0	0	0
Overall Totals	**1,042**	**1,042**	**0**	**0**	**0**

Scheme Financials

2.19 Expenditure on target with Pooled Budget.

Issues/Risks

2.20 This scheme is rated as amber because of delays in recruiting to all of the posts in the single point of access and overnight nursing service to be provided by CNWL that will improve access to the right end of life care and support. The intention was that the service open in February 2018 but it is critical that all of the staff posts have people in place to ensure the effectiveness of the service. Recruitment issues mean that the service unlikely to open until Q1 2018/19.

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

Scheme 4 Funding	Approved Pooled Budget 2017/18	Forecast Outturn to March 2018	Variance as at Quarter 3	Variance as at Quarter 2	Movement from Quarter 2
	£000's	£000's	£000's	£000's	£000's
Hillingdon CCG - Commissioned Services	11,406	11,406	0	0	0
LB Hillingdon - Commissioned Services	4,607	4,417	(190)	(230)	40
Overall Totals	**16,013**	**15,823**	**(190)**	**(230)**	**40**

Scheme Financials

2.21 There is currently a forecast underspend of £305k mainly arising from staffing vacancies in

the Council's reablement service and reductions in the Community Equipment budget of £68k offset by pressures from the granting of care packages of £183k. Expenditure commissioned by Hillingdon CCG is on target with the pooled budget share.

Scheme Delivery

2.22 *Discharge to Assess (D2A)* - The first half of 2017/18 was the testing phase of the D2A model. Three discharge pathways were agreed under this model 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.

2.23 Whilst there has been a reduction in length of stay for people aged 65 and over from 10.9 days between April and December 2017 to 8.6 days during the same period in 2016/17, D2A has not significantly impacted on the number of *'stranded'* patients in the Hospital, i.e. people admitted for seven days or more.

2.24 To address the demand surge that generally occurs during the winter period the Council, the Hospital, CNWL and the CCG have worked closely to develop the hospital discharge model. This included the Council establishing a block contract with a homecare provider for 120 hours care per week specifically to support hospital discharge. The cost of this was underwritten by the Hospital. Finalisation of the discharge model will take place in Q4 with the aim to start the implementation process before the end of 2017/18.

2.25 *Introduction of monthly liaison meetings between Mental Health & Housing* - This started in October 2017 and has assisted in addressing issues at a much earlier stage. This is also being combined with training for mental health teams on the scope of the Council's homelessness responsibilities. Training is also being provided for Housing staff to raise awareness of the needs of people living with mental health conditions.

2.26 *Seven day working* - Table 3 illustrates performance against seven day metrics at Hillingdon Hospital and shows that performance is comparable with 2016/17 activity but some distance away from the 2017/18 targets.

Table 3: Hillingdon Hospital Discharges before Midday and at Weekends			
Item	**2017/18 Target**	**2016/17 Baseline**	**Q1 - Q3 2017/18 Outturn**
Medicine Directorate, inc A & E			
Discharges before midday	33%	21.3%	20.2%
Weekend discharges	65%	16.2%	16.9%
Surgery Directorate			
Discharges before midday	33%	19.2%	18.6%
Weekend discharges	65%	20.9%	12.9%

2.27 *Reablement Team activity* - During Q3 the Reablement Team received 195 referrals and of these 158 were from hospitals, primarily Hillingdon Hospital and the other 37 were from the community. The community referrals represented potential hospital attendances and admissions that were consequently avoided. During the review period there were 80 referrals of new people to the service and of these nearly 88% (70) completed their period of reablement with no on-going social care needs, which is above the target of 85%.

2.28 *Rapid Response Team activity* - In Q3 the Rapid Response Team received 1,136 referrals, 62% (701) of which came from Hillingdon Hospital, 22% (252) from GPs, 9% (99) from community services such as District Nursing and the remaining 7% (84) came from a combination of the London Ambulance Service (LAS), care homes and self-referrals. Of the 701 referrals received from Hillingdon Hospital, 54% (382) came from A&E, of which 212 (55%) were discharged with Rapid Response input, 145 (38%) following assessment were not medically cleared for discharge and 25 (7%) were either out of area or inappropriate referrals. 20% (136 of 701) came from Homesafe, 26% (184 of 701) came from Discharge to Assess. All 435 people referred from the community source received input from the Rapid Response Team. There's also been a reduction in hospital usage of the Rapid Response Team since spring 2017and work is underway to strengthen pathways of care back into the community from A&E.

