SOCIAL SERVICES, HOUSING AND PUBLIC HEALTH POLICY OVERVIEW COMMITTEE - 2019/20 BETTER CARE FUND PLAN PROGRESS UPDATE

Committee name	Social Care, Housing and Public Health Policy Overview Committee
Officer reporting	Gary Collier, Health and Social Care Integration Manager
Papers with report	None.
Ward	All

HEADLINES

The reason for this item is to make the Committee aware of progress in the delivery of the 2019/20 BCF plan.

RECOMMENDATIONS:

That the Committee:

1. **questions officers and partners about the delivery of the 2019/20 plan.**
2. **notes the report.**

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. The first BCF plan was for 2015/16.

2. The *2019/20 Better Care Fund Policy Framework* published in April 2019, required Hillingdon to develop a Better Care Fund Plan (BCF) for the 2019/20 period. The planning requirements for 2019/20 were published in July 2019. This is Hillingdon's fourth BCF plan and its focus is improving care outcomes for older people, people with learning disabilities and/or autism and children and young people. This represents an expansion of scope and ambition on previous iterations of the plan, which were directed at Hillingdon's 65 and over population.

3. The 2019/20 plan was approved at the Health and Wellbeing Board meeting on the 24 September and formally submitted on the 27th September. The plan completed

the CCG's governance processes on 6th September 2019. The plan submission documentation can be accessed via the following link https://modgov.hillingdon.gov.uk/ieListDocuments.aspx?CId=322&MId=3463&Ver=4. Notification that the plan's approval by NHSE was received on the 23rd December 2019.

4. A condition of the BCF is that a pooled budget be established under which Council and NHS funding loses its separate identity. The Council is the lead organisation for the management of the pooled budget.

5. References to the *'review period'* in this report means the period from April to September 2019 unless otherwise stated.

Hillingdon's BCF 2019/20 Plan Summarised

6. The minimum amount required to be included within the BCF pooled budget for 2019/20 is £30,114k. Both the Council and the CCG have agreed to an increase in the level of ambition and a resultant increase of £62.8m above the minimum required in 2019/20 to £92,952k. This is as a result of the extension of the scope of the plan beyond a focus on older people to include children and young people and people with learning disabilities and/or autism. The eight schemes of the plan are summarised in **Appendix 1**.

7. Table 1 below shows the investment of the Council and the CCG in 2019/20 compared with 2018/19.

Table 1: Financial Contributions by Organisation 2018/19 and 2019/20 Compared		
Organisation	**2018/19 (£,000s)**	**2019/20 (£,000s)**
HCCG	27,009	39,418
LBH	27,279	53,534
TOTAL	**54,288**	**92,952**

8. The investment from the Council includes the Disabled Facilities Grant (DFG), the Improved Better Care Fund (iBCF) and Winter Pressures Grants that have been received directly by the Council from the Ministry of Housing, Communities and Local Government. The iBCF and Winter Pressures Grants have been used to stabilise the local care market, which has in turn helped to relieve pressure on NHS partners. The value of the three grants for 2019/20 is as follows:

   - Disabled Facilities Grants: £4,504k
   - Improved Better Care Fund: £6,207k
   - Winter Pressures: £1,041k

9. Table 2 below provides a breakdown of investment by both the Council and the CCG in each of the eight schemes within the plan.

Table 2: HCCG and LBH Financial Contribution by Scheme Summary

Scheme		**Financial Contribution**			
		2018/19		**2019/20**	
		LBH £000s	**HCCG £000s**	**LBH £000s**	**HCCG £000s**
1	Early intervention and prevention	5,426	2,354	3,373	2,566
2	An integrated approach to supporting Carers	878	18	984	19
3	Better care at end of life	51	992	0	819
4	Improved hospital discharge and the intermediate tier	4,643	11,405	6,094	15,038

5	Improving care market management and development	15,893	12,001	11,863	12,549
6	Living well with dementia	306	0	372	0
7	Integrated therapies for children and young people	0	0	441	2,231
8	Integrated care and support for people with learning disabilities and/or autism.	0	0	30,322	6,195
	Programme Management	82	0	86	0
	Total Partner Contributions	**27,279**	**26,770**	**53,534**	**39,418**

Measuring Success

10. There are three types of measures used to determine the success of the plan and these are:

- *National metrics*: There are four metrics against which every health and wellbeing board area in England is required to report progress to NHSE.

