# HILLINGDON'S JOINT HEALTH AND WELLBEING STRATEGY 2022-2025

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| **Relevant Board Member(s)** | Councillor Jane Palmer<br>Caroline Morison |
| **Organisation** | London Borough of Hillingdon<br>Hillingdon Health and Care Partners |
| **Report author** | Kevin Byrne - Health and Strategic Partnerships<br>Gary Collier - Health and Social Care Integration Manager |
| **Papers with report** | Appendix 1 - Draft Joint Health and Wellbeing Strategy<br>Appendix 2 - Single Performance Report (incorporating Better Care Fund performance update |

## 1. HEADLINE INFORMATION

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| **Summary** | This paper presents the draft Hillingdon Joint Health and Wellbeing Strategy 2022-2025 together with a single performance report setting out progress in delivering the Hillingdon Health Care Partner's priorities, the Better Care Fund (BCF) plan and activities set out in the draft strategy. The report also proposes approval arrangements for the 2021/22 BCF plan. |
| **Contribution to plans and strategies** | The Hillingdon Joint Health and Wellbeing Strategy (JHWBS) is the overall strategy for Health and Care in Hillingdon and sets out priorities and actions over the period 2022-2025.<br><br>The development of the JHWBS and BCF plan fulfil requirements within the Health and Social Care Act, 2012. |
| **Financial Cost** | There are no costs arising directly from this report. |
| **Ward(s) affected** | All |

## 2. RECOMMENDATIONS

**That the Health and Wellbeing Board:**

1. **agrees the draft strategy at Appendix 1 and agrees that it be made available for public consultation and that a final version be brought back to the Board at its next meeting.**
2. **notes and comments on the single performance report provided at Appendix 2.**
3. **delegates authority to approve the 2021/22 Better Care Fund Plan to the Corporate Director of Social Care and Health in consultation with the Co-chairmen, the Hillingdon Board representative of the North West London Clinical Commissioning Group and Healthwatch Hillingdon Chair.**

## 3. INFORMATION

### Background Information

3.1. The Joint Health and Wellbeing Strategy (JHWS) is the statement of a borough's intentions for the health, care and wellbeing of its local population. It is a requirement of the Health and Social Care Act 2012 that all local authorities and relevant Clinical Commissioning Groups work together to produce a strategy that reflects local needs and set out intentions across the health and care economy to lead the local place.

3.2. The draft 2022-2025 strategy builds on the good work undertaken with partners in Hillingdon in delivering the 2018 – 2021 strategy as well as the collective response to the considerable challenges presented by the Covid-19 pandemic. The new strategy sets out how services will recover from the pandemic to address the Population Health needs of local residents.

3.3. The new strategy is set at a particular snapshot in time at the end of summer 2021 and sets the approach we expect to take through our health and care partnership to improve services for the local population over the coming years. Our approach will be flexible to enable the system to adjust or refocus should circumstances change.

3.4. There are a number of supporting proposals and strategies cited in the strategy that will provide further direction as developed. The exciting development of a new Hillingdon Hospital is also central to the Strategy.

3.5. An important contributor to the delivery of the JHWS is the Better Care Fund (BCF). This Government initiative was introduced in 2014 with the intention of improving outcomes for local populations through the integration of health and social care. It is the main legal framework for delivering health and wellbeing outcomes that are dependent on integration between health and social care or closer working between the NHS and the Council. The Health and Care Bill currently proceeding through Parliament confirms the Government's intention that this will continue.

3.6. The single performance report in Appendix 2 provides the Board with an update on the delivery of the health and care transformation programmes led by Hillingdon Health and Care Partners (HHCP) and the Council, as well as the aspects within the scope of the BCF, into a single report, which also summarises some of the key issues for the Board. The Board's feedback on this approach would be welcome.

## 4. FINANCIAL IMPLICATIONS

4.1. The minimum financial contributions to the 2021/22 Better Care Fund by the Council and the North West London Clinical Commissioning Group (NWLCCG) are set out in Appendix 2. There are no direct financial costs arising from the recommendations in this report. The detailed financial contributions in respect of the 2021/22 BCF plan will be described in a subsequent report.

## 5. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

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

5.1. The proposed strategy and performance framework will enable the Board to drive forward its leadership to improve health and wellbeing outcomes for Hillingdon's residents.

### Consultation Carried Out or Required

5.2. It is proposed that the draft strategy be made available for public consultation, with responses brought back to the next Board for final approval.

### Policy Overview Committee comments

5.3. None at this stage.

## 6. CORPORATE IMPLICATIONS

6.1. Corporate Finance has reviewed the report and confirms that there are no direct financial implications arising from the report recommendations.

### Hillingdon Council Legal comments

6.2. 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 DHSC and MHCLG, 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. The Borough Solicitor confirms that there are no other specific legal implications arising from this report.

**Appendix 1**

# Joint Health and Wellbeing Strategy

# 1. INTRODUCTION

The aim of Hillingdon's Joint Health and Wellbeing Strategy is to improve the health and wellbeing of all our residents and to reduce disparities in health and care across our communities.

All health and care partners in the borough share this vision and commit to working together to integrate health and care to improve services, to promote wellbeing, prevent ill health wherever possible and to support people when they do become unwell.

This, our Joint Health and Wellbeing Strategy 2022-2025, contains our plans for achieving this vision. Our integrated approach will address these priorities through:

- Being driven by evidence and data
- Strengthening community capacity and resilience
- Building effective integrated teams
- Moving resource to where it will have most impact
- Using joined up information and aligning governance
- Effective management of our quality and performance

The delivery of this strategy between 2022 and 2025 will also be shaped by the Health and Care Bill currently proceeding through Parliament and the anticipated proposals from Government for Adult Social Care.

# 2 BACKGROUND

Hillingdon is the second largest of London's 32 boroughs covering an area of 42 square miles over half of which is a mosaic of countryside including canals, rivers, parks and woodland, interspersed with historic towns and villages. The borough is well served by a network of tube and rail links, especially into central London. The far south of Hillingdon is home to Heathrow Airport and the transportation infrastructure and hospitality services which support it. The Hayes area together with Yiewsley and West Drayton are more urban in nature. Uxbridge provides a metropolitan shopping centre and Tube line terminus and is home to Brunel University.

Our overall population is diverse and growing and people are living longer. It includes more affluent areas (within the top 20% nationally) as well as areas of deprivation (within the lowest 20% nationally).

Hillingdon enjoys many characteristics that makes taking a joint approach to meeting the health and wellbeing needs of our population less of a challenge than for some other areas. We have a single local authority, one acute hospital trust with two sites in the borough, a GP confederation that includes 43 of the borough's 45 practices, a single community health and community mental health provider and an established consortium of the five larger third sector organisations in the borough.

These local advantages, and our record of joint working, enabled Hillingdon to respond quickly to the demands of the Covid-19 pandemic. Together we delivered many changes, including providing more services over the phone or online, setting up joint health and care teams to provide care for people in the community to avoid emergency admissions, increasing capacity in key services such as Rapid Response, Discharge to Assess, Reablement and home care to

speed up the discharge of people from hospital back to their own home. Through joint work we have also helped the local care market to be more stable throughout the Covid-19 emergency.

Across our Health and Care system we have supported families and communities to access services they need. Our Community Hub worked closely with established foodbanks to meet emergency needs and has helped over 2000 with food support. During the pandemic we made direct contact with over 18000 residents who were deemed clinically extremely vulnerable to ensure that they had access to support needed. Through our partnership with the voluntary sector, we have referred residents so that they received emotional and practical support such as befriending and shopping. We have also engaged directly with over 150 local faith and community groups to promote the take up of Covid 19 vaccinations and to listen to views across our population.

In addition, the Government has now agreed that the Hillingdon Hospital site is to be developed as part of the Health Infrastructure Plan. Plans are now underway to development a new, modern, 21st-century hospital. Under the proposals the new hospital will provide the same range of healthcare services but with significant improvements that will mean a better patient experience. This new development offers a great opportunity for Hillingdon as we deliver on the health and care priorities in this strategy both through Hospital provision and in wider population health improvement.

# 3 HEALTH AND CARE CHALLENGES IN HILLINGDON

Hillingdon's Joint Strategic Needs Assessment (JSNA) identifies the key health and wellbeing needs of people in Hillingdon. It is regularly updated with the latest available information to help us respond to the changing needs of our population. For more information see http://www.hillingdon.gov.uk/jsna

On average, people in Hillingdon live longer and healthier lives compared to the rest of England. Data shows that:

*Life expectancy and life chances*

- Overall life expectancy in Hillingdon compares well with the national average.
- The number of years men can expect to live a healthy life, free from disability or poor health also compares well, but the figure is lower for women.
- The degree of variation in life expectancy across different areas within the borough is low for both men and women.
- Inequality in life expectancy for men and women in Hillingdon compares favourably nationally and regionally.

