# 2020/21 INTEGRATED PERFORMANCE REPORT

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| **Relevant Board Member(s)** | Councillor Jane Palmer<br>Dr Ian Goodman |
| **Organisation** | London Borough of Hillingdon |
| **Report author** | Kevin Byrne, Resident Services, LBH<br>Tony Zaman, Social Care Directorate, LBH<br>Caroline Morison, Managing Director, HCCG |
| **Papers with report** | None |

## HEADLINE INFORMATION

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| **Summary** | This report combines reporting on the delivery of the Hillingdon Health and Care Partners' Covid-19 recovery plan and the Better Care Fund (BCF) delivery plan. The production of an integrated performance report is intended to reflect the connectivity between the two so that they are identified as integral parts of the integration agenda in Hillingdon. This first iteration of an integrated report provides the Board with an opportunity to give feedback to shape the future format of performance reports.<br><br>The Better Care Fund (BCF) is a Government initiative intended to improve efficiency and effectiveness in the provision of health and care through increasing integration between health and social care. |
| **Contribution to plans and strategies** | The Hillingdon Health and Care Partners' Covid-19 recovery plan and the Better Care Fund make significant contributions to delivering the objectives within Hillingdon's Joint Health and Wellbeing Strategy. The Better Care Fund also meets requirements of the Health and Social Care Act 2012. |
| **Financial Cost** | The provisional total amount for the BCF for 2020/21 is £91,534k. |
| **Ward(s) affected** | All |

## RECOMMENDATIONS

**That the Health and Wellbeing Board:**

1) **notes the content of the report; and**
2) **gives feedback to officers about the content and structure of future integrated performance reports.**

## INFORMATION

### Strategic Context

1. Hillingdon Health and Care Partners (HHCP) is the local Integrated Care Partnership (ICP), i.e. the vehicle for delivering integrated care at a Borough (also referred to as '*place-based'*) level as required under the NHS Long-term Plan published in January 2019. HHCP comprises of the GP Confederation, Central and North West London NHS Foundation Trust (CNWL), The Hillingdon Hospitals NHS Foundation Trust (THH) and the H4All third sector consortium. H4All includes Age UK, Carers Trust Hillingdon, Disablement Association Hillingdon (DASH), Harlington Hospice and Hillingdon Mind. There is a legally binding agreement in place between members and delegated authority for the Primary Care Confederation to act on behalf of the 6 Primary Care Networks (PCNs).

2. Although not at present a formal signatory to HHCP, the Council is aligned to it and is represented on its board by the Corporate Director for Adult, Children and Young People's Services to ensure that care is integrated at an operational level across the Borough. The Better Care Fund (BCF) provides the legal framework for delivering integration between health and social care where this is necessary and appropriate to deliver better outcomes for residents. HHCP has a Covid-19 recovery plan and there is a 2020/21 delivery plan for the BCF. There are considerable synergies between the two, which should really be seen together as there are deliverables reflected in both. This report is an attempt to recognise this and present the Board with a single performance update.

3. The Board may wish to note that the planning requirements for the 2020/21 BCF have still not been published and the content of this report is based on what has been identified by partners locally as in the interests of residents and the sustainability of the Hillingdon's health and system. This does, however, reflect known national requirements.

4. The Board may wish to note that the Covid-19 Recovery Plan builds on service transformation work that was already being undertaken by partners, which followed the publication in October 2014 of the NHSE's Five Year Forward View. This was further shaped by the NHS Ten Year Plan previously mentioned. The earlier development work in response to these policy directives put Hillingdon in a good position to address the challenges presented by the pandemic, which has accelerated change in some areas and necessitated new developments in others.

5. The Recovery Plan comprises of five service transformation workstreams:

- ***Workstream 1 (W1)***: Primary Care Networks (PCNs)/Neighbourhoods
- ***Workstream 2 (W2)***: Elective Care Recovery
- ***Workstream 3 (W3):*** Urgent & Emergency Care
- ***Workstream 4 (W4):*** Children and Young People
- ***Workstream 5 (W5):*** Mental Health and Learning Disability

6. There are eight BCF schemes and these are:

- ***Scheme 1 (S1):*** Early intervention and prevention.
- ***Scheme 2 (S2):*** An integrated approach to supporting carers.
- ***Scheme 3 (S3):*** Better care at the end of life.
- ***Scheme 4 (S4):*** COVID-19 hospital discharge.
- ***Scheme 4A (S4A):*** Integrating hospital discharge and the intermediate tier.
- ***Scheme 5 (S5):*** Improving care market management and development.
- ***Scheme 6 (S6):*** Living well with dementia.
- ***Scheme 7 (S7):*** Integrated therapies for children and young people (CYP).
- ***Scheme 8 (S8):*** Integrated care and support for people with learning disabilities and/or autism.

