SOCIAL CARE, HOUSING AND PUBLIC HEALTH POLICY OVERVIEW COMMITTEE - BETTER CARE FUND PLAN UPDATE

Committee name	Social Care, Housing and Public Health Policy Overview Committee
Officer reporting	Gary Collier, Adult Social Care Services
Papers with report	Appendix 1 - 2018/19 Better Care Fund Delivery Plan
Ward	All

HEADLINES

To provide the Committee with an update on progress with delivering the 2017/19 Better Care Fund Plan.

RECOMMENDATIONS:

That the Committee notes the report and questions officers about the plan and its delivery.

SUPPORTING INFORMATION

Introduction

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

2. The BCF plan is seen by both the Council and HCCG as a delivery vehicle for those aspects of the 2018 - 2021 Joint Health and Wellbeing Strategy that require integration between health and social care and/or closer working between the Council and NHS partners to implement. The primary focus of the 2017/19 plan (as in previous iterations) is on older people, i.e. people aged 65 and over.

3. Hillingdon's 2017/19 BCF plan was formally submitted on the 27 September 2017 and an approval letter was received on the 30 October 2017. The financial arrangements contained within the BCF plan, e.g. operation of the pooled budget, are governed by an agreement established under section 75 of the National Health Service Act, 2006, and this was approved by both Cabinet and the HCCG's Governing Body in December 2017.

4. This report provides the Committee with a progress report on delivery of the plan during 2018/19 and references in the report to the *'review period'* refer to April to September 2018 unless otherwise stated. A summary of the delivery plan for 2018/19 can be found in Appendix

5. The Committee can access the full range of the documents that formed Hillingdon's formal submission to NHS England (NHSE) by following this link:
https://www.hillingdon.gov.uk/article/28647/Introducing-the-Better-Care-Fund

Integration Explained

6. The BCF was introduced to contribute to the Government priority of achieving full integration between health and social care by 2020. The characteristics of full integration were set out in the 2017/19 *Integration and Better Care Fund Policy Framework* and are summarised in table 1 below.

Table 1: Characteristics of Full Integration

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

7. The approach to integration in Hillingdon has been to develop this incrementally where this will demonstrably deliver benefits for residents. The Committee will see later in this report how some of the characteristics in table 1 above are reflected in the schemes within the 2017/19 plan, e.g. integrated brokerage, integrated homecare, nursing care home commissioning.

8. HCCG's preferred vehicle for delivering integration within the local health system is the ICS. The ICS in Hillingdon is known as Hillingdon Health and Care Partners (HHCP) and comprises of Central and North West London Foundation Trust (CNWL), The Hillingdon Hospitals, the GP Confederation and H4All, a consortium of local third sector organisations that includes Age UK, the Disablement Association Hillingdon (DASH), Harlington Hospice, Hillingdon Carers and Hillingdon Mind. The Hillingdon ICS is still in development and the Council's approach continues to be to keep a watching brief over progress rather than be a formal member, but keep the option of joining at an appropriate point in the future open. However, as said in paragraph 2, the BCF

provides the mechanism for delivering integration with NHS partners where this will benefit residents and support the health and care system at a manageable level of risk for the Council.

2017/19 BCF Plan Objectives

9. Key objectives of the plan include:

- Addressing some of the financial pressures associated with increasing numbers of older people through developing a more integrated model of care where people are supported to remain in their usual place of residence.

- Embedding the shift to planning for anticipated care needs and coordinating care around the person, their family and Carers and supporting self care rather than crisis management and reactive provision of services.

- Reducing fragmentation of service provision should help to improve patient flow through the Hospital and improve their experience of care, as well as alleviating the need for and cost of escalation beds.

- Developing a more integrated approach to managing the private market to improve capacity by making the public sector locally easier to do business with and thereby shape the market.

2017/18 BCF Plan Schemes Summary

10. The 2017/19 plan comprises of six schemes as summarised below:

- Scheme 1: Early intervention and prevention - This scheme seeks to manage demand arising from demographic pressures through early identification of people at risk as a result of a process of care planning in GP surgeries and the provision of support through the voluntary sector to promote self-care and manage risk factors such as social isolation.