The evidence on life chances is also generally good:

- The proportion of children under 16 living in low income families is lower than the regional and national averages.
- Educational attainment is influenced by both the quality of education children received and family socio-economic circumstances. The average attainment score for pupils in Hillingdon at Key Stage 4 is higher than the national average and broadly the same as in London.
- Levels of employment affect life chances, and the proportion of working age people in employment in Hillingdon during 2019/20 was only slightly below the London and England average.

We know however that there are many existing health challenges which need to be addressed. In Hillingdon, compared to the national average:

- The mortality rate from all cardiovascular diseases is higher.
- The percentage of cancer diagnosed at early stage is lower.
- Physical activity among adults is lower.
- Smoking prevalence in adults is higher, including adults in routine and manual occupations.
- The incidence of tuberculosis is higher.
- The increase in overweight and obese children between ages 4-5 and 10-11 is higher.
- The dental health of children is worse.
- Admission to hospital for alcohol-related conditions is higher, including for women over 65.
- Our rate for hospital admissions due to asthma were worse than the England average.

We also know that we need to ensure more support is available from services to support people to take control of their own health and to address the problems caused by Long-Term Conditions including poor cardiovascular health, dementia, diabetes, learning disabilities, mental health, and 'Post Covid'.

Key indicators for Hillingdon's population are:

*Inequalities*

- Life expectancy in Hillingdon is estimated at 80.8 years for males and 83.8 years for females (data from 2015 to 17). There are inequalities within the borough at ward level - based on 2013-17 data, the gap in male life expectancy between Eastcote & East Ruislip and Townfield wards is 7.2 years and the gap in female life expectancy between Eastcote & East Ruislip and Botwell is 3.7 years.

*An ageing population*

- Up to 2025, the population in Hillingdon will increase by 7% with the over 65 population growing by 11%. As people age, the likelihood of them developing long-term conditions, and requiring hospital and other long-term care intervention increases.

*Carers*

- The 2011 census showed that there were over 25,000 Carers in Hillingdon providing unpaid support. The census also showed that 18% of unpaid carers were aged 65 and over and that approximately 10% of Carers were aged under 25, which emphasises the continuing importance of supporting Carers of all ages. An impact of the Covid-19 pandemic is likely to be an increase in the number of Carers in Hillingdon and it is expected that data from the 2021 census will support this.

*Long term conditions (LTCs)*

- 34,000 people in Hillingdon are known to have one or more long-term conditions. 51% of people in Hillingdon over the age of 65 state that their day-to-day activities are limited (either a little or a lot) by LTCs. This figure rises to 82% for those aged 85+.
- An estimated 9,854 people aged 65 and over had conditions which limited their activities a lot in 2020. A further 10,392 within this age group had long-term conditions that limited their daily activities a little in 2020 and it is expected that these needs will increase as the

population group ages.
- Local Hillingdon data analysis shows that 50% of all adult social care activity, 50% of all emergency admissions to Hillingdon Hospital, 51% of all first hospital outpatient appointments and 70% of all outpatient follow up appointments are utilised by just 5,500 people (3% of the adult Hillingdon population). These are local people with one or more unstable long-term conditions.

*Cardiovascular health*

- Deaths from cardiovascular diseases are slightly above the national and regional averages. The rate for men aged under 75 is significantly higher but is lower for women. However, the mortality rate from cardiovascular disease for people age over 65 is high.
- Hospital admissions for alcohol-related cardiovascular disease are high, for both men and women.

*Alcohol*

- Admission to hospitable where alcohol was the main or a contributing factor is slightly below the national average in Hillingdon but is above the London average.

*Smoking*

- The prevalence of smoking is below the national and London averages, but the numbers of people setting a date to quit smoking and numbers who quit successfully after 4 weeks is below average.

*Mental health*

- In 2020 an estimated 36,282 people were predicted to have a common mental health problem such as depression, anxiety, or OCD. 3,597 people over 65 were estimated to suffer from depression, and 1,147 from severe depression.
- The Quality Outcomes Framework records 2,640 patients diagnosed with mental health disorders (schizophrenia, bipolar disorder and other psychoses) on GP registers in Hillingdon in 2019/20, which is 0.81% of the GP register population. This is lower than the London average and lower than the average for England.

*Dementia*

- An estimated 3,033 people aged 65 or over in 2020 are likely to have dementia.
- GP registers record a lower figure. The Quality Outcomes Framework recorded 1,996 patients diagnosed with dementia on GP registers in Hillingdon in 2019/20, 0.63% of the GP register population. This is above the London average for GP observed prevalence of dementia but lower than the national average.

*Learning disabilities*

- Estimates indicate that there were 4,714 adults aged 18-64, plus 874 aged 65 or over, with learning disabilities living in Hillingdon in 2020.

*Autism*

- Estimates suggest that in 2020 there were 1,953 people aged between 18 and 64 living with autistic spectrum disorder (ASD) conditions and a further 396 aged 65 and above.

*Cancer prevention, detection, and survival*

- Figures for 2017 suggest that around 50% of cancers are diagnosed at an early stage in Hillingdon.

- Premature deaths from cancer are below the national average but are higher than the London average.
- Cancer screening coverage for breast and bowel cancers is below the national average but is similar to the rest of London.

*Obesity*

- 65% of adults in Hillingdon are classified as overweight or obese.
- Physical activity among adults remains low, with 31% of adults classed as physically inactive.
- Obesity among school-age children at both Reception and Year 6 is too high. Around one in 5 children at Reception Year are classified as overweight or obese. By Year 6 the proportion has increased to one in three.

*Child dental health*

- Nearly a third of children aged 5 in Hillingdon are reported to have visible tooth decay, which is higher than less than one in four nationally.

*Tuberculosis*

- The three-year incidence of tuberculosis remains higher than average, at 23.4 per 100,000.

*Post Covid*

- We know that the lasting effects of Covid are still being felt. A disproportionate impact of Covid infections and mortality rates have been seen amongst certain groups e.g. BAME communities and those from more deprived backgrounds. We will ensure that there is local support for people experiencing the longer-term effects of Covid.

# 4 PARTNERSHIP ACHIEVEMENTS: OUR STORY SO FAR

We have a history of strong partnership working in Hillingdon both between the different organisations within the NHS and between these bodies and the Council. Since 2015 this has been enhanced by the Government's Better Care Fund (BCF) initiative and then, from early 2020, impacted by the Covid-19 pandemic response.

Our main achievements resulting from partnership working include:

- **Creation of an Integrated Care Partnership (ICP) –** Known as Hillingdon Health and Care Partners (HHCP), Hillingdon's ICP was one of the first to be created in the country. Its purpose has been to bring organisations together to improve efficiency and effectiveness through a reduction in duplication and better use of resources, and thereby to achieve better outcomes for residents and to manage demand. HHCP comprises of the GP Confederation, the Central and North West London NHS Foundation Trust (CNWL), The Hillingdon Hospitals NHS Foundation Trust (THH) and the third sector consortium known as H4All. The latter includes Age UK Hillingdon, Carers Trust Hillingdon, the Disablement Association Hillingdon, Harlington Hospice and Hillingdon Mind. An alliance agreement between these organisations determines how decisions are made.

- **Creation of Primary Care Networks and Neighbourhood Teams** – 6 Neighbourhood Teams were set up in September 2020. These are coterminous with the 6 Hillingdon Primary Care Networks. The PCN/Neighbourhoods were the basic building block of our collective

response to COVID-19. Achievements included:

- Co-ordination and delivery of COVID-19 Vaccination Programme.
- Implemented zoned COVID-19 positive (Hot) and COVID-19 negative (Cold) facilities for managing patients face to face.
- Closer working with the 3rd sector including the volunteer hub to support 3rd sector partners and volunteers in the Borough.
- Developed an integrated Shielded and Vulnerable Person management function with all partners – in order that patients have one personalised care plan and one key worker across health, social care and volunteers.
- Implemented an Integrated COVID-19 Response hub including: a domiciliary visiting service, remote home-based monitoring of people with respiratory conditions (including using oximeters) and testing all patients in hard to reach community settings who need to be tested in a familiar setting (LD, supported living, children).

- **Active case management –** A single Care Connection Team for each PCN/Neighbourhood (6 in total) was put in place from September 2020 to manage the people most at risk of a planned outpatient intervention or an emergency admission. The teams identify people from GP Practice populations who typically have one or more complex or unstable long-term conditions usually with underlying mental health challenges and social care needs and who are more likely to live in poorer Neighbourhoods. A package of care is put together by the team to maintain them at home for as long as possible.

- **Establishing the High Intensity User Service** - By directing support to the top fifty most frequent attenders at Hillingdon Hospital this service has managed to reduce attendances and emergency admissions amongst this group by 38% and 51% respectively.

