BETTER CARE FUND: PERFORMANCE REPORT (JULY - SEPTEMBER 2018)

Relevant Board Member(s)	Councillor Philip Corthorne Dr Ian Goodman
Organisation	London Borough of Hillingdon Hillingdon Clinical Commissioning Group
Report author	Paul Whaymand, Finance Tony Zaman, Adult Social Care Kevin Byrne, Health Integration and Partnerships Caroline Morison, HCCG
Papers with report	Appendix 1) BCF Metrics Scorecard

HEADLINE INFORMATION

Summary	This report provides the Board with the fifth performance report on the delivery of the 2017/19 Better Care Fund plan. It is the second report on delivery during 2018/19.
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 £54,049k for 2018/19 as at month 6.
Ward(s) affected	All

RECOMMENDATION

That the Health and Wellbeing Board notes the progress in delivering the plan during the Q2 2018/19 review period.

INFORMATION

1. This is the fifth 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. It is the second report on the delivery of the second year of the plan, 2018/19 and updates the Board on the position to 12th November where possible. 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. References to the *'review period'* in this report means the period from April to September

2018.

National Metrics

3. This section includes performance against the metrics that Hillingdon is required to report to NHSE.

4. **Emergency admissions target (also known as non-elective admissions): *Not on track*** - 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 against a ceiling for the year of 11,400. This would actually suggest an outturn close to a reduction target that reflected an increase in the older people population.

5. The Board's September meeting asked to see a year on year comparison for emergency admissions for people aged 65 and over. Table 1 below shows the position from 2015/16 with the projected outturn for 2018/19.

Table 1: Emergency Admissions 65 + Population 2016/17 - 2018/19	
Financial Year	**Total Number of Emergency Admissions**
2015/16	10,406
2016/17	10,252
2017/18	11,267
2018/19	11,472*

**Projected*

6. **Delayed transfers of care (DTOCS): *On track*** - Table 2 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.

Table 2: 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**

7. There has been a significant shift in the distribution of DTOCs between acute and non-acute reported in the September update to the Board has continued during Q2. This means that during the review period Q1 53% of delays were in an acute setting like Hillingdon Hospital and 47% in a non-acute setting like mental health provision, which compares to 38% and 62% in 2017/18. This can be explained by the 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. The Board may also wish to note that there have been no delays in CNWL beds for which Social Care has responsibility for five months.

8. During the review period nearly 15% (354) of all delays, 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 Board may 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.

9. **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. The Board may wish to note that the total number of older people living in permanent placements in care homes at 30th September 2018 was 53, which is accounted for by 72 people leaving the service during the review period.

10. **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 Board 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.

Scheme Specific Metric Progress

11. This section provides the Board with the Q2 position against scheme specific metrics where the data was available for the reporting period.

Scheme 1: Early intervention and prevention

12. ***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

13. ***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.

14. ***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

15. ***Seven day working: Not on track*** - Table 3 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.

16. It is the intention of the Hospital to 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. Pharmacy provision is currently available for three hours on a Saturday and on a Sunday and funding has been agreed to extend availability to six hours on both days. The Hospital is in the process of recruiting to enable provision to be extended. There is currently no funding available to support additional Rapid Response provision at weekends.

Table 3: 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*

17. As previously reported, 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 15 above.

Scheme 5: Improving care market management and development

18. ***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.

19. 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.

Key Milestone Delivery Progress

20. The following key milestones for Q2 in the agreed plan that were delivered were:

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

- ***GP support for care homes and extra care***: 6 locum GPs now recruited by GP Confederation, will continue 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.

- ***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 clean or fumigation, home or garden clearance and furniture removals to make a person's home habitable where these will demonstrably expedite a person's return home following a hospital admission.

21. 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.

Successes and Achievements

22. Key successes and achievements for Q2 can be summarised as follows:

- ***H4All Wellbeing Service*** - 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.

- Of the people referred to onward services during the review period nearly 53% (187) were referred to third sector organisations, including both constituent partners of H4All and other groups operating in the borough. This is particularly pertinent to the nearly 30% (104) of referrals who were referred to the service as a result of individual experiencing loneliness and/or social isolation.

- ***Disabled Facilities Grants*** - 13 people aged 60 and over were assisted to stay in their own home through the provision of disabled facilities grants (DFGs) during Q2, which represented 54% of the grants provided. This has prevented the need to identify alternative housing options at a time when housing in short supply and compares to 9 older people being assisted in the same period in 2017/18.