7. Table 1 below shows the interrelationship between the workstreams and the BCF schemes. This illustrates the cross-cutting nature of schemes 2 and 5 that are effectively key enablers to the delivery of the workstreams.

| **Table 1: Interrelationship between HHCP Recovery Plan and BCF Schemes** | |
|---|---|
| **HHCP Recovery Workstream** | **BCF Scheme** |
| • W1: Urgent & Emergency Care | S2, S3, S4, S4A, S5 |
| • W2: Elective Care Recovery | S2, S4A |
| • W3: Primary Care Networks (PCNs)/Neighbourhoods | S1, S2, S5 |
| • W4: Children and Young People | S2, S7 |
| • W5: Mental Health and Learning Disability | S2, S5, S8 |

8. The respective workstreams and the projects that sit under them are at different levels of development, but it is the intention of this report to provide the Board with the following for the review period, which is April to September 2020 unless otherwise stated:
- Workstream Highlights
- Key performance indicator update, where appropriate

**Workstream 1: Primary Care Networks (PCNs) and Neighbourhoods**

9. Under this workstream sit a series of projects and these are:
- Proactive Care
- Core General Practice
- PCN/Neighbourhood Development
- Community Development
- Care Homes
- Medicines Management

## Workstream Highlights

10. **High Intensity User (HIU) Service:** This service is provided by H4All and started in January 2019 with a focus on supporting the people with top 50 attendances at A & E. During the review period a third support worker was recruited and is now in post to assist in delivering the key objective of reducing unnecessary A & E attendances and admissions as well as avoidable calls to the London Ambulance Service (LAS).

11. The Board will be interested to note that the service received the Social Prescribing Programme of the Year Award at the 2020 UK Annual Social Prescribing Link Worker Awards on 8 October 2020. The award was made by the National Association of Link Workers. The judges reflected on how a £90k investment in the team had generated a total saving of £253k to the local health and care economy through their intensive support to just 22 residents.

### Social Prescribing Explained

Social prescribing is a means of enabling health professionals to refer people to a range of local, non-clinical services. It recognises that people's health and wellbeing are determined mostly by a range of social, economic and environmental factors.

Examples of the services to which people would be referred through social prescribing include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.

12. **Development of Single Shielded/Extremely Clinically Extremely Vulnerable List:** During the first phase of the pandemic a single list owned by the CCG was produced and shared between partners. Shielding has ended but been replaced with the clinically extremely vulnerable (CEV) list that has again been shared with partners. A task and finish group has been established to coordinate support through the second wave. Once again practical support will be provided through the community hub based at the Civic Centre and on-going care needs managed through primary care.

13. **Proactive Care Clinics:** These multi-agency clinics offering patient assessment and care planning and are intended to proactively support residents with at least one long-term condition and who are included within the 13% of the adult population at risk of escalating needs. This includes people on the CEV list referred to in paragraph 12 above. A key objective is to support residents to self-manage their health needs to prevent deterioration. People who may benefit from clinic support are identified through the Whole Systems Integrated Care (WSIC) database managed by the North West London Integrated Care System (NWL ICS), formerly known as the NWL Collaboration of CCGs.

14. The local Proactive Care Clinic model has been developed with the support of the NWL ICS and the CCG has developed a specification in line with this that will be taken to the Local Medical Council (LMC) and Hillingdon's Primary Care Board for approval.

15. **Alignment of Neighbourhood Teams with PCNs:** The original eight Neighbourhood Teams have been aligned with the six new PCNs and discussions are in progress about alignment between the eight Care Connection Teams (CCTs) and the PCNs.

