# 2021/22 INTEGRATED HEALTH AND CARE PERFORMANCE REPORT

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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** | Gary Collier - Social Care and Health Directorate, LBH<br>Sean Bidewell - Integration and Delivery, NWL CCG |
| **Papers with report** | None |

## HEADLINE INFORMATION

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| **Summary** | This report provides an update on the delivery of the transformation workstreams established to deliver the priorities within the draft Joint Health and Wellbeing Strategy. This report also includes an update on actions within the scope of the Better Care Fund. |
| **Contribution to plans and strategies** | The Joint Health and Wellbeing Strategy and Better Care Fund reflect statutory obligations under the Health and Social Care Act, 2012. |
| **Financial Cost** | The recommended total amount for the BCF for 2021/22 is £106,454k made up of Council contribution of £57,327k and a CCG contribution of £49,127k. |
| **Ward(s) affected** | All |

## RECOMMENDATIONS

**That the Health and Wellbeing Board notes and comments on the content of the report.**

## INFORMATION

### Strategic Context

1. This report provides the Board with an update on delivery of the priorities within the draft Joint Health and Wellbeing Strategy for the July to September 2021 period (referred to as the '*review period'*), unless otherwise stated.

2. A separate report on the Board's agenda addresses the formal submission of the 2021/22 Better Care Fund (BCF) plan.

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

### Winter Planning

4. Confirmation of available funding to support preparations for increases in demand over the winter period was only received the week beginning the 8th November. This late decision puts the delivery of additional capacity at risk because of existing market circumstances, i.e., staff shortages and care home provider control over placement acceptance. It also fails to address the time lag between securing funding and being able to recruit additional staff. However, partners continue to work together to identify additional capacity and explore innovative ways of attracting and recruiting staff across our organisations.

### Mandatory NHS and Social Care Staff Covid-19 Vaccinations

5. On 9 November 2021 it was announced that all health and social care who have direct, face-to-face contact with people while providing care – such as doctors, nurses, dentists and domiciliary care workers, will need to be double vaccinated by the 1st April 2022 unless they are exempt. This will also apply to ancillary staff such as porters or receptionists who may have social contact with people but are not directly involved in their care. The changes will apply across the CQC-regulated health and social care sector. This expected announcement follows the full implementation of this requirement in care homes on the 11th November 2021.

6. The Council's Quality Assurance Team and health partners will work with care providers to manage the implications of these changes.

### Business Intelligence

7. Issues with access to data and analysis of its messages about developing needs and effectiveness of provision are key challenges for the health and care system in Hillingdon. Data comes from several different sources across the health and care partnership and also nationally and coordinating this is a major part of the business intelligence challenge. The appointment of a HHCP head of business intelligence will provide leadership and capacity to drive this forward locally and also link into North West London Clinical Commissioning Group's (NWL) Business Intelligence (BI) Team.

## B. Workstream Highlights and Key Performance Indicator Updates

8. 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

9. **Population Health:** An application to NHSE/I for a structured programme of analytic support to enable Primary Care Networks (PCNs) to better understand local population need was successful. The application was for the Hayes and Harlington PCN and will allow focused support to be provided in respect of diabetes and associated conditions such as obesity. The

support to PCN will start in January 2022 and will take the form of action learning sets. The Hayes and Harlington prototype will provide learning the results of which can then be rolled out to other PCNs.

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

- *Physical health checks for people with severe mental illness*: In a rolling twelve-month period to November 2021 checks have been completed for 24.1% of eligible people at a Primary Care Network (PCN) level, which compares to 16.9% in the previous twelve-month period.

- *Diabetes:* 60% of eligible people with diabetes have received checks.

- *People with learning disabilities:* The NHS Long Term Plan (NHSE 2019) sets an ambition that by 2023/24, at least 75% of people aged 14 or over with a learning disability will have regular annual health checks. The 2020/21 outturn was 76% and the 2021/22 position to 31st October was 33%. It is expected that the second half of 2021/22 will see an increase in checks to coincide with the anniversary of when the previous check was undertaken.

11. The completion of health checks for the most vulnerable residents is being monitored within primary care and assistance offered where needed.