- *Local metrics*: These are local scheme specific measures where progress is reported to the Health and Wellbeing Board and CCG Governing Body only.

- *Delivery plan milestones*: This is identification of how performance against the agreed delivery plan in progressing. Once again updates are provided to the Health and Wellbeing Board and CCG Governing Body.

National Metrics

11. ***Emergency admissions target (also known as non-elective admissions): Not on track*** - The emergency admission target in previous plans included emergency admissions of all people aged 65 and over. For 2019/20 the target has been focussed on people aged 65 and over population who are living with ambulatory care sensitive conditions, i.e. cases where effective community care and case management can help prevent the need for hospital admission, such as chronic hepatitis B; asthmas; congestive heart failure; diabetes; chronic obstructive pulmonary disease; hypertension; epilepsy; and dementia. During the period April to October 2019 there were 1,598 emergency admissions, which would suggest a forecast outturn of 2,739 admissions against a ceiling of 2,411. This would represent a 6% increase over the 2018/19 outturn of 2,585 admissions.

12. The main objective of the Neighbourhood Teams (see below) is to identify and actively manage the 15% of the population within their neighbourhood at greatest risk of future hospital admission and developing long-term care needs. Although at different points of development across the borough, this work is having results and without it the numbers of emergency admissions would undoubtedly be higher.

Neighbourhood Teams Explained

The eight Neighbourhood Teams are multi-disciplinary teams comprising of staff within a range of GP practices, community health professionals, professionals concerned with the assessment, diagnosis and treatment of adults with urgent medical needs, a mental health professional and voluntary and community sector staff.

13. ***Delayed transfers of care (DTOCS): On track*** – The definition of a DTOC is shown below.

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; AND

c) The patient is safe to discharge/transfer.

14. Table 3 below shows that there were 1,820 delayed days in the period April to October 2019. This would suggest an outturn for 2019/20 of 3,714 delayed days on a straight line projection, which would be 1,250 delayed days below the target imposed on Hillingdon by NHSE for 2019/20. The Committee may wish to note that NHSE has not set specific reduction targets for the NHS, Social Care or those delays attributed to both the NHS and Social care. However, table 3 provides a breakdown for the April to October period.

Table 3: DTOC Performance April - October 2019			
Delay Source	**Acute**	**Non-acute**	**TOTAL**
NHS	1,654	346	**2,000**
Social Care	59	57	**116**
Both NHS & Social Care	3	48	**51**
TOTAL	**1,716**	**451**	**2,167**

15. When compared with other London authorities, 24 boroughs had higher DTOC levels than Hillingdon and 16 CCGs had higher NHS levels. Hillingdon had the fourth lowest level of social care delays in London.

16. During the period April to October 2019 83% (1,791) of delayed days were attributed to four reasons that remain consistent with the position in 2018/19. The reasons were:

- 42% (914): Access to care homes.
- 20% (431): Further non-acute NHS care, such as access to specialised mental health services, access to end of life hospice care, etc.
- 11% (233) Patient/family choice, i.e. where a reasonable offer of care to meet assessed needs has been refused.
- 10% (213): Housing, e.g. where there are housing delays relating to people for whom the Council does not have a social care responsibility under the 2014 Care Act.

17. The Council works with care home providers to identify imaginative solutions where service users present with challenging behaviours. The full mobilisation of the Enhanced support in care homes service (see below) may also help to increase local care home capacity. However, there is a national shortage of specialised, bed-based mental health services that also affects Hillingdon.