| Terms Explained | | |
|---|---|---|
| **Care Connection Teams** | **Neighbourhood Teams** | **Primary Care Networks** |
| The CCT model seeks to proactively identify the top 2% of people within a Neighbourhood at high risk of hospital admission or attendance. Each CCT is comprised of:<br><br>• *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;<br><br>• *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.<br><br>• *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. | Neighbourhood Teams (NTs) are multidisciplinary teams but with a core team of GPs, community staff, social care staff and health and wellbeing officers and wider third sector staff, mental health professionals, practice staff and acute consultants.<br><br>There are 6 NTs in Hillingdon aligned to the PCNs. Each team is supporting a population of between 30 and 50,000.<br><br>The NTs identify and manage 15% of people within their population at greatest risk of future hospital admission or attendance.<br><br>At risk people are identified through:<br><br>• Use of risk stratification tools.<br><br>• Intelligence gathering from health and care providers.<br><br>• Frequent user information from the ambulance service and acute hospital | PCNs are collaborations of GP practices serving a total population of between 30 and 50,000 people.<br><br>Each PCN has a clinical director and must agree a collective system of governance, including identification of the lead practice for accepting funding.<br><br>Practices within a PCN must collectively decide which one will lead on enhanced services, such as extended opening or support for care homes.<br><br>The PCN workforce will include a pharmacist and social prescribing link workers in addition to a clinical director. |

16. **My Health Programme:** H4All and the Confederation have won a joint bid to deliver the programme, which consists of a series of workshops for residents and other stakeholders intended to assist in the prevention or self-management of a range of long-term conditions that include childhood asthma, asthmas in adults, chronic obstructive pulmonary disease (COPD), diabetes prevention and type 2 diabetes. A programme is being developed to reflect the needs of the population in each Neighbourhood/PCN.

17. **Delivery of the Care Home Direct Enhanced Services (DES) Contract**: The new contract imposes new requirements on the PCNs with regards to support for care homes. Hillingdon was already in a good position prior to the DES coming into effect on the 1st October as a Care Home Support Service had already been established with three Care Home Matrons supporting the care homes for older people. Each care home for older people is currently contacted daily by the matrons to identify whether support is required. The Care Homes Support Service's Registered Mental Health Nurse contacts the care homes for people with learning disabilities and/or mental health needs on a weekly basis pending the appointment of two additional care home matrons, which will then lead to all care homes being contacted daily. This is in addition to the daily calls that the homes receive from the Council's Quality Assurance Team.

18. **Care Home Multidisciplinary Team Meetings (MDTs):** Weekly care home MDTs started prior to the implementation of the DES and have now become established in the care homes for older people. The intention behind the MDTs is to consider the needs of people considered to be at risk of escalated needs identified as a result of the daily calls by the care home matrons.

19. **Transition of Care Homes Supported by Harrow:** GP support for four care homes in the Borough had previously been provided by practices in Harrow. In order to simplify access to community services, which is linked to GP registration, these homes are being brought under local PCN support arrangements. Two have transferred already and arrangements for ensuring the transfer of the other homes in the near future are under discussion.

20. **Flu campaign:** GP practices have started to run flu vaccination clinics for eligible groups as shown in table 2 below. The PCNs are coordinating vaccinations of residents in care homes and officers are working with three community pharmacies to coordinate access to vaccinations for care home staff. There are unfortunately no reliable data sources for rates of health and social care staff across the system who have been vaccinated.

| **Table 2: 2020/21 Flu Vaccination Campaign Eligibility and Uptake Ambition** | | |
|---|---|---|
| **Eligible Groups** | **Uptake Ambition** | **Current Position** |
| • Aged 65 years and over | **At least 75%** | 71% |
| • Clinically vulnerable | | 36% |
| • Pregnant women | | 27% |
| • Children aged 2 and 3 years old | | 42% |
| • Frontline health and social care workers | **100% offer** | N/A |

**Workstream 2: Urgent and Emergency Care**

21. The projects that sit under this workstream include:
- Track and Trace
- End of Life
- Step-down Physical Needs
- Integrated Urgent Response Hub (IURH)
- THH Emergency Department Flow

**<u>Workstream Highlights</u>**

22. **Track and Trace:** Track and trace is largely being managed nationally within the remit of NHS Track and Trace, although the Council has recently acquired responsibility to trace anyone who has not been contactable by the Public Health England London Coronavirus Response Cell (LCRC) within the first 48 hours following notification. The local focus is therefore on testing. Key priorities concern residents and staff in care homes, extra care and supported living settings, which all support the most vulnerable residents and venues at scale that therefore pose the greatest risk of transmission. Access restrictions to the national portal in August and September were addressed by local arrangements, as were limitations on availability to testing in extra care and supported living settings. Local plans are in place for the re-prioritisation of local laboratory capacity in the event there are issues with national testing arrangements over the winter period.