- Scheme 2: An integrated approach to supporting Carers - The key objective of this scheme is to maximise the amount of time that Carers are willing and able to undertake a caring role.
- Scheme 3: Better care at end of life - The main goals of the scheme are to ensure that people at end of life are able to be cared for and die in their preferred place of care

- Scheme 4: Integrated hospital discharge - This scheme seeks to prevent admission and readmission to hospital following an escalation of need. An aim is to maximise a person's independence by expediting their return to their usual place of residence following a hospital admission.

- Scheme 5: Improving care market management and development - This scheme seeks to develop a local market capable of meeting the health and care needs of the Hillingdon's residents within financial constraints. It also seeks to develop a diverse market of quality providers to maximise choice for residents.

- Scheme 6: Living well with dementia - This scheme seeks to maximise the wellbeing of people living with dementia and that of the people caring for them

2017/19 Financial Arrangements

11. The BCF regulations require the Council and Hillingdon Clinical Commissioning Group (HCCG) to establish a pooled budget, which is intended to make it easier to address need. This is because the key benefit of a pooled budget is that the funding going into it from a local authority and the NHS loses its separate identity, thus enabling the focus to be more about addressing the need rather than whether it is health or social care related. There are requirements about the minimum contributions that the Council and HCCG have to contribute and in both 2017/18 and 2018/19 both organisations have contributed more than was required. However, as most this money is tied up in existing contracts this has diluted the potential opportunities presented by the BCF concept.

12. The financial contributions to the BCF pooled budget are summarised in table 2 below. This includes £6,085k in 2017/18 and £6,263k in 2018/19 passported from the NHS via HCCG to protect social adult care and also £4.1m in 2017/18 and £2.9m that came directly from the Ministry of Housing, Communities and Local Government to support social care it was mandated should be included.

Table 2: Council and HCCG Financial Contributions Summary

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

Measuring Success

13. The success of the plan is measured against a combination of four nationally determined metrics, a range of scheme specific metrics and implementation of the agreed delivery plan. Hillingdon is required to report performance against the national metrics to NHSE on a quarterly basis. There is no requirement to report on the scheme specific metrics.

14. **Performance against national metrics** - For the purposes of the 2017/19 plan there are four reportable metrics and performance against these in 2018/19 is shown below.

15. ***Emergency admissions target (also known as non-elective admissions): Not on track*** - The ceiling for 2018/19 is 11,400. There were 5,736 emergency admissions of people aged 65 and over during the April to September 2018 period. On a straight line projection this would suggest an outturn for 2018/19 of 11,472 and therefore above the ceiling, although close to it.

16. ***Delayed transfers of care (DTOCS)****: On track* - Hillingdon's was very successful in 2017/18 in achieving 2,796 delayed days below the ceiling of 9,338 delayed days imposed by NHS England. The 2017/18 success led to the most exacting ceiling in London being set for Hillingdon for 2018/18, which 4,991 delayed days. Table 3 below shows that there were 2,398 delayed days in the period April to September 2018. On a straight line projection this would suggest an outturn for 2018/19 of 195 delayed days below the ceiling for the year. However, this is subject to the severity of the winter.

Delayed Transfers of Care (DTOCs) defined

A DTOC occurs when a patient is ready for transfer from a hospital bed, but is still occupying the bed. A patient is ready for transfer when:

a) A clinical decision has been made that the patient is ready for transfer; AND
b) A multi-disciplinary team decision has been made that the patient is ready for transfer;
c) The patient is safe to discharge/transfer.

17. In respect of Hillingdon's comparative position, there were seventeen areas in London where the total number of DTOCs was higher than Hillingdon's, fourteen areas higher for delays attributed to the NHS, nineteen for social care and seventeen for delays attributed to both the NHS and Social Care.