Enhanced Support in Care Homes and Extra Care Service Explained

This specialist service comprising of GPs, 4 matrons, a dietician, a speech and language therapist and a mental health nurse is intended to provide support to care homes and extra care housing schemes with the main aim of preventing unnecessary admissions to hospital. The support available from the service should also give homes more confidence about accepting people with more challenging needs.

18. **Permanent admissions to care homes target:** ***Not on track*** - There were 116 permanent admissions to care homes during the period between April and November 2019, which would suggest an outturn for 2019/20 of 174 permanent admissions. This would be very close to the ceiling for the year of 170. 28% of permanent admissions were into nursing homes and nearly 18% into residential dementia care homes. 53% of permanent admissions were conversions of short-term placements. The delay in the delivery of the Park View Court extra care sheltered housing scheme has contributed to this conversion, which reflects the speed with which people become institutionalised once admitted to a care home.

19. The Committee may wish to note that 9 people moved out of care homes into an extra care setting during the review period. The availability of extra care also prevented another older person from being admitted to a care home during this period.

20. **People discharged from hospital to reablement still at home 91 days after discharge –** The review period for this metric is people aged 65 and over discharged to reablement in Q3 who are still at home at the end of Q4. This data will therefore not be available until May 2020. 2019/20 is actually the final year of this metric.

Local Metrics

Scheme 1: Early intervention and prevention

21. ***Falls-related Admissions*: Not on track** – During the period April to October 2019 there were 540 emergency admissions of people aged 65 and over related to falls. This would suggest an outturn for 2019/20 of 925 against a ceiling of 892. A programme of interventions by partners continues to identify and support people at risk of falling. In view of the increasing 80 and over population in the borough and the increased susceptibility to further falls once a person within this age group has fallen, it is suggested that the target setting methodology is reviewed for 2020/21.

Scheme 2: An integrated approach to supporting Carers

22. ***Carers' assessments*: Not on track** – There were 466 Carers' assessments undertaken during the period April to October 2019. On a straight line projection this would suggest a full year outturn of 799 against a target for the year of 1,090. Assessments include those undertaken by the Council and by Hillingdon Carers. However, it should be noted that there are services available through the Hillingdon Carers' Partnership that do not require Carers to go through an assessment process for them to access.

Scheme 4: Integrated hospital discharge

23. ***Seven day working*: Not on track** – If the health and care system was working effectively then approximately 30% of hospital discharges would be taking place at weekends (2 days/7 days). Table 4 below shows apportionment of discharges between weekdays and weekends for the April to September 2019 review period.

Table 4: Seven Day Discharge at Hillingdon Hospital April – September 2019

Week Days	Week Ends	TOTAL	W/e as % of total discharges
12,472	2,882	**15,354**	18.7

Scheme 5: Improving care market management and development

24. ***Emergency admissions from care homes*: Not on track** – During the period April to August 2019 there were 361 admissions of older people from care homes in Hillingdon. On a straight line projection this would suggest an outturn of 866 admissions against a ceiling of 844. Taking into consideration the increase in the bed base during 2018/19 by 77 beds a 3% increase on the 2018/19 outturn would still suggest that demand is being controlled, although not as much as desirable. Partners will undertake further analysis work to determine whether people admitted from care homes have a longer length of stay in 2019/20 than in the previous year, which would indicate that more admissions were appropriate.

25. There has been an issue about the reliability of the emergency admissions from care homes data and a verbal update will be provided to the Committee on progress.

Delivery Plan Milestones

26. The section provides the Committee will an update on the key milestones for Q1 and 2 of the agreed BCF delivery plan. The agreed delivery plan priorities for 2019/20 are described in **Appendix 2**.

27. ***Establish named Adult Social Care contacts for each of the emerging Neighbourhood Teams: Completed –*** The three Adult Social Care Locality Managers have been identified as the key contacts and attended monthly meetings with guided care matrons within the relevant Neighbourhood Teams.