- **Establishing the Care Home Support Service -** This multi-disciplinary service comprising of GP's, nurses and therapists, provides daily calls to care homes for older people and weekly calls to people with learning disabilities and/or mental health needs. Working closely with the Council's Quality Assurance Team the intention is to provide clinical advice and support to care homes to avoid unnecessary demand on the London Ambulance Service (LAS) and avoidable attendances at A & E. The new service has reduced ambulance call outs from Care homes by 5% and emergency admissions by 13%. This service also supports the Council's four extra care sheltered housing schemes and is now based in one of them, Grassy Meadow Court.

- **Supporting the care market** - Close working between the Council, HHCP and the North West London Clinical Commissioning Group (NWLCCG) has resulted in targeted infection prevention and control information, advice and training being delivered to care home and homecare providers to help maintain key services during the pandemic.

- **Reformed "intermediate tier" services** – These services support discharge from hospital and the prevention of admission. The following changes have been introduced:
  - Establishment of a discharge hub to improve patient flow from the Hillingdon Hospital including integration of our community and discharge teams (HHCP and the Council).

- Establishment of an Integrated Urgent Response Hub to manage the needs of people requiring an urgent 2-hour response in the community to avoid unnecessary attendances at A & E and emergency admissions.

- Enhanced bridging care capacity delivered by an independent sector provider has meant that we have been able keep more people out of hospital in a crisis.

- The repurposing of flats within an extra care scheme for use as intermediate care has supported early discharge from hospital and prevented admission.

- **Transformed Outpatient Services –** The implementation of digital advice and guidance to GP surgeries from specialist hospital consultants at Hillingdon Hospital and the use of video as opposed to face-to-face appointments where clinically appropriate has reduced unnecessary outpatient referrals to the Hospital by 29%.

- **Integrated therapies for Children and Young People (CYP)** – Contractual arrangements for the provision of therapies to CYP with special education needs and disabilities (SEND) were brought together into a pilot single service focussed on triage and early intervention.

# 5 OUR PRIORITIES FOR 2022 – 2025

Our joint plan is intended to enable us to deliver on the following six priorities between 2022 and 2025:

- **Priority 1:** Support for children, young people, and their families to have the best start and to live healthier lives.

- **Priority 2:** Tackling unfair and avoidable inequalities in health and in access to and experiences of services.

- **Priority 3:** Helping people to prevent the onset of long-term health conditions such as dementia and heart disease.

- **Priority 4:** Supporting people to live well, independently and for longer in older age and through their end of life.

- **Priority 5:** Improving mental health, learning disability and autism services through prevention and self-management.

- **Priority 6:** Improving the way we work within and across organisations to offer better health and social care.

# 6 DELIVERING OUR PRIORITIES: WHAT WE WILL DO.

Annex 1 sets out the delivery plan actions required to deliver our priorities and sets out the metrics that will enable us to monitor and measure that a difference is being made to the lives of our residents and to the sustainability of Hillingdon's health and care system.

## Delivering Our Priorities

### Priority 1: Support for children, young people and their families to have the best start and to live healthier lives.

We know that the first year of life can have a huge impact on the health and wellbeing of an individual and that family and environmental factors will impact on the overall health of a child.

We have redesigned our offer of early help and prevention for families, and teams will adopt a multi-agency, locality approach to support children at the earliest possible stage by working closely with partners across Hillingdon in services for young people.

A new Stronger Families service, launched in August 2021, will engage families earlier and provide long-lasting solutions to ensure a safe, stable and nurturing environment in which children, young people and parents can thrive. The introduction of a unique Stronger Families 'hub' will offer a wide range of information, advice and support 24 hours a day, seven days a week.

Key actions will also seek to reduce the levels of obesity in our young children. We wish to see the increase in levels of overweight and obesity recorded at reception, through the National Child Measurement Programme of currently over 1 in 5, and at year 6 (currently over 1 in 3) reduced. Our Child Healthy weight plan seeks to work across partners, especially schools, to improve diet and nutrition and to increase levels of physical activity. We will promote greater uptake of breast feeding. We will work to see the levels of tooth decay reduced. We will also work to reduce smoking in families.

We will consolidate the integration of therapy services for children and young people (CYP) to redirect resources into early intervention and address unmet need through the reduction of duplication, the rationalisation of bureaucratic processes and embedding integrated triage and intervention teams.

### Priority 2: Tackling unfair and avoidable inequalities in health and in access to and experiences of services.

We will take a stronger evidenced based approach to identifying inequalities in Hillingdon and engage directly with our communities to understand how we can support their health and wellbeing. We will undertake, through collaboration with Brunel University, a new approach to our Joint Strategic Needs Assessment so that it not only provides an accurate picture of health in the borough but supports thinking as to how we can meet future needs and reduce health inequalities. This work will provide our evidence base to guide decisions for our public health programme and to tackle inequalities.

We will help to improve the life chances of people with learning disabilities and/or autism through increased integration between health and social care.

Informal Carers are crucial to the sustainability of Hillingdon's health and care system and many people undertaking a caring role do not recognise themselves as Carers. As a partnership we will increase the opportunities for people undertaking an unpaid caring role to be identified and ensure access to the support that will enable them to continue caring for as long as they are willing and able to do so.

**Priority 3: Helping people to prevent the onset of long-term health conditions such as dementia and heart disease.**

Cardiovascular disease and cancers are two of the main causes of death in Hillingdon, particularly in the 65 and over population. Actions to address the causes or contributors to these conditions, such as obesity, smoking and reducing alcohol consumption will assist in enabling our population to live longer and healthier lives. Increasing early detection will also facilitate early treatment and increase survival rates.

Vascular dementia is a type of cardiovascular disease and the actions taken to prevent other forms such as heart disease and stroke, would also apply. The promotion of a balanced healthy diet, keeping weight within recommended levels, keeping hydrated, stopping smoking, avoiding drinking too much alcohol and keeping cholesterol and blood pressure under control are all actions that will assist in stopping, or at least delaying, the onset of Alzheimer's disease, which is the main form of dementia. Increasing rates of detection also ensures access to early treatment and appropriate support networks.

We will also continue our work to support and prevent diabetes.

**Priority 4: Supporting people to live well, independently and for longer in older age and through their end of life.**

The focus of this priority is the 65 and over population. During the lifetime of the strategy partners will further embed neighbourhood working to identify people most at risk of losing their independence and ensure timely access to services that will prevent avoidable attendance and/or admission to hospital. This will include addressing risk factors such as susceptibility to falls and loneliness deriving from social isolation.

We will work through primary care networks to identify older people who may be at risk and offer proactive support and access to care. We will continue to support older people to live well through social activity programmes and support to voluntary and community groups.

We will further develop services to prevent a hospital admission where possible and expedite discharge where it is not or where an admission is appropriate to address medical need.

Taking into consideration the projected expansion in the older population during the lifetime of this strategy and beyond, we will plan for future retirement accommodation provision to address the future expected range of need.

For people who are on the end of life pathway, dying in hospital may not be their preferred choice. We will improve end of life services to ensure that people who wish to die in their own home rather than hospital are able to do so.

**Priority 5: Improving mental health, learning disability and autism services through prevention and self-management.**

Our aim is to ensure that people with mental health needs including learning disabilities and/or autism are able to live longer healthier lives.

We will expand the scope of the new model of care to support people living with mental health challenges and/or people with learning disabilities and/or autism at a neighbourhood level. We will work across partners to offer support early to prevent crisis but also to ensure that should crisis occur we have the right response in place to provide timely and appropriate support. We will offer a range of crisis alternatives to support both early intervention and those going through crisis. We will widen the offer of community support availability with the development of mental health and remodelled community mental health teams including primary care, additional roles reimbursement scheme.

We will expand the scope of our model of care to support people with learning disabilities and/or autism at a neighbourhood level.

We will work with partners to prevent suicide in Hillingdon and to offer support to those who are bereaved.

**Priority 6: Improving the ways we work within and across organisations to offer better health and social care.**

This priority concerns the key enablers upon which delivery of the other five priorities are dependent. The enablers are:

- *Care market management and development*: 92% of the Council's spend on care and support services for adults is with independent sector providers. NHS spend on care home and homecare provision is much lower than the Council's, but the same providers tend to be used. The sustainability of the independent sector care market is of critical importance to residents remaining independent in their own homes and to managing demand on more expensive services, which includes in-patient hospital services.

- *Digital and business intelligence led improvements*: This is about better use of data to improve understanding of need, capacity and pressure points and increasing efficiency and effectiveness through the use of digital technologies, e.g., telecare in people's homes and remote monitoring technologies in care homes.

- *Workforce development*: The availability of a suitably trained workforce is crucial to the delivery of the services required to support the independence and wellbeing of residents both within the independent sector provided care market and within HHCP. This enabler considers how early warning systems will provide alerts to possible capacity issue within the independent sector as well as the development of workforce development plans within and across HHCP.