Table 3: DTOC Performance April - September 2018						
Delay Source	Acute	Non-acute	TOTAL	2018/19 Ceiling (Delayed Days)	Projection	Variance
NHS	997	775	1,772	3,289	3,544	255
Social Care	263	312	575	1,392	1,150	-242
Both NHS & Social Care	0	51	51	310	102	-208
TOTAL	1,260	1,138	2,398	4,991	4,796	-195

18. The review period has seen a considerable reduction in the delays in CNWL beds. For example, there were 579 delayed days in CNWL beds during the review period in 2018/19 compared to 1,775 in the same period in 2017/18, which is a 67% reduction. This can be attributed to improvements in discharge planning. The Committee may also wish to note that there have been no delays in CNWL beds for which Social Care has responsibility in 2018/19.

19. Nearly 15% (354) of all delays during the review period, e.g. health and social care, were attributed to issues with securing residential care placements and nearly 26% (635) to difficulties with securing nursing home placements. 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 which continue to be the main causes of these difficulties. The Committee may also wish to note that 99% of people referred to the Council's Brokerage Team for a care home placement are placed between 0 and 2 days and with 0 meaning the day of referral.

19. ***Permanent admissions to care homes target*****:** *Not on track* - There were 86 permanent admissions to care homes in the period April to September 2018, which would suggest an outturn of 172 for the year against a ceiling of 145. Nearly 70% (60) of these placements were conversions of short-term into permanent placements, therefore emphasising the importance of seeking to avoid making short-term care home placements, where possible. The opening of Grassy Meadow Court in October means should start to result in a reduction of permanent placements into residential care. It may also impact on the number of short-term placements that

convert to long-term placements. For the Committee's information there were actually 53 older people living in care homes placed by the Council as at 30th September 2018.

20. ***Percentage of people aged 65 and over still at home 91 days after discharge from hospital to Reablement*****:** *On track* - An average of 94% of service users were still at home 91 days after discharge against a target of 88%. The Committee should be aware that performance against this metric is measured against the number being discharged from hospital into the service in Q3 and still being at home 91 days later.

21. **Scheme Specific Metric Progress** - There a range of scheme specific metrics and this section provides the Committee with the position for the review period where the data was available.

Scheme 1: Early intervention and prevention

22**.** ***Falls-related Admissions: Not on track*** - There 460 falls-related emergency admissions during the review period. On a straight line projection this would suggest an outturn for 2018/19 of 920 admissions against a ceiling of 880 falls-related admissions.

Scheme 2: An integrated approach to supporting Carers

23. ***Carers' assessments:*** *On track* - There were 584 Carers' assessments in were undertaken during the review period. If this level of activity continues throughout the year then could result in 1,048 assessments being undertaken against a target of 1,010. Assessments include those undertaken by the Council and by Hillingdon Carers.

24. ***Carers in receipt of respite or other Carer services*** - During the review period 457 Carers were provided with respite or another carer service at a cost of £779k. This compares to 429 Carers being supported at a cost of £823k during the same period in 2017/18. 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.

Scheme 4: Integrated hospital discharge

25. ***Seven day working: Not on track*** - Table 4 below illustrates performance against seven day metrics at Hillingdon Hospital and shows that performance is lower than 2017/18 activity. The following infrastructure needs to be put in place in order to support seven day discharge:

- Consultant cover to sign off discharges.

- Hospital Discharge Coordinators availability at weekends.
- Transport infrastructure.
- Pharmacy availability.
- Rapid Response cover for weekend triage and assessments.

26. It is the intention of the Hospital consult with its staff about changing terms and conditions to support seven day working but this process will not be completed before the New Year. Funding for additional weekend pharmacy provision has been agreed and the Hospital is in the process of recruiting. There is currently no funding available to support additional Rapid Response provision at weekends.

Table 4: Hillingdon Hospital Discharges before Midday and at Weekends			
Item	2017/18 Baseline	2018/19 Target	April - Sept 2018/19 Outturn
Medicine Directorate, inc A & E			
Discharges before midday	20.4%	33%	18.5%
Weekend discharges	17%	65%*	15.9%
Surgery Directorate			
Discharges before midday	19%	33%	18.8%
Weekend discharges	15.9%	65%*	16.6%

* *Percentage of weekday discharges*

27. The Council continues to have in place provision to support discharges on a Saturday that are notified on a Friday through its Reablement Service and the Bridging Care Service. Any additional social care support could be considered in alignment with the required infrastructure being established by the Hospital as outlined in paragraph 23 above.