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

**Table 3: Covid-19 Vaccinations by Priority Group**

| Priority Group | Plan | First Dose % Completed | Second Dose % Completed | Booster % Completed |
|---|---|---|---|---|
| Age 80+ | 11,167 | 92.7% | 92.0% | 63.1% |
| Age 75-79 | 7,797 | 93.3% | 92.8% | 65.2% |
| Age 70-74 | 10,257 | 92.2% | 91.3% | 49.6% |
| Age 65-69 | 10,886 | 89.2% | 88.0% | 41.7% |
| Age 60-64 | 10,472 | 86.1% | 84.8% | 8.2% |
| Clinically Extremely Vulnerable | 6,546 | 91.6% | 89.2% | 58.0% |
| Vulnerable 16-65 | 23,448 | 85.3% | 81.7% | 11.1% |
| Age 16-17 | 6,187 | 54.2% | 5.2% | N/A |
| Age 12-15 | 15,885 | 34.9% | N/A | N/A |
| **TOTAL** | **80,870** | | | |

Source: Whole Systems Integrated Care Vaccination Dashboard 16/11/21

13. 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: Covid-19 Vaccination Rates by Care Settings | | | | | | |
|---|---|---|---|---|---|---|
| **Vaccine Recipient** | **Hillingdon** | | **North West London Average** | | **London Average** | |
| | **Dose 2** | **Booster** | **Dose 2** | **Booster** | **Dose 2** | **Booster** |
| Care Home Residents | 92% | 76% | 92% | 69% | 92% | 65% |
| Care Home Staff | [redacted] | 27% | [redacted] | 19% | [redacted] | 19% |
| Homecare Staff | 63% | 2% | 67% | 2% | 66% | 2% |

Source: Capacity Tracker 10/11/21

14. **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. Through the scheme, Primary Care Networks (PCNs) are entitled to access funding to recruit staff for additional roles that will provide multi-disciplinary support according to local needs. In Hillingdon the scheme is being used to develop an additional 39 posts across the PCNs that include clinical pharmacists, dieticians, mental health practitioners and physiotherapists. The project to establish these roles in Hillingdon is being jointly managed between The Confederation and CNWL with the goal of having posts filled by the end of 2021/22.

15. **Medicines management:** The systematic transfer between services of information about the medication needs of individuals is a national issue. This becomes an issue particularly at the point of admission to or discharge from hospital, or where there is a transfer of medication prescribing responsibility. To improve medicines management locally NWL is looking at the development of an integrated partnership between Hillingdon Hospital, community health services, community pharmacists and PCN pharmacy professionals. As part of this work a pathway will be developed to follow up recently discharged patients and the local Medicines Management Team (MMT) will work with NWL to determine local implementation.

## Key Performance Indicators

- ***Admission avoidance:*** This new BCF metric is intended to measure a reduction in adults admitted to hospital for ambulatory care sensitive conditions. The conditions within the scope of this metric include acute bronchitis, angina, heart disease, heart failure, dementia, emphysema, epilepsy, high blood pressure, diabetes, chronic obstructive pulmonary disease (COPD) and fluid on the lungs (pulmonary oedema). The ceiling for 2021/22 is 2,550 admissions.

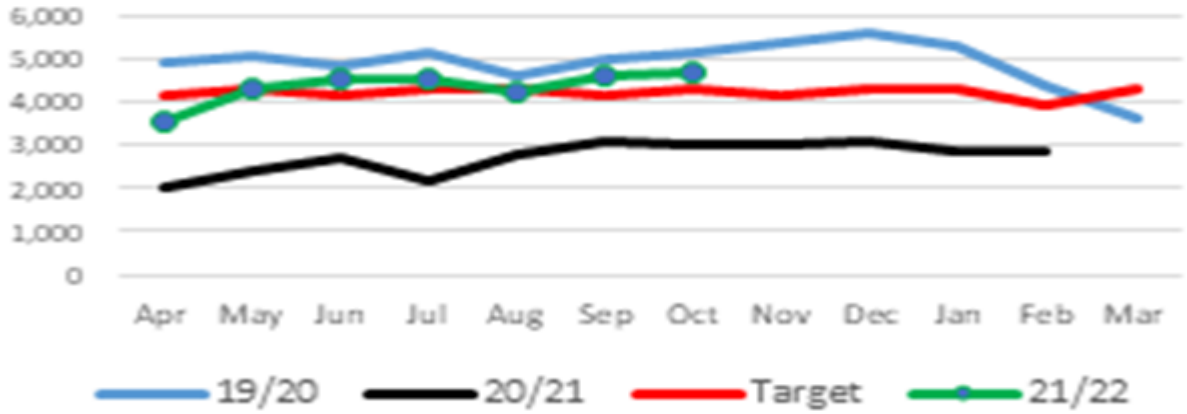
16. The data for this new BCF metric will be provided by the Better Care Support Team as it is based on population level information rather than NHS trust or GP. The Q3 position will be reported to the Board at its March 2022 meeting.