- *Delivering our strategic estate priorities*: This enabler ensures that most effective use is made of existing NHS or Council owned assets to meet the current and future health and wellbeing needs of residents.

## Our Model of Care

The delivery of the above priorities is underpinned by the ways in which we work, or our "model of care" based on neighbourhood working. The cornerstone of the model is the implementation of a fully integrated health and care system through the six Neighbourhood Teams.

Hillingdon's model sets out to:

1. Boost '*out-of-hospital*' care and remove the distinction between primary (GP based) and community health services.
2. Redesign and reduce pressure on emergency hospital services.
3. Give people more choice and control over their own care, regardless of whether this is health or local authority funded. This includes through more personalised options, such as Personal Health Budgets.
4. Make digitally enabled primary and outpatient care mainstream.
5. Enabling people to live as independently as possible in the least restrictive, least supported care setting appropriate to meet their needs and wishes.

Key components of the model of care include:

- **Integrated Primary Care Networks (PCNs)/Neighbourhood Teams –** Neighbourhood teams are working with Primary Care Networks to meet the needs of people in their neighbourhood through active case management.

- **Expanding Active Case Management –** Neighbourhoods actively manage the top 15% cases within their population based on the level of need and the support required. Some of the key Neighbourhood interventions include:
  - The extension of Care Connection Teams (CCTs).
  - Continuation of the support service for frequent attenders at A & E.
  - Enhanced support to care homes through the Care Home Support Service.
  - Development of support for people with mental health needs.
  - A revised approach to delivering end of life services.

- **A reformed Intermediate Tier -** The Intermediate Tier includes a range of short-term services, i.e., up to six weeks, intended to support independence by promoting faster recovery from illness, preventing unnecessary emergency hospital admissions and attendances and premature admission to long-term residential care. Examples include rapid response, rehabilitation and reablement and short-term homecare to enable home-based assessments to take place, thereby reducing unnecessary stays in hospital.

- **Transformed Outpatient (Planned) Care –** Transforming outpatient care to reduce the number of unnecessary hospital interventions by investing in primary and community care alternatives, maximising the opportunities presented by the rapid digitisation of health during the COVID-19 pandemic and through the active case management by PCN/Neighbourhoods of the 5,500 patients most at risk of a hospital outpatient intervention.

- **Hillingdon Hospital Redevelopment** – Subject to all necessary approvals being obtained, a new hospital will be opening on the existing THH site within the lifetime of this strategy. The new build will reflect modern practices, including the use of technology and form an essential part of Hillingdon health and care system.

- **Integrated commissioning arrangements** - Lead commissioning arrangements between the Council and NHS partners are agreed where this will lead to better outcomes for residents and the health and care system. The commissioning of homecare services, a hospital discharge bridging care service known as D2A, nursing care home placements, community equipment and integrated therapies for children and young people are examples of where lead arrangements have been agreed.

# 7 DELIVERING OUR PRIORITIES: MONITORING DELIVERY

Six workstreams have been created to deliver the priorities. The workstreams and the priorities featured within their scope are shown below.

- **Workstream 1:** Neighbourhood Based Proactive Care - Priorities 2,3,5 and 6.
- **Workstream 2:** Urgent and Emergency Care - Priorities 2,3, 5 & 6.
- **Workstream 3:** End of Life Care - Priorities 3, 4 & 6.
- **Workstream 4:** Planned Care - Priority 3 & 6.
- **Workstream 5:** Care and support for Children and Young People - Priority 1 & 6.
- **Workstream 6:** Care and support for People with Mental Health challenges (including addictions) and/or People with Learning Disabilities and/or Autism - Priorities 2, 5 & 6.

Each workstream is led by a transformation board with a senior responsible officer (SRO) who holds an executive level position within HHCP or the Council. The transformation boards have responsibility for project managing the implementation of the delivery plan actions shown in Annex 1. The boards also have responsibility for monitoring performance against the metrics shown in Annex 1. Monthly performance reports are considered by the HHCP Delivery Board and quarterly progress updates by the Health and Wellbeing Board. The latter is jointly chaired by the Council's Cabinet Member for Health and Social Care and HHCP's Managing Director.

The cross-cutting nature of priority 6 means that the implementation of related delivery plan actions shown in Annex 1 impacts on all of the workstreams. Accountability for this aspect of the delivery plan sits with the Integrated Care Executive, which includes as its members the Corporate Director for Social Care and Health from the Council, the Hillingdon Joint Borough Directors from NWL CCG and the Managing Director for HHCP.

**Annex 1**

| Key Outcome Metrics: Joint Health and Wellbeing Strategy | | | |
|---|---|---|---|
| **Priority** | **Delivery Plan Actions** | **Place Based (Outcome) Metrics** | **Service (Lead) Metrics** |
| **1. Support for children, young people and their families to have the best start and to live healthier lives.** | • Transform the support offered across partners to families and children to promote healthy weight and reduce obesity. | • Percentage of term babies with low birth weight (under 2.5 kg)<br>• Levels of overweight and obesity in CYP at reception and Yr6.<br>• Hospital admissions for tooth decay under 5s<br>• Percentage of physically active CYP | • Improve take up and continuance of breastfeeding (to stage 3 of Unicef heathy baby standard)<br>• Reduce the increase in levels of overweight or obese children under the NCMP at reception and yr 6.<br>• Improve level of tooth decay in under 5s to the national average. |
| | • Develop a strong universal offer to ensure that CYP enjoy good physical, mental and emotional health. | • School readiness at end of reception.<br>• Children in absolute and relative low-income families.<br>• Age-standardised avoidable, treatable and preventable mortality rates in children and young people (aged 0 to 19 years) by sex.<br>• Children in need due to family stress or dysfunction or absent parenting: rate per 10,000 children aged under 18.<br>• Children in need due to abuse or neglect: rate per 10,000 children aged under 18 years.<br>• D&A and substance misuse under 18. | • Achieve national targets for waiting times for Eating Disorder services.<br>• Meet national targets for CYP Immunisation and vaccinations uptake rates (95% herd immunity).<br>• 35% of CYP with diagnosed MH condition seen by NHS funded community mental health services.<br>• % of patients treated within 18 weeks of referral to CAMH services. |
| | • Implement the long-term new integrated therapies pathway model for CYP. | • Percentage of children with a disability or long-term limiting illness. | • *85%* of referrals (reviewed by the MDT Panel) with referral decision communicated to the referrer within 2 weeks. |
| | • Work with Schools and families to improve participation, inclusion and attendance to | • Pupil absence<br>• Levels of school attainment including children not in school. | • Support families sooner through new family hubs<br>• Numbers of children out of school. |

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| | drive up levels of attainment. | | • Numbers of looked after children (LAC) |
| | • Support CYP and families experiencing SEN. LD and autism to ensure needs are met and the child's development is supported. | • Number of CYP with EHCP in employment, education, or training. | • Numbers of EHC Plans<br>• Timeliness of EHC Plans |
| **2. Tackling unfair and avoidable inequalities in health and in access to and experiences of services.**<br>(Learning Disability issues covered in priority 5) | • Undertake a Public Health review of disparities and inequalities in Hillingdon and recommend actions. | Note: metrics on this action will be agreed following completion of the next iteration of our JSNA with a strong focus on inequalities<br>• Life expectancy at Birth by Neighbourhood | • Levels of disparity in health and care services.<br>• Levels of disparity across wider determinants of health.<br>• Levels of disparity at neighbourhood level. |
| | • Ensure that all patients have fair and equal access to services, starting at the local level in Primary Care Networks and proactive approaches to wellbeing. | • The rate of unplanned hospitalisations by Neighbourhood per 100,000 weighted for population and need<br>• The rate of unplanned hospitalisations per 100,000 by Neighbourhood by ethnic group<br>• The rate of referrals per 100,000 moving to MH recovery by ethnic group (IAPT) by Neighbourhood. | • Develop neighbourhood plans to tackle local inequalities.<br>• 95% of YP will have a documented care plan in place on handover to Adult services / leaving care (taken from new Hillingdon Transitions service specification). |
| | • Reduce barriers to employment for adults with SEN, LD or autism and support people to access opportunities. | • Levels of employment, education or training in adults with SEN, LD or autism | • % of people with learning disabilities known to services in a) Part-time education; b) Training; c) Voluntary Employment; d) Paid Employment. |
| | • Reduce homelessness. | • Number of homeless people | |
| | • Tackle violent crime by reducing and preventing domestic abuse, supporting victims and reducing and preventing knife crime. | • Levels of knife crime<br>• Youth violence incidents<br>• Levels of first-time offenders/reoffenders<br>• Domestic abuse reported | • Youth justice strategic partnership action plan and dashboard |
| | • Ensure mechanisms are in place to identify and support Carers to enable them to continue in their caring role. | • Carers quality of life outcomes | • Deliver against Carers strategy targets<br>• % of Carers on the Carers' Register.<br>• Support for young carers |