Scheme 5: Improving care market management and development

28. ***Emergency admissions from care homes: Not on track*** - There were 167 emergency admissions from care homes during Q1. On a straight line projection this would suggest an outturn for the year of 668 admissions, which is marginally above the target for the year of 637.

29. During the review period 13 care homes in Hillingdon have seen a change of manager, which is a significant factor that contributes to instability. The review period has also seen the expansion of three care homes within a short space of time. For one care home this entailed the opening of another floor comprising of 30 additional beds that are now full. Partners are working with these homes to monitor progress and provide necessary support where required.

30. **Performance against delivery plan milestones** - The following key milestones in the agreed plan shown in Appendix 1 that were delivered were:

Implementation of the 'Red Bag' scheme completed - Training for the final participating care homes was completed and they went live with the scheme. Outcomes from the scheme will be monitored and an update provided to the Board in due course.

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.

Joint Housing and Mental Health protocol pilot implemented: This establishes mechanisms and criteria for referrals and an escalation route where there are blockages. Direct liaison between an identified housing officer at the Riverside Centre, .i.e. adult mental health wards on the Hillingdon Hospital main site, has supported earlier planning and contributed to a reduction in housing-related delayed transfers of care. In addition, improved liaison has helped to reduce the number of people being referred to the Council from the Riverside Centre who are homeless on the day. The protocol will now be refined to reflect experience over the review period and implemented as business as usual.

Launch of End of Life Single Point of Access**:** This became operational in September and is intended to improve access to information and advice and support access to appropriate services.

Launch of Palliative Overnight Nursing Service**:** This service provides out of hours nursing support to people in the last few days or weeks of life where help is needed to manage pain and attend to other nursing needs.

Handover of the Grassy Meadow Court extra care scheme: The first tenant moved into the

scheme on 5 October. The scheme was formally opened by the Mayor of Hillingdon on the 8 November.

***GP support for care homes and extra care*:** 6 locum GPs have been recruited by the GP Confederation, to support 6 care homes and provide care planning. Aim is for all the residents in care homes for older people to have been care planned in this way by end of March 2019. A GP from this service is also attending Grassy Meadow Court on a weekly basis to undertake care planning in respect of health needs.

***Care home staff training programme delivered*:** A programme comprising of training in falls management, tissue viability, nutrition, medication and leadership for managers and/or aspiring managers as well as recognising signs of deterioration has been delivered. This was funded by Health Education North West London and has been promoted by the Council's Quality Assurance Team.

***Hospital Discharge Grant pilot agreed for a three month period*:** This is a non-means tested grant provided utilising flexibilities in the Disabled Facilities Grant Regulations. It is intended to cover adaptations such as the installation of a ramp and a basic stair lift as well as minor works such as home deep cleaning or fumigation, home or garden clearance and furniture removals to make a person's home safer where these will demonstrably expedite a person's return home following a hospital admission.

31. The following milestones were not achieved:

***Development and delivery of a provider engagement plan*:** This will be developed during Q3.

***Opening of Dementia Resource Centre at Grassy Meadow Court*:** This actually took place on 25th October 2018.

Successes and Achievements

32. The following are examples of key achievements during 2018/19, unless otherwise stated.

H4All Wellbeing Service - The Wellbeing Service is key to the delivery of the objectives of scheme 1 of the plan. It is funded by HCCG and the Council provides core grant funding to four of the constituent members of H4All. H4All has reported that the Wellbeing Service received 330 new referrals during the review period and undertook 196 Patient Activation Measure (PAM) assessments. PAM is a tool that measures the extent to which a person is motivated to manage their own long-term conditions. It was reported that 110 people either had an improved score during this period or a score that remained the same following a further assessment. Improved scores are important as studies show that there is a reduction in demand on health and care services the more motivated a person is to manage their long-term conditions.

Integrated brokerage - A 2017/18 achievement, the co-location of HCCG's brokerage team with the Adult Social Care team started in September 2017/18 as a pilot. The purpose of this was to develop a more integrated approach to managing the market that will help to improve quality of service provision and value for money. It was 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. The outcomes of the pilot are currently being evaluated with a view to making this arrangement business as usual.