## Workstream 2: Urgent and Emergency Care

## Workstream Highlights

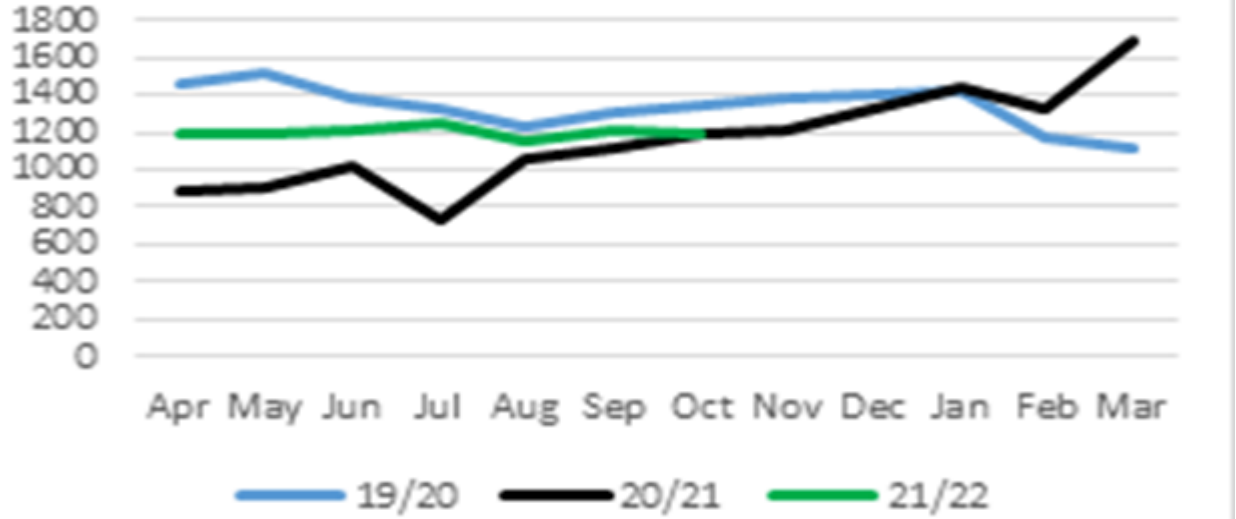
17. **A & E Attendances:** Graph 1 below shows that attendances from the Hillingdon population have been increasing since April. The trend reported to the September Board of attendances just over the 140 a day target has continued. The Board may wish to note that 72% of attendees are people registered with Hillingdon GPs; 12% with Ealing GPs and the rest from a range of areas or not registered.

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

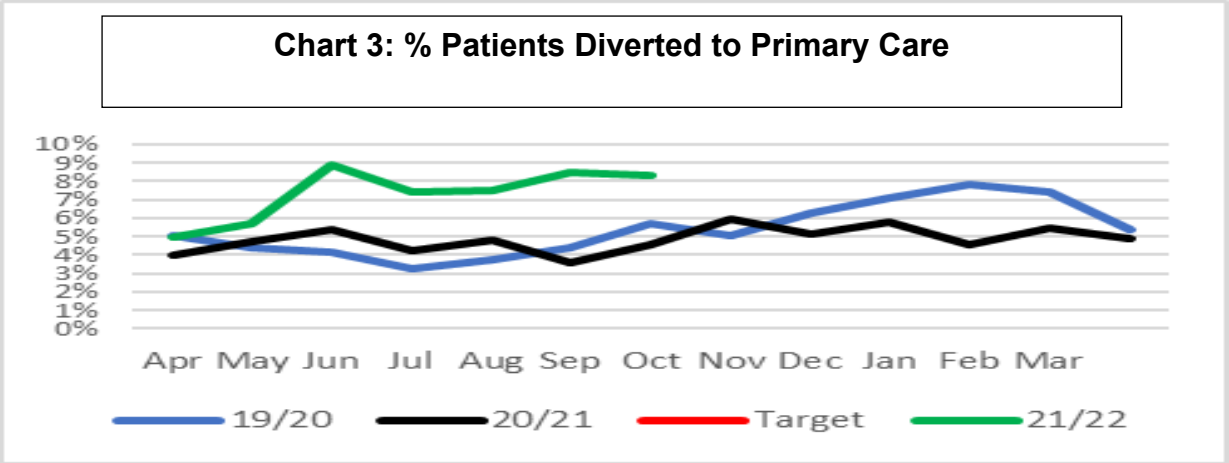



18. **Emergency Admissions:** Graph 2 below shows that there has been a levelling off in the number of emergency (also known as non-elective or NEL) admissions during Q2 compared to Q1 and that activity is aligning more to 2020/21 levels.