28. ***Review the Hospital Discharge Grant pilot and implement the result: Completed*** – The pilot was extended until January 2020 when a further review will determine whether the grant can be established as business as usual. Since its inception in November 2018 the grant has assisted the timely discharge from hospital of 20 people, 80% of which were aged 60 and over.

Hospital Discharge Grant Explained

This is a non-means-tested grant of up to £2,000 that can be made available if any of the following eligible works are required to enable a Hillingdon resident to return home from hospital once they are well enough to do so:

- Home garden/clearance
- Home deep cleaning
- Home fumigation
- Furniture removals to make your home safe for you
- Heating repairs, e.g. repairing or replacing boilers
- Repairs to essential electrical appliances, e.g. cooker, refrigerator/freezer.

29. ***Explore feasibility of extending 'Red Bag' scheme to extra care: Completed*** – The red bag scheme for care homes has been relaunched in 2019/20. Extension of the scheme to extra care will therefore be deferred to 2020/21 to allow more time for the existing care home scheme to become established.

Red Bag Scheme Explained

The scheme is intended to improve the discharge process for people living in care homes who are admitted to hospital. When a resident becomes unwell and is assessed as needing hospital care, care home staff pack a dedicated red bag that includes the resident's standardised paperwork and their medication, as well as day-of-discharge clothes and other personal items.

30. ***Review liaison and referral arrangements between Housing and both Hillingdon Hospital and CNWL***: ***Some slippage*** – Arrangements between Housing and CNWL's Mental Health Teams have been reviewed and are considered to be working well. Officers will be working with Hospital partners during Q3 to identify whether there is any scope to improve liaison arrangements to expedite discharge of people who no longer need treatment in a hospital bed.

Successes and Achievements

31. The key successes and achievements within the review period include:

- *Health partner programme*: Funding secured by the local third sector consortium H4All (i.e. Age UK, the Disablement Association Hillingdon, Harlington Hospice, Hillingdon Carers and Hillingdon Mind) through the City Bridge Trust has provided additional capacity to support the development and networking of third sector organisations in Hillingdon and a starting point was two engagement events held in June 2019 that were attended by 63 voluntary and community organisations. The intention behind this initiative is to improve the collective capacity of the sector to achieve the following through, for example, social prescribing:

  - Addressing social issues;
  - Better engaging people in managing their own health needs;
  - Addressing wider determinants of health;
  - Prevention of ill-health and promotion of independence and social connectivity for as long as possible;
  - Tackling loneliness and isolation.

Social Prescribing Explained

This is a process by which people are connected with a range of community groups and agencies for practical and emotional support.

- *Identification of Carers:* The identification of Carers is a critical first step in being able to sign-post them to relevant information, advice and support that will help support them in their caring role, a by-product of which is to reduce pressure on Hillingdon's health and care system. During the review period 404 new Adult Carers were identified and 145 new Young Carers, i.e. Carers aged under 18, were identified. The 2019/20 target for Adult Carers is 750 new Carers and the target for Young Carers is 50 new Carers.

- *Integrated discharge programme director appointed and in post:* This newly created jointly funded post has responsibility for managing the integrated discharge programme. The focus of this post is on discharges from Hillingdon Hospital.

- *Care Act training for Neighbourhood Teams:* A recommendation that arose from a sub-group meeting of the Council's External Services Select Committee that looking into pressures on GPs was that training should be provided on the Council's adult social care responsibilities under the Care Act to ensure that expectations are set correctly. A presentation was given to a meeting of matrons working within the Neighbourhood Teams on the 26th September.

- *Dementia-friendly communities:* There is a range of activities that have taken place over the review period under the umbrella of the Dementia Action Alliance intended to support residents living with dementia and their Carers and these include:

  - *Coffee mornings*: Dementia friends' coffee mornings have taken place across nine libraries in the borough. 1,850 residents have attended these events and 69 people attended groups on a regular basis. New weekly coffee morning sessions will be established at Oak Farm, Harefield and Yeading libraries by the end of 2019;

  - *Tovertafel:* Already installed in three of Hillingdon's libraries these have been used by 1,234 residents during the review period, including people living with dementia in the community as well as people in care homes. Three additional Toverfatel systems will be installed in Oak Farm, Harefield and Yeading libraries by the end of 2019;

Tovertafel Explained

The Tovertafel is a little box that can be mounted on the ceiling, for instance, above a dining room table. 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. This stimulates both physical and cognitive activity and encourages social interaction.