Integrated homecare - A 2017/18 achievement, a new contract started in November 2017 for a Dynamic Purchasing System (DPS) intended to address the homecare needs of HCCG 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 HCCG.

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.

Carers' Memorandum of Understanding (MoU) - Agreement was secured from statutory health partners such as HCCG, the GP Confederation, Hillingdon Hospital and CNWL, the Council and the third sector partners H4All and the Hillingdon Carers' Partnership to be signatories to the MoU and the principles contained within it that shape how support is provided to Carers in Hillingdon. The Joint Carers' Strategy and related delivery plan will turn these principles into action that will be reported as part of the BCF performance updates and annual reports to the Council's Cabinet and HCCG's Governing Body.

Carers' Champions in GP Surgeries - Carers' champions were identified in 35 of the 43 GP practices in Hillingdon's GP Confederation and the first training event was held on 27th September. The role of the Carer's Champion is to raise awareness of Carer-related issues within surgeries to promote the importance of identifying and addressing their needs.

Care Connection Team Implementation - All 15 of the Care Connection Teams (CCTs) are now operational and are described below.

Care Connection Teams Explained

The 15 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.

The Council's Principal Social Worker attends the regular meetings of the community matrons to ensure linkages with Adult Social Care.

Frailty Assessment Area within Frailty Unit - People attending the A&E at the Hospital are screened for frailty, using a nationally recognised screening tool. This identifies people who would benefit from further in-depth assessment and rather than this happening in the A&E, patients are transferred to the Frailty Assessment Area within the Frailty Unit at THH where they receive a comprehensive assessment from doctors, nurses and therapists specialised in frailty. This service operates Monday to Friday.

Patients may be discharged home on the same day, with appropriate input from the Rapid Response Team or Age UK and rapid follow up, if needed, at an outpatient clinic. Alternatively, patients may be admitted for a short stay (up to 72 hours) to the in-patient beds on the Frailty Unit or to a medical or care of the elderly ward at THH, dependent on their needs.

Frailty Defined

Frailty is related to people getting older. It describes how ageing makes some people vulnerable to sudden and dramatic changes in health triggered by seemingly small events such as a minor infection or a change in medication or environment. In medicine, frailty defines the group of older people who are at highest risk of adverse outcomes such as falls, disability, admission to hospital, or the need for long-term care. Older people with moderate to severe frailty will walk slowly, get exhausted easily and struggle to get out of a chair or climb stairs.

Disabled Facilities Grants - 32 people aged 60 and over were assisted to stay in their own home

through the provision of disabled facilities grants (DFGs) during the review period, which has prevented the need to identify alternative housing options at a time when housing in short supply.

Hospital Discharge Bridging Care Service - In its capacity as the lead organisation for managing the homecare market the Council was asked to commission this service on behalf of HCCG to expedite discharge from the Hospital of people who no longer need to be in a hospital setting to receive treatment. Care is provided for 72 hours after discharge pending a full assessment in the individual's usual place of residence. If there are ongoing care needs a referral to a homecare agency through the homecare DPS referred to above may be made.

Issues and Challenges

33. The following are examples of the issues and challenges faced by Hillingdon's health and care system that influence its ability to manage demographic growth and deliver better outcomes for residents:

- Complexities of the current health and care architecture.
- Protectiveness over organisational sovereignty.
- Partner organisations managing existing deficits.
- Establishing interoperability between IT systems to enable residents to tell their story once and improve efficiency.
- Maintaining workforce stability in a high employment area.

Next Steps

34. ***Post-April 2019 BCF Plan*** - It is understood that the longer-term future of the BCF will be outlined in the forthcoming Adult Social Green Paper, which was scheduled to be published alongside the 10-year plan for the NHS. This is now awaited.