- ***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.

- ***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.

Key Issues for the Board's Attention

23. **Integrated Hospital Discharge Model** - The November meeting of the Accident and Emergency (A & E) Delivery Board considered a business case for the creation of an Integrated Discharge Service under a single management structure which would become the single point of access for the following two main pathways out of Hillingdon Hospital for people requiring

assistance to return home shown below. The decision about which pathway would be most appropriate for a person would result from a triage process undertaken by the Integrated Discharge Service.

- **Pathway 1** is for people whose needs can be met at home with rehabilitation or reablement. This pathway applies to approximately 18% of people being discharged from the Hospital. This pathway is managed either by the CNWL's Rapid Response Team or the Council's Reablement Team depending on the needs of the resident. Whether a person is referred to Rapid Response or Reablement is determined by triage undertaken by the Integrated Discharge Team. Care and support for up to 72 hours is provided by the Hospital Discharge Bridging Care Service to enable a person to be discharged from Hospital at the earliest opportunity once they are well enough to do so. This service is delivered by a private provider;

- **Pathway 2** is for people who cannot return home because they require a bed based service due to them having more complex needs, although these needs do not have to be met in a hospital setting. This pathway accounts for approximately 5% of people being discharged from the Hospital.

24. The A & E Delivery Board did not make a decision about the new model and its funding pending further discussions about the use of additional funding to support Social Care recently announced by the Government. These discussions will be informed by the detail of the grant conditions once published by the Ministry of Housing, Communities and Local Government.

25. ***Michael Sobell House*** - The latest position concerning Michael Sobell Hospice and the provision of end of life services in the north of the borough is addressed in the CCG update report also on the Board's agenda.

26. ***Post-April 2019 BCF Plan*** - Officers reported to the September Board meeting the expectation that the operational guidance for the next iteration of the BCF would follow the publication of the Adult Social Care Green Paper, with the understanding that this would coincide with the publication of the 10-year NHS Plan at the end of November. However, it would now appear that the publication of the Green Paper has been postponed further, which may lead to the operational guidance not being published until the New Year. It is understood from the Better Care Support Team that the guidance will mirror that for 2018/19. As previously reported to the Board, the intention is that the next iteration for the plan will be for one year only. Officers have secured support from the Better Care Support Team for Hillingdon to develop a three year plan as this would be more fitting with some of the proposed developments, e.g. integrated therapies for children and young people, care and support for people with learning disabilities, etc. These proposals will therefore be further developed for the Board's consideration in due course.

Financial Implications

27. The pooled budget is forecasting a pressure of £1,172k at the end of Q2, £1,062k of this pressure is within HCCG Services and £239k is within Social Care Services.

28. The LB Hillingdon Social Care forecast has increased by £110k since Q1. This increased pressure mainly relates to Scheme 5: Improving Care Market Management and Development and is from additional domiciliary care packages for clients. This pressure is being offset within

the overall Social Care budget.

29. HCCG's overspend largely relates to Scheme 5: *Improving Care Market Management and Development*, which is overspent by £1.055m. This is mainly attributed expenditure on domiciliary care for older people and younger adults with physical disabilities as well as nursing care home provision for frail elderly and people with palliative care needs. The overspend is balanced by underspends in other Programme areas.

Table 4: BCF Financial Summary 2018/19

Key Components of BCF Pooled Funding (revenue unless classified as Capital)	Approved Pooled Budget 2018/19	Forecast Quarter 2 2018	Variance as at Q2	Variance as at Q1	Movement from Q1
		£,000's	*£,000's*	*£,000's*	*£,000's*
Hillingdon CCG - Commissioned Services	26,770	27,832	1,062	0	1,062
LB Hillingdon - Commissioned Services	23,105	23,344	239	129	110
LB Hillingdon - Commissioned Capital Expenditure	4,174	4,174	0	0	0
Overall Totals	**54,049**	**55,350**	**1,301**	**129**	**1,172**

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

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

Consultation Carried Out or Required

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

Policy Overview Committee Comments

32. None at this stage.

CORPORATE IMPLICATIONS

Corporate Finance Comments

33. Corporate Finance has reviewed the report, noting that a net underspend of £239k is projected against the Council managed elements of the pooled Better Care Fund Budget, an adverse movement of £110k from Quarter 1. There are no direct financial implications associated with the recommendation that the Board note progress in delivery of the Better Care Fund plan.

Hillingdon Council Legal Comments

34. 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 Metrics Scorecard.