23. **End of Life:** A new 24-hour service called *Your Life Line* led by CNWL went live on 2nd

November and is intended to assist people aged 18 and over who are in the last weeks or months of life to support them to remain in their own home, prevent avoidable admissions to hospital and respond to their choice about their preferred place of care at the end of their life. This is supported by a 2-hour face to face response service that is delivered by the third sector, i.e. Harlington Hospice. An in-reach palliative care nurse has also started at THH to support the discharge process for people on the palliative care pathway.

24. **Step-down Physical Needs**: Step-down provision to facilitate timely discharge comprises of a combination of bed-based and home-based supported. Non-weight bearing provision for Pathway 2 (see below) is delivered through the Hawthorn Intermediate Care Unit provided by CNWL and through beds commissioned by the CCG at Franklin House. 6 flats at Park View Court extra care scheme have been used for step-down purposes since May 2020 and will continue to be used for this purpose for the remainder of 2020/21.

**Discharge to Assess Pathways Explained**

- ***Pathway 0:*** 50% of hospital discharges – simple discharge, no formal input from health or social care needed once home.
- ***Pathway 1:*** 45% of hospital discharges – support to recover at home; able to return home with support from health and/or social care.
- **Pathway 2:** 4% of hospital discharges – rehabilitation or short-term care in a 24-hour bed-based setting.
- ***Pathway 3:*** 1% of hospital discharges – require ongoing 24-hour nursing care, often in a bedded setting. Long-term care is likely to be required for these individuals.

25. The D2A homecare service provided by Comfort Care Services supports the discharge of people from the Hospital. Care is provided for 72 hours pending a handover to Reablement or long-term care if required. Where there are clinical needs these are addressed by CNWL's D2A Community Service.

26. **Designated settings**: In October 2020 the DHSC directed that no one with Covid-19 should be discharged from hospital to a care home and that alternative venues should be identified that would subsequently need to be approved by the CQC. One 25 bed nursing home in Ealing has been commissioned by the NWL ICS but officers to continue to work with partners to identify alternatives in the event that there is insufficient availability within this facility to meet Hillingdon's needs as the pandemic develops over the winter period. Two proposed sites specifically for people with learning disabilities have been tentatively agreed by CQC and will be progressed.

27. **Single Point of Coordination within Hillingdon Hospital for Hospital Discharges:** An Interim Head of Integrated Discharge has been appointed and this post is jointly funded by the Council, CNWL, Hillingdon Hospital and HCCG.

28. **Criteria-led Discharge Roll Out:** '*Criteria-led'* discharge sets out the parameters under which clinicians other than doctors can approve discharges, e.g. nurses. Currently in limited use within THH, discussions are in progress with the intention of applying this in surgical and

medical wards to assist in expediting discharge.

29. **Integrated Urgent Response Hub:** This pilot service opened on the 2nd November 2020. The service is delivered by a multi-agency team comprising of GPs, Emergency Nurse Practitioners, Rapid Response, Mental Health and Age UK. The objective of the service is to prevent unnecessary referrals to the Emergency Department at Hillingdon Hospital. It is intended for people who:

- Need medical help fast, but the matter is not a 999 emergency;
- Do not know who to call for medical help;
- Have attended the Urgent Treatment Centre (UTC) inappropriately or are unsure if they need to go to A & E or another urgent care service;
- Need health information or reassurance about what to do next; or
- Require continuity of care when in-hours GP services are closed.

**Key Performance Indicators**

30. The following key indicators have been agreed across the system in respect of workstream 2:

- ***Daily bed occupancy rate at Hillingdon Hospital:*** The bed occupancy rate should be at no more than 90%, i.e. 31 bed capacity at the start of each day. *On track* – Currently weekly average is 87%.

- ***Length of stay of seven days or more:*** Percentage of people in hospital with a length of stay of seven days or more (known as '*stranded patients'*) should be no more than 30% of the bed base, i.e. 90 based on 315 core beds. *Slippage* – This is currently at 39% of bed base.

- **Weekend surplus of discharges (people admitted as emergencies) v admissions (people admitted as emergencies) should be more than or equal to 1.** Slippage – current weekly average is -14.

- ***Out of hospital capacity:*** Health and social care capacity at no more than 90% utilisation. *On track* – weekly average is 86%.