- *Dementia Friends training*: Five local retailers attended Dementia Friends' training in May 2019, including Marks and Spencer, TSB Bank, Decathlon (INTU), Nat West Bank and Top Shop. An immediate outcome of this was the provision of monthly chairobics sessions being offered in the Decathlon store in Uxbridge for people with dementia. 60 Police officers also attended a training session in September 2019.

- *Dementia friendly film screenings*: Following Dementia Friends training, the Beck and Compass Theatres have started to provide closed film screenings every two months for people with dementia. The special screenings entail adjustments to lighting to accommodate the physical effects of the onset of dementia.

- *Training for care home staff:* The falls prevention champion course training started in June 2019. This is delivered over a number of sessions, concluding in November 2019. It is the third year this course has been delivered. A leadership programme attended by managers or their deputies from eleven of Hillingdon's care homes was completed. This training provision intended to improve quality of service provision within the local care home market was funded by the North West London CCG Collaboration enhanced health in care homes programme.

Conclusions

32. The conclusion from the 2017/19 plan was that delivering step-change within a complex and constantly evolving health and care system is very challenging, especially when considering the financial difficulties being faced by partners. The experience of 2019/20 thus far reinforces this conclusion.

2020/21 BCF Plan

33. It has been confirmed by the Government that there will be a further one year plan for 2020/21 with the possibility of a three year plan from April 2021.

34. Further details of requirements for 2020/21 are awaited. In the meantime officers and NHS partners will be exploring options for inclusion in the 2020/21 plan for consultation with the Health and Wellbeing Board.

Appendix 1 can be seen below.

Scheme	Scheme Aim
Scheme 1: Early intervention and prevention.	To manage demand arising from demographic pressures by reducing the movement of Hillingdon residents/patients from lower tiers of risk into higher tiers of risk through proactive early identification and facilitating access to preventative pathways.
Scheme 2: An integrated approach to supporting Carers.	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.	To realign and better integrate the services provided to support people towards the end of their life in order to deliver the ethos of a 'good death.' The main goals of the scheme are to: • Ensure that people at end of life are able to be cared for and die in their preferred place of care; and • To ensure that people at end of life are only admitted to hospital where this is clinically necessary or where a hospital is their preferred place of care or death.
Scheme 4: Integrated hospital discharge and the intermediate tier.	This scheme seeks to prevent admission and readmission to acute care following an event or a health exacerbation and enabling recovery through intermediate care interventions with the aim of maximising the person's independence, ability to self-care and remain in their usual place of residence for as long as possible. A further objective of this scheme is to support discharge from mental health community beds in recognition of the impact of these delays on patient flow through Hillingdon Hospital.
Scheme 5: Improving care market management and development	This scheme is intended to contribute to the STP 2020/21 outcomes of achieving: • A market capable of meeting the health and care needs of the local population within financial constraints; and • A diverse market of quality providers maximising choice for local people.

Scheme 6: Living well with dementia	The objective of this scheme is that people with dementia and their family carers are enabled to live well with dementia and are able to say: • *I was diagnosed in a timely way.* • *I know what I can do to help myself and who else can help me.* • *Those around me and looking after me are well supported.* • *I get the treatment and support, best for my dementia, and for my life.* • *I feel included as part of society.* • *I understand so I am able to make decisions.* • *I am treated with dignity and respect.* • *I am confident my end of life wishes will be respected. I can expect a good death.*
Scheme 7: Integrated therapies for children and young people	This scheme seeks to: • Provide early intervention therapy services that offer early assessment and advice, support self-care and reduce dependence on services in future years. • Provide a robust integrated triage process that directs children and young people to the most appropriate therapy and support without delay.
Scheme 8: Integrated care and support for people with learning disabilities and/or autism.	This scheme aims to: • To improve the quality of care for people with a learning disability and/or autism;

	• To improve quality of life for people with a learning disability and/or autism; • To support people with a learning disability and/or autism down pathways of care to the least restrictive setting; • To ensure that services are user focused and responsive to identified needs.