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




19. **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. A key objective of the service is to redirect people to primary care who do not need inpatient treatment at Hillingdon Hospital. The redirection rate has increased from 7.4% in July to 8.6% in October 2021. Chart 3 below illustrates progress during 2021/22 in comparison with previous years.




20. **Same Day Emergency Care Unit (SDEC):** This new unit has been established and provides same-day assessment and treatment of patients who require a secondary care assessment but not necessarily a hospital admission. The SDEC unit has a dedicated direct line for GP advice and operates 7 days a week and the aim is to increase direct referrals from the GPs and therefore reduce unnecessary attendances at the UTC and the Hospital's Emergency Department.

21. **Step-down, Discharge and Winter Pressures:** A range of service provision continues to be in place within the community to support the discharge pathways (see below).

**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.

22. A range of initiatives are in the process of being mobilised to address a potential demand surge at Hillingdon Hospital during the winter months and these include:

- *Primary Care Surge Hub***:** The service aims to provide additional primary care capacity to meet a surge in demand over winter. It will pick up 111 calls and reduce UTC attendances. The service, which is due to go live in late November 2021, will offer both virtual and face to face same day response.
- *Increased D2A bridging care capacity:* This service is delivered by Comfort Care Services and supports pathway 1 discharges. Relevant assessments are then undertaken in a person's usual place of residence after discharge from hospital.

- *D2A clinical support*: This service is provided by CNWL and the aim of increased funding is to raise the number of sessions that can be provided in the community from 48 to 60 a week.

- *Increased Reablement capacity:* This service is also delivered by Comfort Care Services and funding for an additional 200 hours a week is intended to support people living in the community to prevent admission.

- *Block step-down beds*: This block of 6 beds (3 dementia residential and 3 dementia nursing) is intended to support pathway 2 discharges. The block means that the provider gets paid the bed price regardless of occupancy but ensures availability to the health and care system.

- *7-day support (social care):* This includes pathway 3 co-ordinators to cover provisioning of care and coordinating admission and discharge to the block beds referred to above over 7 days (including the Christmas & New Year public holidays) as well as a minimum of 3 social workers and 1 social work team manager to support 7-day discharges.

- *Providing Assessment & Treatment of Children at Home (PATCH):* Provision includes extending this five day a week service to seven days and up to 10pm.

- *Escalation beds*: The number of funded beds has been increased from 22 to 30, which will reduce impact on planned procedures in the event of increased emergency bed demand over the winter.

23. **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. 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. Since the service opened in April 2021 4,858 people have been treated of which 2,116 (44%) were registered with Hillingdon GPs. The most common reason for people attending is for minor injuries.

**Key Performance Indicators**

24. 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*: Q2 average was 96%.

- ***Length of stay of seven days or more (Hillingdon Hospital):*** This metric measures the 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*: Q2 average was 56% (175 people based on 313 core beds)

- **Length of stay of fourteen days or more (Hillingdon residents):** This new BCF metric measures the proportion of inpatients resident in hospital for 14 days or more. The metric applies to all Hillingdon residents aged 18 and above and the ceiling for Q3 2021/22 is 10.9% and for Q4 it is 12.6%.

- **Length of stay of twenty-one days or more (Hillingdon residents):** This new BCF metric measures the proportion on inpatients resident in hospital for 21 days or more. As above, the metric applies to all Hillingdon residents aged 18 and above and the ceiling for Q3 2021/22 is 5.6% and for Q4 2021/22 it is 6.2%.

- **Percentage of people, resident in the HWB, who are discharged from acute hospital to their usual place of residence**: This is also a new BCF metric and the expectation is that most people will be discharged from hospital to their usual home, i.e., in most cases, their address at the time of admission. Once again, the metric applies to all Hillingdon residents aged 18 and above and the target for 2021/22 is 91%. The Board may wish to note that the provision of step-down provision to support pathway 2 discharges has a negative impact on this metric because step-down does not count as a '*usual place of residence*.'

- ***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 Q2 average was 79%, therefore suggesting that there was sufficient community capacity to meet demand.