31. The following are mandated BCF indicators:

- ***Permanent admissions to care homes*** - This applies to permanent admissions to care homes by the Council of people aged 65 and over. The target (or ceiling) for 2020/21 is 170 permanent admissions. The outturn for 2019/20 was 174 admissions against a target of 170. *On track* – There were 31 placements during the review period and this low number is linked to a reduction in the number of homes accepting placements during the first wave of the pandemic.

- ***Effectiveness of reablement*** - This is seeking to identify the proportion of people aged 65 and over who have been discharged home from hospital into reablement who are still at home 91 days after the discharge. The review period for the national metric is people discharged in Q3 who are still at home by the end of Q4. The target in 2019/20 was 90% and the outturn was 89.4%. The target for 2020/21 is 90%. The outturn data for this metric will not be available until May 2021.

32. The Board may wish to note that it was expected that a target for emergency admissions would be set for 2020/21 as part of the BCF requirements. In the absence of the BCF planning requirements no specific BCF target has been set and this is in the context of emergency admissions to THH for the review period being 28% below the same period in 2019/20. In addition, attendances at THH during the review period is also 23% below the same period in 2019/20.

**Workstream 3: Elective Care Recovery**

**Workstream Highlights**

33. **Elective Care Business Case:** Redesign on the delivery of elective care pathways focused on 5 specialities which account for over 50% of outpatient activity, namely: musculoskeletal (MSK), ophthalmology, dermatology, gynaecology and gastroenterology in order to address current and 'backlog' demand related to the pandemic. The business case is scheduled to be considered by the HHCP Delivery Board in December 2020.

34. **Integrated Advice and Guidance Hub**: A new pilot Advice and Guidance system (A&G) went live across Hillingdon GP practices, THH, community and primary care providers in June 2020. The scope of the project was focused on enabling GPs to obtain rapid access to consultant advice and guidance prior to a routine/urgent referral being requested across all specialties. During this period the service has successfully enabled consultants to triage approximately 50% of requests to primary care and ensure that patients that require an outpatient appointment are prioritised. This pilot was part of the process of reinstating planned care on a phased basis and the outcomes from it fed into the business case referred to in paragraph 33 above.

**Workstream 4: Children and Young People (CYP)**

35. The projects that sit under this workstream include:

- Community step up/step-down model (Providing Assessment & Treatment for Children at Home (PATCH))
- Children and Adolescent Mental Health Service (CAMHS) Early Help and Intervention Hub
- Preparation for Adulthood (PfA)
- Special Educational Needs (SEND) Review and Education, Health and Care Plans

**Workstream Highlights**

36. **Community step up/step-down model:** With the intention of establishing the PATCH service as soon as possible, THH is in the process of recruiting to vacant CYP nursing posts and CNWL is exploring the feasibility of providing short-term temporary support.

37. **CAMHS Early Help and Intervention Hub:** CAMHS is the subject of a separate report on the Board's agenda.

38. **Preparation for Adulthood:** Two new PfA nurses have joined the service to support young people in the transition from Children to Adult Services. A steering group has been established to oversee this service development with good engagement and wide representation from stakeholders, which in addition to the Social Care includes THH, CNWL and Young

Healthwatch. A framework for the involvement of young people has been developed through a proposed quarterly Young People's Transition Network meeting and supported by Young Healthwatch.

**Workstream 5: Mental Health and Learning Disability**

39. The projects that sit under this workstream include:
- Mental Health Single Point of Access
- Multimorbidity Mental Health Rehab and Recovery
- Mental Health Urgent and Crisis Care
- Learning Disabilities Integration

**Workstream Highlights**

40. **Mental Health Single Point of Access:** A multi-agency project group has been established to explore how the current model can be improved. This work is in its early stages.

41. **Multimorbidity Mental Health Rehabilitation and Recovery:** This is focused on the step down and person flow across the wider system. This is linked to the SPA project and is also in its early stages.

42. **Mental Health Urgent and Crisis Care:** The Coves safe haven for adults aged 18 and above who are in mental health distress or crisis was commissioned by CNWL and delivered by Hestia and sent live during the review period. This is open from 4pm until midnight 7 days a week and is intended to divert people from attending A & E unnecessarily.

43. **Learning Disabilities Integration**: An options paper exploring the different integration models for community teams for people with learning disabilities is in development for consideration and decision in Q4 and implementation during 2021/22.

44. **Supported living setting model for people with learning disabilities that maximises independence**: Following a competitive tender, contracts for the provision of care and support to people with learning disabilities living in ten supported living schemes will transfer from six different providers to two. Completion of the transfer process has been delayed by the pandemic but will be completed by the end of 2020/21. This will facilitate stronger working relationships between providers and relevant partners within HHCP.