35. Advice from the Better Care Support Team, which is part of NHSE, is that the next iteration of the BCF plan will be for 2019/20 only pending the Green Paper proposals and the details of the next three year spending review due in 2019/20. However, officers have proposed a three year plan to fit local developments and this has been supported. Proposals under consideration include:

Integrated therapies for children - This is referred to in the report on the Joint Health and Wellbeing Strategy. There is an opportunity to bring spend on therapy services by the Council, the CCG and schools together within a single procurement exercise and supported by one organisation acting as the lead commissioner and establishing pooled budget arrangements. This would require closer partnership arrangements with schools but creates the potential for improved efficiency and better outcomes for children and young people, the Council, the CCG and schools.

Integrated services for children and young people - The development of integrated therapies for children could be a stepping-stone for the creation of pooled budget arrangements for children

and young people. This would include Children and Adolescent Mental Health Services (CAMHS). The key benefit of having a pooled budget is that it enables relevant services to be provided according to need rather than funding responsibility.

People with mental health needs and/or learning disabilities: step- down from treatment-based services to less restrictive environments - A review is currently in progress that is looking at accommodation-based services provided for people with mental health needs and/or learning disabilities and how current provision can be used more effectively to step people down to less supported environments. The review also includes looking at the services in the community that are required to make the accommodation-based services sustainable and prevent avoidable escalation of need. Key drivers behind this work is the expiry of Council commissioned contracts for care in supported living services in 2019 (mental health) and 2020 (learning disabilities). The reviews are being undertaken on the basis that partners are receptive to doing things differently in order to achieve better outcomes.

BCF Section 75: Extending the partners included - The section 75 (NHS Act, 2006) provides the legal framework that governs partnership arrangements between local authorities and statutory health organisations, e.g. CCGs and NHS foundation trusts. The current BCF section 75 agreement is between the Council and the CCG. However, this does not adequately reflect the complexity of the local health and care system where funding can go directly to provider trusts like Hillingdon Hospital and CNWL without going through the CCG. An implication of the creation of Hillingdon Health and Care Partners (HHCP) is also that it will have the freedom to direct how resources provided to its constituent parts by the CCG are utilised to deliver outcomes agreed with the CCG.

36. It is suggested that including Hillingdon Hospital and CNWL within the post April 2019 BCF section 75 agreement would establish a legal basis for partnership arrangements between the Council, the CCG and the health providers that would govern the transfer of funds between organisations, the delegation of functions and pooling of budgets where these provide opportunities to deliver better outcomes for residents and support the sustainability of Hillingdon's health and care system. It would also establish an agreed governance structure with clear accountabilities. Any changes to financial arrangements during the term of the agreement would need to be made by variation and approved in accordance with each partner's scheme of scheme of delegations.

37. The Committee will be consulted on the next iteration of the BCF plan.

Appendix 1
2018/19 Better Care Fund Delivery Plan

Task	Task Description	Lead Organisation	Start Date	End Date
Scheme 1: Early intervention and prevention.				
1.1	Relaunch and promote the online information system, Connect to Support and ensure linkages with the NHS Directory of Services.	LBH	June 18	Mar-19
1.2	Extend remit of Care Connection Teams to include adults living with mental distress.	HCCG	Apr-18	Mar-19
1.3	Review the model of voluntary sector support for older people funded by the Council and CCG to maximise the outcomes for residents aligned to the Accountable Care Partnership.	LBH/HCCG	Jul-18	Dec-18
1.4	Explore the increased application of assistive technology to support the independence of residents in the community.	LBH	Apr-18	Mar-19
1.5	Develop a prevention strategy, including approach to delivering health checks.	HCCG/LBH	Apr-18	Dec-18
Scheme 2: An integrated approach to supporting Carers.				
2.1	Secure partner sign-up to the Carers Memorandum of Understanding.	LBH	Oct-17	June-18
2.2	Develop the Carer Referral pathway for CNWL.	CNWL	Apr-18	Dec-18
2.3	Identify a Carer's lead in all GP practice.	GP Confederation	Apr-18	Dec-18
2.4	Deliver a communications campaign to schools to raise awareness of Young Carers so that teachers and staff are better placed to support them.	HCP	Apr-18	Mar-19
2.5	Develop a mechanism for reflecting the needs of Young Carers within existing assessment processes in Primary Care, Social Care and across all partners.	HCP/HCCG	Jun-18	Dec-18
Scheme 3: Better care at end of life.				
3.1	Implement the Single Point of Access for End of Life Care.	HCCG	Oct-17	Sept-18
3.2	Clarify the end of life model of care for people who wish to die at home. Links to schemes 4 and 5.	LBH/HCCG	Apr-18	Nov-18
Scheme 4: Integrated hospital discharge				
4.1	Implement the Integrated Discharge Team.	LBH/HCCG	Jul-17	Oct-18