2.29 *Hospital Discharge Team activity* - The Council's Hospital Discharge Team supported the early discharge of 197 people from Hillingdon Hospital and Mount Vernon Hospital during Q3 and also 76 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 643 bed days avoided, thereby assisting the Hospital with patient flow. For other hospitals 355 bed days were avoided.

2.30 *DFGs* - During the review period 64 people aged 60 and over were assisted to stay in their own home through the provision of disabled facilities grants (DFGs), which represented 66% of the grants provided. 27% (17) of the people receiving DFG's were owner occupiers, 70% (45) were social housing tenants and 3% (2) were private tenants.

Issues/Risks

2.31 During the review period nearly 37% (273) 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. The work referred to in paragraph 2.25 to develop the hospital discharge model should address this issue.

2.32 The RAG rating of this scheme is attributed to a number of items within the DTOC action plan where there has been slippage (including significant slippage) and these include:

Acute Care, e.g. Hillingdon Hospital

- *Establish robust systems for verifying numbers of delayed transfers of care prior to submission by providers to NHS Digital* - Changes in personnel at Hillingdon Hospital has resulted in some issues regarding the verification of DTOCs in Q3. This will be addressed by the creation of written procedures that will in the future militate against the risks posed by movement of staff within partner organisations. Work is also in progress with CNWL to address a similar issue in respect of mental health-related DTOCs.

- *Establish electronic transfer of assessment and discharge notices and withdrawal and change of circumstances notices* - Progress has been delayed due to a technical issue that ICT Teams within the Council and Hillingdon Hospital are seeking to address.

- *Complete development of a joint discharge policy based on patient choice* - This will be completed once there is final agreement on the integrated hospital discharge model.

- *Review weekend infrastructure requirements at THH to support seven day working* - The issue for the Hospital is the consistent availability of medical decision making capacity, pharmacy and transport to support discharges at weekends.

- *Establish trusted assessor arrangements between health and care partners and care home providers* - The outcome of this action would be to expedite discharge of people from the Hospital where a care home was the appropriate destination. It would mean that care homes would accept assessments from health professionals without the need to undertake their own assessments. Discussions with care home managers on taking this forward will be started in Q4 and this will include how to address their concerns about the consistent accuracy and reliability of assessments.

Mental Health

- *A section 117 funding split policy to be developed between the Council and HCCG* - Section 117 after care is provided to people free of charge who have previously been detained in a mental health hospital under the 1983 Mental Health Act. A tool and protocol has now been developed and is awaiting approval by the CCG.

- *Review Funding Panel decision-making process* - A workshop in Q4 will look at the operation of the panels and how the decision-making process can be expedited.

- *Training and guidance to staff to improve quality of cases presented to the Funding Panel to expedite decision-making* - This will now take place in Q1 2018/19 once the review of the decision-making process has been completed.

- *Establish a joint mental health/housing working protocol* - This will be completed in Q4.

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

Scheme 5 Financials	Approved Pooled Budget 2017/18	Forecast Outturn to March 2018	Variance as at Quarter 3	Variance as at Quarter 2	Movement from Quarter 2
	£000's	£000's	£000's	£000's	£000's
Hillingdon CCG - Commissioned Services	2,389	2,389	0	0	0
LB Hillingdon - Commissioned Services	8,695	8,694	(1)	84	(85)
Overall Totals	**11,084**	**11,083**	**(1)**	**84**	**(85)**

Scheme Financials

2.33 Expenditure on target with Pooled Budget.

Scheme Delivery

2.34 *Integrated homecare* - The new contract started in November for the Dynamic Purchasing System intended to address the homecare needs of the CCG and provide additional capacity for the Council where existing block contract providers are unable to assist. This is a two year pilot that is intended to help inform the model from October 2019 when the Council's block homecare contracts end. The pilot represents an increase in the integration ambitions of both the Council and the CCG.

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.

2.35 *Emergency admissions from care homes - Not on track*: During the review period there were 609 emergency admissions of people aged 65 and over from care homes. On a straight line projection this would suggest a total of 812 admissions during 2017/18, which would represent a 3% increase on the 2016/17 outturn of 791 admissions. 77% of admissions from care homes were to Hillingdon Hospital, which has seen a nearly 10% (45) increase on the same period in 2016/17. 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.