Appendix 2
2019/20 Delivery Plan Priorities

Appendix 2 can be seen below.

Scheme 1: Early intervention and prevention.
• Establish a single online information system as the directory of services across Health and Care Partners in Hillingdon. • Establish named Adult Social Care contacts for each of the emerging Neighbourhood Teams. • Explore the increased application of assistive technology to support the independence of residents in the community. • Review the model of voluntary sector support for adults to improve options for social prescribing, including through provision of Personal Health Budgets. • Establish the eight Neighbourhood Teams aligned to the Primary Care Networks across the borough. • Provide opportunities for older people to participate in sport and physical activity.
Scheme 2: An integrated approach to supporting Carers.
• Ensure the identification of a Carer's Champion in all GP practices. • Review and develop the Carer Assessment Tools to simplify the assessment process. • Support schools and colleges in identifying and recognising the role of Young Carers. • Review and develop 'first point of contact' arrangements for Carers in emergency situations outside of working hours, including for adults with mental health needs. • Ensure Carer identification markers are included in the development of information sharing platforms. • Coordinate the design and development of an 'App' for Young Carers.
Scheme 3: Better care at end of life.
• Clarify the end of life model of care for people who wish to die at home.
Scheme 4: Integrated hospital discharge and the intermediate tier.

- Complete the roll out of criteria-led discharge to all wards within Hillingdon Hospital.
- Establish a point of coordination within Hillingdon Hospital for hospital discharges.
- Establish a point of coordination for access to community resources to build up suitable packages of care and support.
- Develop a service specification for the integrated discharge service.
- Develop and implement pathways with inclusion criteria that support the discharge of patients on pathway 2.
- Develop and implement the standards for the triaging process, including the automation of data reporting.
- Agree a simplified joint assessment for patients on all discharge pathways.
- Review the Hospital Discharge Grant pilot and implement the result.
- Seek organisational sign-up to the CHC, shared care and section 117 memorandum of understanding.
- Review liaison and referral arrangements between Housing and both Hillingdon Hospital and CNWL.
- Review the Hillingdon Hospital discharge policy that includes the Choice policy.

Scheme 5: Improving care market management and development.

- Develop and deliver a provider engagement plan.
- Secure agreement on long-term integrated brokerage arrangements.
- Undertake a competitive tender for new model of integrated homecare provision.
- Explore the feasibility of rapid access care provision to prevent admissions that are avoidable.
- Implement Enhanced Support for Care Homes and Extra Care Service.
- Develop a lead commissioning pilot for nursing care home provision by the Council on behalf of the CCG.
- 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.
- Explore feasibility of extending 'Red Bag' scheme to extra care.
- Open Park View Court and manage implementation of fill strategy in partnership with GP practices.
- Continue to explore with partners opportunities to maximise the benefits of available resources at Grassy Meadow and Park View.

Scheme 6: Living well with dementia.

- Develop training for care homes in how to manage people with challenging behaviours.
- Enable people living with dementia to continue to live independently in our community and feel supported and knowledgeable about where to access advice and help when required.

Scheme 7: Integrated therapies for children and young people
• Implement the integrated therapies pathway model.
Scheme 8: Integrated care and support for people with learning disabilities and/or autism.
• Regularise current operational case management arrangements. • Deliver a model of care and support for people with learning disabilities and/or autism who are in a supported living setting that maximises their independence and supports their health and wellbeing. • Implement the action plan from reviews completed between health and social care under the Learning Disabilities Mortality Review Programme. • Agree 'to be' integration model.