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| **3. Helping people to prevent the onset of long-term health conditions such as dementia and heart disease and to successfully manage the impact of LTCs on their daily life.** | • Improve levels of prevention, detection, and survival for:<br>➢ Cancers<br>➢ Cardiovascular disease<br>➢ Dementia<br>➢ Covid -19 and Long Covid<br>➢ Alcohol and substance misuse. | • Under 75 mortality rate from Cardiovascular Disease by Neighbourhood | • No of Emergency Admissions to Hospital Bed by Neighbourhood<br>• No of ED attendances by Neighbourhood. |
| | | • Cancer prevalence per 100,000 population by Neighbourhood | • % of suspected cancer patients seen within 2 weeks by a specialist by Neighbourhood |
| | | • Dementia diagnosis rate by Neighbourhood | |
| | | • % of people in Hillingdon stating that their day-to-day activities are limited (either a little or a lot) by LTCs.<br>• Screening rates<br>• Obesity rates<br>• Physical activity<br>• Smoking cessation levels<br>• D & Alcohol misuse levels<br>• Patient education/self help | • Elective Care: % of patients treated within 18 and 52 weeks of referral by Neighbourhood<br><br>• Elective Care: No of New and Follow Up Attendances by Neighbourhood compared to target |
| **4. Supporting people to live well, independently and for longer in older age and through their end of life.** | • Embed PCNs and neighbourhood approaches to population health management (HIU, CEV list, Care homes etc) BCF W1 | • The rate of unplanned hospital admissions for adults with chronic ambulatory care sensitive conditions by Neighbourhood | • % of people in receipt of short-term services who achieved their agreed outcomes and require no further ongoing support. |
| | • Develop Urgent and Emergency Care and end of life support (BCF W2) | • The rate of emergency admissions for Hillingdon people aged 65+ with a stay of <24 hours by Neighbourhood<br>• % of deaths occurring in a hospital bed by Neighbourhood v regional and national averages. | • Proportion of people on an end-of –life pathway on CMC who achieved their preferred place of death per neighbourhood. |
| | • Determine capacity requirements for intermediate tier provision, i.e.., D2A and step-down/step-up, to support hospital discharge and admission prevention and implement. | • No of Permanent Admissions 65 + to Care Homes.<br>• % of people aged 65 and over discharged to reablement still at home 91 days later.<br>• % of Reablement users discharged requiring no ongoing long-term service. | • The proportion of Hillingdon people aged 65+ in hospital for more than 7 days by Neighbourhood |

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| | • Work with the voluntary and community sector to support people to live well, remain independent and to reduce loneliness. | • Falls prevention<br>• Care homes<br>• Re-admission rates to hospital by Neighbourhood | |
| **5. Improving mental health, learning disability and autism services through prevention and self-management.** | • Support people to remain in the community by reconfiguring community mental health services to provide MH expertise in primary care. | • Gap in the employment rate for adults known to MH services v overall adult population.<br>• Life expectancy for people living with mental illness (and by neighbourhood). | • Reduce delayed transfers of care.<br>• Reduce acute length of stay.<br>• Increased support to self-manage.<br>• Increased MH support in the community.<br>• ARRS roles recruited to.<br>• Further ARRS KPIs determined.<br>• Reduction in High Intensity Users. |
| | • Implement roles in primary care arising from the Additional Roles Reimbursement Scheme (ARRS). | | |
| | • Complete transition of Community Framework Transformation to a hub model. | | |
| | • Ensure universal and mental health services make reasonable adjustments for people with autism. | • Implement the requirements of the Autism Strategy published in July 2021. | • Reduction in adult assessment waiting times.<br>• Increased support for people newly diagnosed with ASD.<br>• Dynamic Support Register in place.<br>• Reduction in hospital admissions to make medication changes.<br>• Reduction in avoidable deaths. |
| | • Implement crisis and short-term intensive support teams for people with autism. | | |

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| | • Develop a collaborative approach to improve services for people who misuse drugs and alcohol and are mentally ill. | • Streamline the MH pathway.<br>• Adults in contact with secondary MH services living in stable and appropriate accommodation. | • Reduction in re-admissions rate.<br>• Reduced acute MH length of stay.<br>• Increased support to people to self-manage. |
| | • Remodel the MH pathway and provide a range of crisis alternatives that offer earlier intervention and support. | • Adults in contact with secondary MH services living in stable and appropriate accommodation. | • Reduction in acute crisis presentations.<br>• Increased access to community-based alternatives. |
| | • Deliver partnership plan to prevent and reduce suicide | • Rates of suicides per 100k population for both M&F | • develop real time surveillance approaches for suspected suicides and identify learning.<br>• monitor postvention bereavement support<br>• roll out MH 1st aid training and support for front line staff |
| **6. Improving the ways we work within and across organisations to offer better health and social care.** | <u>Care market management and Development</u><br>• Embed Adult Social Care provider engagement arrangements.<br>• Secure agreement on long-term integrated brokerage arrangements.<br>• Review Adult Social Care provider risk management arrangements.<br>• Establish and implement lead commissioning arrangements to address local health and care system care home placement requirements.<br>• Coordinate response to Covid-19 outbreaks within care homes and supported living services. | • % of Adult Social Care providers registered by CQC as '*good*' and above.<br>• Number of emergency admissions from care homes. | • Uptake of Covid vaccines in the community. |
| | <u>Digital and business intelligence led improvements</u>:<br>• Maximise scope for sharing | • Number of care homes approved to use CMC. | |

| | | | |
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| | activity data to ensure system wide understanding of capacity and pressure points and opportunities for early intervention.<br>• Promote roll out of advanced planning tool Coordinate My Care (CMC) in care homes.<br>• Embed remote consultation technology in care homes to facilitate access to timely advice from health and social care professionals.<br>• Establish a remote vital signs monitoring pilot in care homes to facilitate early intervention by relevant health professional.<br>• Promote use of telecare technology to support independence of residents.<br>• Maximise opportunities for sharing relevant activity data to ensure system wide understanding of capacity and pressure points. | | |
| | <u>Workforce development</u>:<br>• Complete and implement the HHCP integrated community workforce plan.<br>• Monitor vacancy and retention levels among Adult Social Care providers and identifies possible interventions to provide support where there are issues. | | |
| | <u>Delivering our strategic estate priorities</u>:<br>• Review Council and NHS | | |

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| | partner owned assets and determine scope for meeting current and future population and system needs. | | |

**Appendix 2**

# 2021/22 Integrated Health and Care Performance Report

## INFORMATION

### Strategic Context

1. In 2020/21 the Board received for the first time reports that integrated progress updates on the delivery of the Hillingdon Health and Care Partners (HHCP) Covid-19 recovery plan as well as the Better Care Fund (BCF) delivery plan. This report provides the Board with an update on delivery of the priorities within the draft Joint Health and Wellbeing Strategy for the April to June 2021 period (referred to as the '*review period'*), unless otherwise stated.

2. The progress towards an updated Joint Health and Wellbeing Strategy (JHWS) and associated delivery plan means that there will be a single delivery plan for Hillingdon. This will demonstrate how the six priorities within the proposed strategy shown in Appendix 1 will be delivered.

3. The report is structured as follows:
   A. Key Issues for the Board's consideration
   B. Workstream highlights and key performance indicator updates

### A. Key Issues for the Board's Consideration

**2021/22 BCF Planning: Policy Framework**

4. The policy framework for the 2021/22 BCF was published on the 19th August but the detailed planning requirements are awaited. Under a provisional timetable provided by NHSE, a plan would need to be submitted on the 30th October. The content of the policy framework is suggesting a hospital discharge focus for 2021/22.

5. The policy framework states that there are four national conditions and these are:

- **A jointly agreed plan between local health and social care commissioners that is signed off by the Health and Wellbeing Board**. *Commentary*: This condition is consistent with previous plans and forms the basis for the recommendation to delegate authority, which has been the practice in previous years.

- **NHS contribution to adult social care to be maintained in line with the uplift to the CCG minimum contribution**. *Commentary*: This condition is consistent with previous plans and has not proved an issue in previous years.

- **Investment in out of hospital services**. *Commentary*: This condition is consistent with previous plans and does not present an issue for Hillingdon as the value of the investment in out of hospital services exceeds the minimum requirement.

- **A plan for improving outcomes for people being discharged from hospital**. *Commentary*: There was a similar condition for the 2019/20 plan, which required a plan for

the implementation of the High Impact Change Model for Discharge. This condition appears to be broader but should not present an issue in view of the work already in progress in Hillingdon. The publication of the detailed planning requirements is awaited to confirm this position.

6. The framework identifies five metrics that will be mandatory. The two discharge-related metrics are consistent with the emphasis of the policy framework on hospital discharge. The metrics are:

- **Discharge indicator: Reducing the length of stay in hospital**. *Commentary*: The measure will be the number of hospital inpatients who have been in hospital for no longer than 14 and 21 days.