2.36 As a result of this data there will be more detailed analysis that will also consider London Ambulance Service (LAS) conveyances to Hillingdon Hospital, reasons for conveyance and length of stay post admission. The latter will help to shape conclusions about the appropriateness of admission.

2.38 *Care homes* - A pilot support service for four care homes started run by a GP with a specialist interest started. This will help to inform the model of GP support for care homes and extra care schemes which the CCG's Governing Body will be asked to consider in Q4.

2.37 *Care homes* - Training for care home staff on the better management of falls, a major cause of admissions to hospital from care homes, concluded. All 30 care homes supporting older people have receiving briefings in using a specially designed falls pack that provides information about key issues and approaches and 28 of these homes have sent staff on falls management training. The remaining two homes wished to rely on their corporate in-house training and corporate processes and procedures.

2.38 *Support for extra care sheltered housing schemes* - The new contract for the Care and Wellbeing Service provided in the Council's two existing extra care schemes, Cottesmore House and Triscott House, started in November. The provider, Carewatch Services Ltd will also be providing care in the two new schemes, Grassy meadow Court and Park View Court, due to open in June and September 2018 respectively. Mobilisation work is in progress and task and finish groups have been established to focus on the significant and varied actions required to deliver these schemes, which also includes how health needs of tenants will be addressed.

Issues/Risks

2.39 This scheme is RAG rated as amber against delivery because of performance against emergency admissions from care homes metric.

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

Scheme 6 Financials	Approved Pooled Budget 2017/18	Forecast Outturn to March 2018	Variance as at Quarter 3	Variance as at Quarter 2	Movement from Quarter 2
	£000's	£000's	£000's	£000's	£000's
Hillingdon CCG - Commissioned Services	0	0	0	0	0
LB Hillingdon - Commissioned Services	300	299	(1)	(0)	(1)
Overall Totals	**300**	**299**	**(1)**	**(0)**	**(1)**

Scheme Financials

2.42 Expenditure on target with Pooled Budget.

Scheme Delivery

2.43 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:

- ***Tovertafel -*** 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. The first Tovertafel was installed in Uxbridge library and launched on the 24th November. A regular Friday group has been established with between 6-14 older people attending to *'play'* with the table weekly. Some older people have started to book to come and use the table in their own time. Work is currently underway to develop an efficient booking system which can accommodate both groups and individuals. A further three tables are due to be installed at Northwood Hills, Ruislip Manor and Botwell libraries.

- ***Dementia Action Alliance*** - The final Alliance meeting of the year was held on the 15th November at Uxbridge Library. 23 partners attended. The event showcased the Tovertafel to partner organisations. As a result there have been requests from a Care Home and the Memory Clinic to bring a group in to Uxbridge library to use the Tovertafel. The Alliance will be working towards gaining dementia friendly accreditation in 2018. A series of topic based events were agreed for the new year including a first event in February focused on 'building a dementia friendly generation.' The Alliance currently has 27 partner organisations.

- ***Dementia Coffee Mornings*** - The coffee mornings continue at both libraries with members now attending other activities such as the Tovertafel sessions and events. There are regular new attendees at Uxbridge and new links were established with Triscott House to promote residents attendance at the Botwell Coffee morning. Overall there are 40 older people who regularly make use of the coffee mornings.

- ***Dementia Friends*** - Three sessions were held with a total of 15 people attending. Sessions are now booked on a bimonthly basis for 2018.

- ***Dementia Friendly Walk*** - The walks continue although attendance has been low during the colder weather. Plans are to link the walk with Grassy Meadow Court when it opens in the summer.

- ***Christmas Extravaganza*** - This was held at the Civic Centre on the 28th November for people living with dementia and older people who are housebound or socially isolated. A total of 95 older people attended the event. Transport was provided. Feedback included several older people stating this was the first time they had been out of the house in a long while. A further event is planned for Q4.

BCF Programme Management Costs

Programme Management Costs	Approved Pooled Budget 2017/18	Forecast Outturn to March 2018	Variance as at Quarter 3	Variance as at Quarter 2	Movement from Quarter 2
	£000's	£000's	£000's	£000's	£000's
BCF Programme Management Expenditure	82	82	0	0	0
Overall Totals	**82**	**82**	**0**	**0**	**0**