**Enabling Workstreams**

45. The successful and sustainable delivery of the five workstreams are dependent on five key enabling workstreams and these are:
- Supporting Carers.
- Care Market Management and Development.
- Digital, including Business Intelligence
- Workforce Development
- Estates

46. **Enabler 1: Supporting Carers:** The critical role that Carers have in supporting the local care system is now accepted by partners across Hillingdon's health and care system and the

agreed focus during 2020/21 is on embedding the achievements of the 2018-2021 Carers' Strategy as business as usual pending the availability of new data about Carers and their needs being published from the national census that is due to take place in March 2021. The Council is the lead organisation for this enabling workstream.

47. A detailed report on the delivery of the Carers' Strategy was considered by the Council's Cabinet and the CCG's Governing Body in May and June 2020 respectively. This report can be accessed via the following link https://modgov.hillingdon.gov.uk/ieListDocuments.aspx?CId=115&MId=3483&Ver=4. An update report was also considered by the Council's Social Care, Housing and Public Health Policy Overview Committee on 26 November 2020 and this report can be accessed via this link https://modgov.hillingdon.gov.uk/ieListDocuments.aspx?CId=385&MId=3709&Ver=4

48. **Enabler 2: Care Market Management and Development:** In accordance with its duties under the Care Act, 2014, the Council is the lead organisation for this enabling workstream, the primary objective of which is to support the sustainability of the market during the pandemic and beyond and integrate commissioning arrangements where this will produce better outcomes for residents and the local health and care system. The key components of this workstream are set out below.

**Workstream Highlights**

49. **Provider Engagement Plan**: During the first wave of the pandemic weekly conference calls were held with providers registered with CQC to deliver personal care in the different care settings, i.e. care homes, homecare, supported living. After a period where this was stepped down to once a month it has now increased to fortnightly and calls also include a range of partners across HHCP. The provider fora present an excellent opportunity to both update providers about developments but also get feedback on what is happening in their respective care settings. The fortnightly calls are supplemented by a weekly newsletter that goes to all registered providers operating within the Borough.

50. **Single Point of Contact (SPoC):** A named individual has been identified for registered providers and partners and this person is based in the Council's Quality Assurance Team (QAT).

51. **COVID-19 Testing for Care Providers**: In addition to paragraph 22 the Board may wish to note that the QAT staff currently address outbreak, testing and results issues with care home managers on their daily calls with care home managers. Care home managers are required to update this information on Capacity Tracker, which is database developed by the NHS. Unfortunately, the accuracy of the data on this system is still evolving, thus necessitating a separate situation report being updated twice a week for submission to NWL. The QAT are also in daily contact with supported living schemes and identify outbreaks and testing issues. Data about the outbreak and testing situation in supported living will be included in the sitrep reporting referred to Gold Command via NWL. Additional staff resources have been allocated to the team funded through the BCF in order to provide additional capacity to support providers.

52. **Infection Control Fund:** This grant was introduced in May 2020 to prevent the transmission of Covid-19 between care homes and support workforce resilience. Of Hillingdon's total allocation of £2,114k, £1,635k was paid as required under the grant conditions to the 39 providers of Hillingdon's 48 care homes that were supporting up to 1,486 care home residents.

The Council decided to use its discretionary allocation from the Fund to pay £452,278 to 17 providers of 43 supported living schemes in the Borough that were supporting the independence of approximately 470 residents. A second round of the grant has been introduced covering he period between 1 October 2020 and 31 March 2021 and Hillingdon has been allocated£2,052k, 80% of which must go to care homes and providers registered with CQC to deliver personal care to residents in their own homes, including in extra care and supported living settings. In view of the higher levels of risk of Covid transmission in settings where people are receiving personal care, the Council has decided to use its £410k discretionary allocation to also support CQC registered providers.

53. **Personal Protective Equipment (PPE):** During the first phase of the pandemic the Council used funding from its allocation from the Government's Covid-19 emergency funding to purchase for distribution to care homes and homecare providers in the Borough. Providers are now able to access PPE through a national portal. The Council, however, continues to maintain a stock for emergencies.