4.2	Review Hospital Discharge Bridging Care Service and secure decision on model post March 2019.	LBH	Jun-18	Oct-18
4.3	Secure decision on Hospital Discharge Grant and implement if approved.	LBH	Jan-18	Aug-18
4.4	Pilot the Housing/Mental Health Protocol.	CNWL/LBH	Apr-18	Sept-18
4.5	Deliver changes to the operation of the mental health funding panel process to expedite decision making.	HCCG/LBH	Apr-18	Nov-18
4.6	Model community-based service provision requirements to support discharge of people with complex mental health needs. Links to scheme 5.	HCCG/LBH	Apr-18	Oct-18
4.7	Seek organisational sign-up to the CHC, shared care and section 117 memorandum of understanding.	HCCG/LBH	Apr-18	Nov-18
Scheme 5: Improving care market management and development.				
	Cross Cutting			
5.1	Develop and deliver a provider engagement plan.	LBH	Jun-18	Sep-18
5.2	Review the provider failure policy and procedure.	LBH	Jun-18	Oct-18
	Integrated Brokerage			
5.3	Review outcomes to inform decision on longer-term model.	LBH/HCCG	Jun-18	Oct-18
	Integrated Homecare			
5.4	Review outcomes from pilot to determine procurement options to be undertaken in 2019 for delivery from Oct 2019.	LBH/HCCG	Jul-18	Dec-18
	Care Homes			
5.5	Implement interim multi-disciplinary support service for care homes and extra care schemes.	HCCG	Apr-18	Oct-18
5.6	Explore feasibility of LBH being included within nursing home AQP and benefits of doing so.	LBH	Jun-18	Oct-18
5.7	Embed training programme for care home staff on range of issues, including falls management, tissue viability, nutrition, medication and leadership for managers and/or aspiring managers.	HCCG	Apr-18	Oct-18

5.8	Systemise provision of care home LAS conveyance and admission data to inform provider risk management process.	HCCG	Apr-18	Mar-19
5.9	Complete implementation of *'Red Bag'* scheme and monitor impact.	HCCG	Sept-17	Jun-18
5.10	Explore with Hillingdon Health and Care Partners (HHCP) opportunities for developing a career pathway for nurses as part of a workforce strategy to support nursing homes.	HCCG	Oct-18	Mar-19
	Extra Care			
5.11	Open Grassy Meadow Court and start implementation of fill strategy.	LBH	Apr-18	Sep-18
5.12	Open Park View Court and start implementation of fill strategy.	LBH	Apr-18	Jan-19
5.13	Continue to explore with partners opportunities to maximise the benefits of available resources at Grassy Meadow and Park View. Links to scheme 1.	LBH	Apr-18	Mar-19
5.14	Explore scope for utilising flats at Park View Court extra care scheme as intermediate care. Links to scheme 4.	LBH	Apr-18	Oct 18
Scheme 6: Living well with dementia.				
6.1	Deliver the Dementia Resource Centre. Links to scheme 5.	LBH	Apr-18	Oct 18
6.2	Develop community-based solutions to support discharge (or prevent admission) of older people with challenging behaviours.	HCCG/LBH	Oct-18	Mar-19

Implications on related Council policies

A role of the Policy Overview Committees is to make recommendations on service changes and improvements to the Cabinet who are responsible for the Council's policy and direction.

How this report benefits Hillingdon residents

The Better Care Fund is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

Financial Implications

As set out in the report.

Legal Implications

None. The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the BCF. It allows for the mandate to NHS England to include specific requirements to instruct NHS England over the BCF, and NHS England to direct Clinical Commissioning Groups to pool the necessary funding.

BACKGROUND PAPERS

NIL