- **Discharge indicator: Improving the proportion of people discharged to their usual place of residence**. *Commentary*: This appears to be straightforward as it is a case of looking at where people were admitted to hospital from and where they were discharged to. It is unclear how a spell in a step-down facility before returning to their usual place of residence would be counted. The published planning requirements will hopefully address this point.

- **Avoidable emergency admissions:** *Commentary*: This new metric is intended to measure a reduction in people admitted to hospital for ambulatory care sensitive conditions.

- **Permanent admission to care homes of 65 and over population**. *Commentary*: This metric is from the Adult Social Care Outcomes Framework (ASCOF) and has been a national metric for the BCF since its inception. The aim is for admissions to be as low as possible. Subject to the publication of NHSE planning requirements, the provisional ceiling for 2021/22 is 170 permanent admissions. There were 55 permanent placements in Q1, 87% (48) of which were of people living with dementia. Although it is premature to make assumptions based on one quarter's data, a straight line projection would result in an outturn of 220 permanent placements.

- **Effectiveness of reablement.** *Commentary:* This is also an ASCOF metric that measures the percentage of the 65 and over population discharged into reablement from hospital who are still in hospital 91 days after discharge. It has also been a BCF metric since its inception but is widely discredited because the way it is calculated disincentivises people with high needs being accepted into reablement.

7. Areas will be required to set targets for the first three metrics shown in paragraph 6 above that will show improvement from Q3.

8. Following the submission of the 2021/22 plan there will be an assurance process undertaken jointly between NHSE, the LGA and ADASS. Once the plan has assured status it will then be possible to conclude the section 75 (NHS Act, 2006) agreement that gives legal effect to the partnership and financial arrangements within the plan.

## 2021/22 BCF Planning: Proposals

9. Table 1 below shows how the value of the BCF has increased in each successive year since its inception, which reflects increased trust and ambition.

| Table 1: BCF Plan Value, 2015 – 2021: Minimum Required v Actual | | | | | | |
|---|---|---|---|---|---|---|
| **Financial Year** | **2015/16** | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020/21** |
| **Minimum Required Value *(£,000)*** | 17,991 | 20,015 | 24,724 | 26,607 | 30,114 | 31,760 |
| **Actual Plan Value *(£,000)*** | 17,991 | 22,531 | 36,814 | 54,288 | 92,952 | 103,457 |

10. Officers and partners are asking the Board to delegate plan approval responsibility within the context of the following proposed changes that, if agreed, will result in further expansion of Hillingdon's BCF plan:

- *Scheme scope proposal*: That the scope of schemes is changed to directly align with the workstreams as identified in the draft JHWS shown in Appendix 1 of this report. This is illustrated in table 2 below.

| Table 2: Alignment of JHWS Delivery Workstreams, Priorities and BCF Schemes | | |
|---|---|---|
| **Workstream** | **JHWS Priorities in Scope** | **BCF Scheme** |
| **Workstream 1:** Neighbourhood Based Proactive Care. | 2,3,5 and 6. | ***Scheme 1:*** Neighbourhood development. |
| **Workstream 2:** Urgent and Emergency Care. | 2,3, 5 & 6 | ***Scheme 4:*** Urgent and emergency care. |
| **Workstream 3:** End of Life Care. | 3, 4 & 6 | ***Scheme 3:*** Better care at the end of life. |
| **Workstream 4:** Planned Care. | 3 & 6 | No related scheme. |
| **Workstream 5:** Care and support for Children and Young People. | 1 & 6 | ***Scheme 7:*** Integrated care and support for children and young people. |
| **Workstream 6:** Care and support for People with Mental Health challenges (including addictions) and/or People with Learning Disabilities and/or Autism. | 2, 5 & 6 | ***Scheme 6:*** Integrated care and support for adults with mental health needs. ***Scheme 8:*** Integrated care and support for people with learning disabilities and/or autism. |

- *Care budgets proposal:* That Council and NHS budgets for adult mental health and also for children and young people are included. Mental health budgets would include section 117 (Mental Health Act, 1983) after care funding, i.e., for support after a person has been detained in hospital and is discharged into the community. This serves to provide clarity and transparency about investment in supporting adults with mental health needs and children and young people. This clarity creates opportunities for achieving efficiencies.

- *Lead commissioning responsibility for third sector provided services proposal*: That

commissioning responsibility for services would transfer between the Council and the CCG where the other partner is the majority funder. The intention behind this is to eliminate dual reporting demands on providers.

## Hospital Discharge Funding

11. The NHS funded new or additional service provision for six weeks between April and June and four weeks from July to 30th September 2021. A decision is awaited on funding arrangements from the 1st October and the delay impacts on the ability of the system to plan for the second half of 2021/22.

## Winter Planning

12. Partners are working together to undertake planning to ensure that sufficient capacity is in place within Hillingdon's health and care system in the event that there is an increase in demand on capacity at Hillingdon Hospital. However, there is currently a lack of clarity about how much funding is available to support the process, which impacts on when it will be possible to mobilise additional capacity.

## Mandatory Care Home Staff Covid-19 Vaccinations

13. From 11th November 2021 it will be a legal requirement that staff working in care homes must have had both vaccine jabs unless they are exempt. The Council is currently working with providers to identify the impact of this new requirement on staff capacity.

## B. Workstream Highlights and Key Performance Indicator Updates

14. This section provides the Board with progress updates for the six workstreams, where there have been developments. It also provides updates on the five enabling workstreams. The absence of a workstream update indicates no significant milestone developments during the review period.

### Workstream 1: Neighbourhood Based Proactive Care

15. **Population Health:** Regular data about hospital attendances and admissions is now being provided to support the Care Connection Teams (CCTs) and ensure that the right people are being supported through case management. Validated CCT impact information for Q1 is not yet available but data for 2020/21 shows very positive outcomes. For example, by looking at the A&E attendances and emergency admissions of people joining CCT case lists in 2020/21 three months before and three months after they joined this shows an average reduction in attendances of 39.6% and emergency admissions of 34.4%.

16. **Health Checks:** In a rolling twelve month period progress has been made in the following areas:

- In a rolling twelve month period to August 2021 physical health checks for people with severe mental illness have been completed for 22% of eligible people at a Primary Care Network (PCN) level, which compares to 10% in the previous twelve month period.
- 54% of eligible people with diabetes have received checks.

17. The completion of health checks for the most vulnerable residents is being monitored within

primary care and assistance offered where needed.

| Some Terms Explained | | |
|---|---|---|
| **Care Connection Teams** | **Neighbourhood Teams** | **Primary Care Networks (PCNs)** |
| 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,<br>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. 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. |

18. **Covid-19 Vaccination Programme:** Table 3 below provides a summary breakdown of vaccinations by priority group that have been delivered to 16 August 2021.

| Table 3: Covid-19 Vaccinations by Priority Group | | | |
|---|---|---|---|
| **Priority Group** | **Plan** | **First Dose % Completed** | **Second Dose % Completed** |
| Age 80+ | 11,146 | 92.6% | 91.7% |
| Age 75 - 79 | 7,661 | 94.4% | 92.3% |
| Age 70 - 74 | 10,367 | 92.9% | 90.6% |
| Age 65 - 69 | 10,796 | 89.9% | 87.3% |
| Age 60 - 64 | 10,594 | 86.7% | 83.8% |
| Clinically Extremely Vulnerable | 6,660 | 92.2% | 87.6% |
| Vulnerable 16 - 65 | 23,646 | 83.6% | 77.3% |
| **TOTAL** | **80,870** | | |

Source: Whole Systems Integrated Care Vaccination Dashboard 18/08/21

19. Vaccination rates in care homes and amongst homecare staff are shown in table 4 below. The Board is reminded of the legal requirement from 11 November 2021 that staff in care homes must have received a double vaccination unless exempt.

| Table 4: Care Home and Homecare Covid-19 Vaccination Rates | | | | | | |
|---|---|---|---|---|---|---|
| **Vaccine Recipient** | **Hillingdon** | | **North West London Average** | | **London Average** | |
| | **Dose 1** | **Dose 2** | **Dose 1** | **Dose 2** | **Dose 1** | **Dose 2** |
| Care Home Residents | 95.5% | 91% | 95% | 92% | 91% | 88% |
| Care Home Staff | 91% | 84% | 87.5% | 79.5% | 86% | 76% |
| Homecare Staff | 83% | 64% | 76.8% | 55.5% | 73% | 49% |