54. **Lead Commissioning Arrangements**: During the first wave of the pandemic, i.e. from 19th March to 31st August 2020 the Council led on behalf of the CCG in the commissioning of homecare and residential care home provision and the CCG led on the commissioning of nursing care home placements, although the Council's Brokerage Team provided support. This arrangement has continued post 1 September and discussions are in progress about the development of integrated brokerage arrangements.

55. **Training Programme for Care Home Staff:** Clinical support has been provided to care homes by CNWL via the care home matrons and other staff on a range of issues, including falls management, tissue viability, nutrition and medication. This has been supplemented, particularly for homes supporting people with learning disabilities and/or mental health needs by support from the NWL Care Home Support Team about infection control and the '*donning'* and '*doffing*' of PPE.

56. **Enabler 3: Digital, including Business Intelligence:** The main objectives of this enabling workstream are to reduce the risk of Covid-19 transmission through the application of digital technology and to utilise the opportunities present by it improve efficiency across the health and care system. This includes the improved utilisation of data to inform interventions and the allocation of resources.

**Workstream Highlights**

57. **E-consultations in primary care**: e-Consultation best practice has been developed following a trial in some surgeries and this will be extended to all practices. This is with the intention of scaling up e-consultation across all PCNs.

58. **Remote Consultations in Care Homes:** 29 tablets have been distributed to 14 care homes for older people in Hillingdon through a national campaign coordinated by the NWL ICS to facilitate easier access to GP and other health professional support without the necessity of an in-person visit to care homes. This has been supplemented by an i-pad offer through NHSx, the unit within the DHSC with responsibility for setting national policy and developing best practice for National Health Service technology, digital and data, which will benefit care homes in the Borough supporting people with learning disabilities and/or mental health needs.

59. **Remote monitoring:** NWL is currently in the process of commissioning a company to deliver a system that will monitor vital signs in care homes and the results of the process should be known in the New Year. Vital signs include oxygen saturation, heart rate, respiratory rate, temperature, blood glucose level, blood pressure and weight.

60. The Board is reminded that the Council also has in place its TeleCareLine Service, which includes access to a range of sensors, e.g. exit, movement, epilepsy, involuntary bed wetting (enuresis), and detectors, e.g. falls, smoke, carbon monoxide, flooding. This is available free of charge to residents aged 70 and over and the service is supported by a mobile response service for residents who do not have anyone who can act as a first responder in the event of a call or in instances where this person cannot be contacted.

61. **Integrated Business Intelligence**: The business intelligence function across HHCP is being integrated to ensure consolidation and consistency of data. This will link into activity data provided at an NWL level, as well as through the Whole Systems Integrated Care System (WSIC) that will help to ensure that the resources allocated across PCNs are directly linked to the health needs of local populations. This function also links into the Council's own Business Intelligence Team and will contribute to shaping the Joint Strategic Needs Assessment (JSNA).

62. **Enabler 4: Workforce Development:** The sustainability of Hillingdon's health and care system is dependent on having a workforce with the capacity and capability to meet the needs of the local population.

**Workstream Highlights**

63. **Workforce Wellbeing**: A psychological therapy service called *Keeping Well* is available to support health and care workers working in the eight boroughs across North West London, including Hillingdon. This service is intended to support staff through any mental health challenges they are facing during the coronavirus pandemic and beyond.

64. **Integrated Community Workforce Plan:** A plan is under development intended to expand and embed integrated roles across HHCP to reduce duplication and improve efficiency, e.g. integrated management structures for Neighbourhoods, Intermediate Tier Services (also known as step-up or step-down services) and End of Life.

65. **Independent Sector Workforce Resilience:** It is the responsibility of each social care provider to ensure that they have a sufficient and appropriately qualified workforce available to meet their CQC registration requirements. However, the QAT monitors vacancy and retention levels and identifies possible interventions to provide support where there are issues. This can include training delivered by HHCP partners as previously mentioned.

66. **Enabler 5: Estates:** This workstream concerns maximisation of available property assets to meet current and future needs of the health and care system. There is a separate item on the Board's agenda about strategic estates development across HHCP partners.

**Finance**

67. Provisional financial arrangements for the 2020/21 BCF plan were reported to the Board at its September 2020 meeting and for ease of reference these are summarised in tables 3 and 4 below. The provisional arrangements were pending the publication of the final planning

requirements by NHSE, which has not occurred. In the meantime, discussions have been taking place to secure agreement on the respective financial contributions by the Council and the CCG to meeting Covid-19 hospital discharge related costs. A resolution of this issue will enable the Council and the CCG to finalise the financial aspects of the 2020/21 BCF plan, as it is now understood from NHSE that a formal assurance process following a plan submission is not going to be required due to the lateness in the year. As reported to the September Board, the Council has approached discussions based on a cost neutral position for the authority, which means that our contribution will be the budgeted allocation for homecare and residential packages during the year.