Source: Capacity Tracker 12/08/21

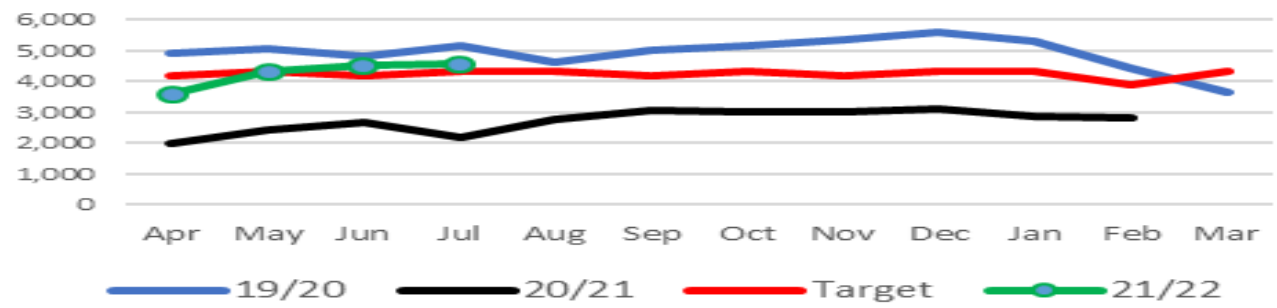
20. With the intention of addressing issues of vaccine hesitancy in care homes, the GP Confederation managed to secure agreement from Professor Sarah Gilbert to lead a webinar for care home staff. Professor Gilbert was one of the people who led the development of the Astrazeneca vaccine. The webinar took place in July and 30 people across a range of providers took part. This has now been distributed to all care homes in the borough as well as other providers, as the concerns addressed cut across the whole care sector.

## Workstream 2: Urgent and Emergency Care

### Workstream Highlights

21. **A & E Attendances:** Graph 1 below shows that attendances from the Hillingdon population have been increasing since April. They are now slightly over the 140 a day target and work will focus on maintaining the target number as we approach the autumn and winter period.

**Graph 1: A & E Attendances – Hillingdon Hospital Only**

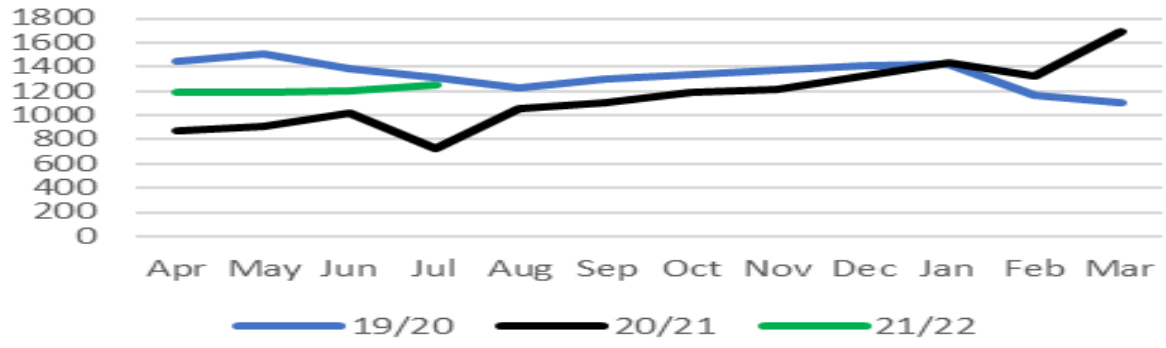



22. **Urgent Treatment Centre (UTC):** This is for residents who have an urgent or severe condition or minor injury that cannot wait for a GP appointment (usually 48 hours). Hillingdon's UTC is based on the Hillingdon Hospital main site and has seen attendances increase from an average of 256 a month in the four months between April and July 2021 compared to 165 a month in the previous four month period, which coincided with the third lockdown.

23. A UTC survey in July 2021 showed that 60% of people attending the UTC had contacted their GP and were unable to get an appointment and/or had been advised to use this service. The CCG's Primary Care Team is working together with GP practices that have high numbers of attendances at the (UTC) to ensure that patients are able and aware of how to access appointments at their practice as well as that there are an appropriate number of GP appointments for NHS111 to book directly. The number of NHS 111 bookings into GP practices has increased from 70 a week in April 2021 to 144 a week in July. NHS 111 is available to help residents if they have an urgent medical problem and are unsure what to do.

24. **Emergency Admissions:** The graph below shows that there has been a steady increase in the number of emergency (also known as non-elective or NEL) admissions during the Q1 and that these are progressing towards similar activity levels to the same period in 2019/20, i.e., that is, pre-pandemic.

**Graph 2: Emergency Admissions – Hillingdon Hospital**




25. **Step-down and Discharge:** A range of service provision continues to be in place within the community to support the discharge pathways (see below). An issue for Hillingdon is about length of stay and to help reduce partners are working towards an integrated therapy model that

will support residents both in and out of hospital. A task and finish group has been established to drive this forward with the further objective of improving efficiency by reducing duplication.

**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 people.

26. **Home Therapy Pilot:** The pilot, which is being delivered by CNWL, began on 1st June to support discharges of people who need therapy at home but not necessarily the next day. Further promotion of this service amongst partners will be undertaken to raise awareness.

27. **Urgent Care Nurse Practitioner Service:** This service provides advice and can offer treatment for minor injuries or illnesses. It is led by Hillingdon Hospital and is based at Mount Vernon. It went live on the 19th April. The service operates 8am to 7pm seven days a week and bookings are via the UTC or GP practice staff. Appointments are initially by telephone with a face to face follow up if appropriate.

## Key Performance Indicators

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

- ***Daily bed occupancy rate at Hillingdon Hospital:*** The current bed occupancy target should be at no more than 90%, i.e. 31 bed capacity at the start of each day. *Slippage*: Q1 average was 95%
- ***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. 94 people based on 313 core beds. *Slippage*: Q1 average was 48% (148 people based on 303 core beds).
- ***Out of hospital capacity:*** Health and social care step-down capacity should be at no more than 90% utilisation. This includes bedded services such as the Hawthorn Intermediate Care Unit (HICU), Park View Court step-down flats and beds in three care homes, as well as services such as the Rapid Response D2A service and District Nursing. *On track: The Q1 average was 77%,* therefore suggesting that there was sufficient community capacity to meet demand.

## Workstream 3: End of Life Care

### Workstream Highlights

29. **Compassionate Neighbours:** This is a project that provides community-led support for anyone who is living with a long-term or terminal illness, is elderly or frail, socially isolated or nearing the end of life through age or illness. Funding has been secured via NWLCCG to develop this initiative in Hillingdon and Brunel University is currently working on an evaluation proposal that will be considered by NHSE.

## Workstream 4: Planned Care

### Workstream Highlights

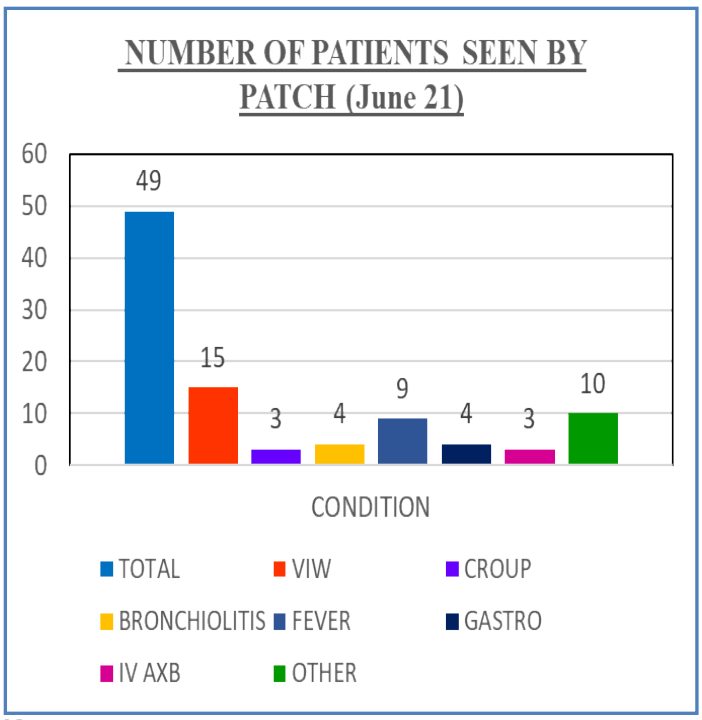
30. **Pathway redesign:** Priority is being given to gynaecology, gastroenterology and musculoskeletal (MSK), ophthalmology and dermatology to determine what activity can take place in the community rather than in hospital.