68. The financial contribution mechanism for hospital discharge arrangements has been agreed in principle across NWL, although final agreement has yet to be formally reached. This is expected imminently. Once agreed, it will be possible to finalise the financial provisions of the BCF plan and utilise the approval delegation arrangements agreed at the September Board meeting, i.e. sign-off by the Chairman and Chairmen of HCCG's Governing Body and Healthwatch Hillingdon. The Council and CCG can then proceed to secure formal sign-off of the agreement under section 75 of the NHS Act, 2006, that will give legal effect to the agreed 2020/21 BCF arrangements.

69. It is understood that the Council will be required to submit a detailed financial template at the end of the financial year confirming the use of the funding streams within the BCF.

**Table 3: 2020/21 BCF Mandated Financial Requirements Summary**

| Item | 2019/20 Income | 2020/21 Income | % Difference |
|---|---|---|---|
| DFG *(LBH)* | 4,504,510 | 4,504,510 | 0 |
| Minimum CCG contribution | 18,361,811 | 19,401,312 | 5.4 |
| iBCF *(LBH)* | 6,207,140 | 7,248,248 | 0 |
| Winter Pressures *(LBH)* | 1,041,108 | | |
| **Minimum Total** | **30,114,569** | **31,154,070** | **3.4** |
| | | | |
| To Adult Social Care from minimum CCG contribution | 6,695,773 | 7,057,345 | 5.4 |
| NHS commissioned out of hospital services | 5,217,906 | 5,513,302 | 5.4 |

Key: DFG: Disabled Facilities Grant

| Table 4: Summary of Financial Contributions by Scheme, 2020/21 | | | | | |
|---|---|---|---|---|---|
| Scheme | | Financial Contribution | | | |
| | | 2019/20 | | 2020/21 | |
| | | HCCG (£,000s) | LBH (£,000s) | HCCG (£,000s) | LBH (£,000s) |
| 1 | Early intervention and prevention | 2,566 | 3,373 | 2,566 | 3,315 |
| 2 | An integrated approach to supporting Carers. | 19 | 983 | 19 | 939 |
| 3 | Better care at the end of life. | 819 | 0 | 819 | 0 |
| 4. | Covid-19 hospital discharge | 0 | 0 | tbc | tbc |
| 4A | Integrated hospital discharge and the intermediate tier. | 15,039 | 6,094 | 15,039 | 6,270 |
| 5 | Improving care market management and development. | 12,549 | 11,949 | 12,549 | 12,099 |
| 6 | Living well with dementia. | 0 | 372 | 0 | 379 |
| 7 | Integrated therapies for children and young people. | 2,231 | 441 | 2,246 | 542 |
| 8 | Integrated care and support for people with learning disabilities. | 6,195 | 30,322 | 5,224 | 29,530 |
| **TOTAL** | | **39,418** | **53,534** | **38,462** | **53,072** |
| **GRAND TOTAL** | | **92,952** | | **91,534** | |

## EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

### What will be the effect of the recommendations?

70. The Board will be able to see how integration and partnership working is proceeding in Hillingdon in order to support the health and wellbeing of residents during the pandemic and beyond. It will also guide officers and partners on how the Board wishes to see information presented to future meetings.

### Consultation Carried Out or Required

71. HHCP and the CCG have been consulted in the drafting of this report.

### Policy Overview Committee comments

72. None at this stage.

## CORPORATE IMPLICATIONS

### Hillingdon Council Corporate Finance comments

73. Corporate Finance has reviewed this report, noting that there are no direct financial implications associated with the recommendations set out above. Council contributions to the Better Care Fund outlined with the financial implications section of this report are fully reflected in the Council's monthly budget monitoring position.

### Hillingdon Council Legal comments

74. Section 223GA of the NHS Act, 2006, provides the legal basis for the BCF and gives NHSE power to make any conditions it considers reasonable in respect of the release of NHS funding to the BCF. Where it considers that an area has not met these conditions it also has the power, in consultation with the DH and DCLG, to make directions in respect of the use of the funds and/or impose a spending plan and impose the content of any imposed plan.

## BACKGROUND PAPERS

None.