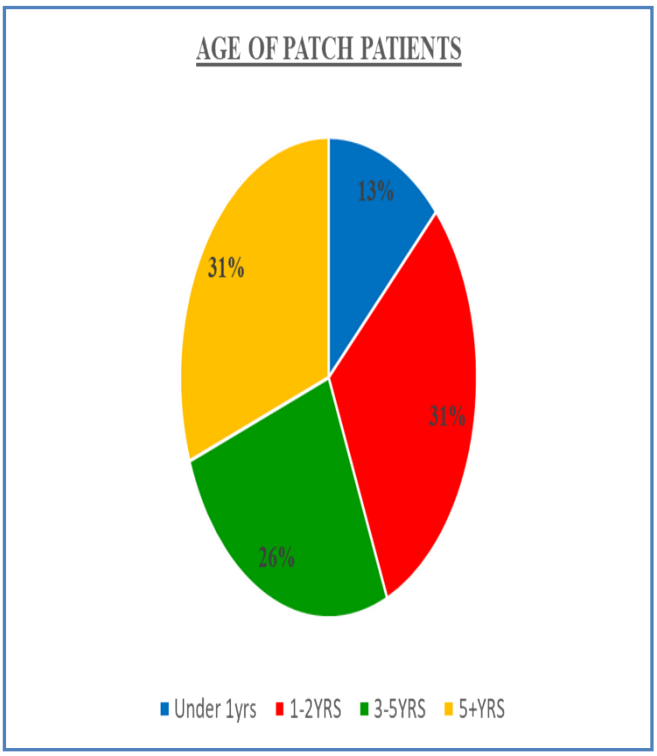
31. **Integrated Advice and Guidance Hub**: The Advice and Guidance system (A&G) went live across Hillingdon GP practices, THH, community and primary care providers in June 2020 with the intention of enabling consultants to triage requests from primary care to ensure that patients who required an outpatient appointment were prioritised. During the review period there have been 3,900 requests a month. The three main specialties about which advice is sought are cardiology, gastroenterology and haematology. On average, 63% contacts were for advice only and did not lead to a referral, thereby reducing demand on planned care services.

## Workstream 5: Children and Young People (CYP)

### Workstream Highlights

32. **Community step up/step-down model:** The Providing Assessment & Treatment for Children at Home (PATCH) service went live in June 2021. 49 children were supported by the new service in June and the graphs below show cause of referral and a breakdown of the age of people seen by the service.




**Key:**
IV AXB – Intravenous anti-biotics
VIW – Viral induced wheeze.

33. **Children and Adolescent Mental Health Service (CAMHS) Early Help and Intervention Hub**: The service model for an urgent advice line has been developed and an operational lead and some clinical posts recruited to. 70% of posts have been recruited to and the service will become operational once the full staff complement is in place.

## Workstream 6: Mental Health, Learning Disability and Autism

### Workstream Highlights

34. **Older Adults:** The Older People Safely Home Service operated by H4All to support the discharge home of older people from the Woodland Centre on the Hillingdon Hospital main site is now live. A discharge coordinator has been recruited to work with H4All staff to facilitate proactive discharge planning.

35. **Additional Roles Reimbursement Scheme (ARRS):** This scheme is designed to expand the primary care work force and enable more proactive, personalised and integrated health and social care. In Hillingdon this scheme is being utilised to provide additional mental health clinical support at a PCN level. A project to establish these roles in Hillingdon is being jointly managed between The Confederation and CNWL with job descriptions agreed for recruitment.

## Enabling Workstreams

36. The successful and sustainable delivery of the six workstreams is dependent on five key enabling workstreams and these are:

1. Supporting Carers.
2. Care Market Management and Development.

3. Digital, including Business Intelligence
4. Workforce Development
5. Estates

37. **Enabler 1: Supporting Carers:** The Council is the lead organisation for this enabling workstream.

**Workstream Highlights**

38. A multi-agency working group has been convened to implement the 2021/22 delivery plan and develop an updated strategy once the data from the 2021 census has been published. Carers Trust Hillingdon is leading on a process to recruit Carer representatives on this group in time for its December 2021 meeting. A key target for this enabling workstream is for face to face provision of Hillingdon Carers Partnership provided services to be restored by September and this is on track.

39. **Enabler 2: Care Market Management and Development:** The Council is the lead organisation for this enabling workstream, the primary objectives of which are to support the sustainability of the market as it emerges from the pandemic and also to integrate commissioning arrangements where this will produce better outcomes for residents and the local health and care system.

**Workstream Highlights**

40. **Provider Engagement Plan**: Conference calls with care home managers take place fortnightly and with homecare providers monthly and involve partners across the Council and HHCP in order to support the local care market. In addition, weekly newsletters for CQC registered providers are produced by the Council, i.e., there are targeted newsletters for care home, home care and supported living providers. The newsletters provide an opportunity for key messages from the Council and HHCP to be targeted to the appropriate recipients. These also provide a single location for updates to national guidance.

41. **Infection Control and Testing Fund:** In May 2020 a new grant was introduced by the Government to support care providers in reducing the transmission of Covid-19 in and between care settings. Since 13th May 2020 the Council has received £5,425k up to the 30th September 2021. In December 2020 a further grant was introduced to support care providers with testing arrangements for Covid-19. Since the 2nd December 2020 the Council has received £1,436k up to 30th September 2021. The majority of the funding has been used to support care home providers. Homecare providers and providers registered with the Care Quality Commission (CQC) based in extra care and supported living have also benefitted. Unfortunately, strict and inflexible criteria have made it difficult for some providers to make use of the funding. Additionally, burdensome monitoring requirements have made administering the funding resource intensive.

42. **Care Home Support Team**: This team now comprises of six care home matrons and a dietician. The team provide clinical advice and support to Hillingdon's 47 care homes and also to the care provider within extra care. Each care home and extra care scheme has a designated care home matron. Care homes for older people receive daily support calls from both the Council's Quality Assurance Team (QAT) and their designated care home matron. Care homes for people with learning disabilities and/or mental health needs receive daily calls from the QAT

and weekly calls from their designated care home matron. The difference in frequency of contact from the relevant care home matron for care homes supporting people with learning disabilities and/or mental health needs is that occupants tend to be younger and have lower levels of physical needs than the care homes for older people. The Board may wish to note that in June 2021 Grassy Meadow Court became the base of the Care Home Support Team.

43. **Enabler 3: Digital, including Business Intelligence:** The main objectives of this enabling workstream continue to be to reduce the risk of Covid-19 transmission through the application of digital technology and to utilise the opportunities presented 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**

44. **Remote monitoring:** NWL has commissioned a company to deliver a system that will monitor vital signs in care homes. Vital signs include oxygen saturation, heart rate, respiratory rate, temperature, blood glucose level, blood pressure and weight. Provider workshops on the operation of the monitoring equipment and related support will be taking place during August and September with the intention that the pilot will become operational incrementally by the end of September 2021.

45. **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**

46. **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.

47. **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.

48. **Enabler 5: Estates**: A Strategic Estates Group involving partners from NHS Property Services, Hillingdon Hospital, CNWL and the Council now meets on a regular basis to review available assets and opportunities for effective utilisation. As a result, a separate project board has been established to consider the development of the north of Hillingdon health hub on the Northwood and Pinner Cottage hospital site development.

**Health Hubs Explained**

Health hubs will provide centres where multi-disciplinary teams of health and other professionals are able to support local communities through joining up care planning and provision. The intention with health hubs is to deliver more services at a local level. It is intended that there will be three hubs in Hillingdon, i.e., in North Hillingdon (Northwood and Pinner Hospital), Uxbridge and West Drayton (site tbc) and Hayes and Harlington (site tbc).

Tbc – To be confirmed.

49. Two other developments in respect of estates are:

- **Care Home Support Team based in extra care:** Referred to in paragraph 42, the two consulting rooms within Grassy Meadow Court now provide the base for the care home support team. This helps to make best use of available accommodation and provides additional clinical support to the care provider.

- **Comfort Care Services based at the Civic Centre:** Comfort Care Services delivers a range of services for the Council, e.g., homecare, D2A, extra care and supported living and is a key strategic independent sector partner. In August 2021 they moved into the Civic Centre. This will provide a single CQC registered office for their homecare operation and aid communication with care management, the NHS and other Council services.

**Finance**

50. The sources and allocation of funding under the BCF are set out in table 5 below. This shows that the minimum value of Hillingdon's BCF plan in 2021/22 can be no lower than £32,798k. The full value of the 2021/22 BCF plan will be included in a subsequent report, subject to the Board's feedback on the recommendation to delegate plan approval authority.

**Table 5: 2020/21 BCF Mandated Financial Requirements Summary**

| Item | 2020/21 Income | 2021/22 Income | % Difference |
|---|---|---|---|
| DFG *(LBH)* | 5,111,058 | 5,111,058 | 0 |
| Minimum CCG contribution | 19,401,312 | 20,439,581 | 5.3 |
| iBCF *(LBH)* | 7,248,248 | 7,248,248 | 0 |
| **Minimum Total** | **31,760,618** | **32,798,887** | **3.17** |
| | | | |
| To Adult Social Care from minimum CCG contribution | 7,074,835 | 7,449,801 | 5.3 |
| NHS commissioned out of hospital services | 5,513,302 | 5,805,507 | 5.3 |

**Key**: DFG - Disabled Facilities Grant; iBCF – Improved Better Care Fund.