25. As stated in paragraph 6, mechanisms for the systematic collecting and reporting of the data for the new BCF metrics is being established.

**Workstream 3: End of Life Care**

**Workstream Highlights**

26. **Single point of coordination:** Partners have been working on establishing a single point of coordination across all borough end of life services. Key to this is creating one telephone number that all services can be accessed by and which links with 111. A pilot will start in December and this will include looking at how partners share resource across services to support CNWL's Rapid Response Team.

27. **End of life dashboard:** A dashboard has been created and circulated to partners for feedback. This would include measures such people dying in their preferred place of residence. Desired measures and availability of data make this a complex issue, but the aim is to have an initial dashboard agreed in Q3. The outcome of this work will subsequently be reported to the Board.

**Workstream 4: Planned Care**

**Workstream Highlights**

28. **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.

29. **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

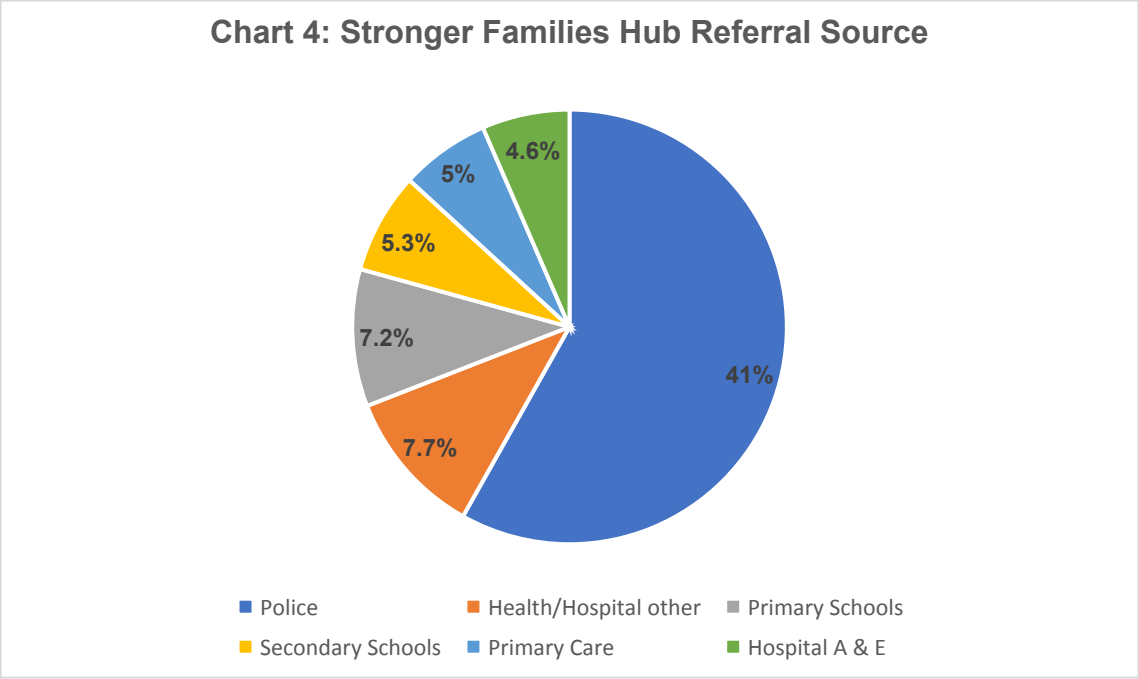
who required an outpatient appointment were prioritised. Data suggests that the service is being effective in reducing unnecessary referrals to the Hospital. For example, the period April to October 2021 has seen a 39% reduction in referrals by GPs on the same period in 2019/20, which equates to 6,800 avoided referrals.

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

### Workstream Highlights

30. **Community step up/step-down model:** The Providing Assessment & Treatment for Children at Home (PATCH) service went live in June 2021. Work is in progress to improve the activity reporting process. However, the latest available information shows that in August 2021, 65 people were supported compared to 49 the previous month. Of the 65 24 were those relating to bronchiolitis, i.e., a common lower respiratory tract infection that affects babies and young children under 2 years old. 55% (36) of the people using the service were those with children aged between 0 and 1 year, which suggests a good outcome for younger babies. It is also interesting to note that when asked nearly 53% (19) of this group of parents said that they would have gone to A & E had the service not existed.

31. **Stronger Families Partnership:** The hub was launched on the 2nd August 2021 and has received 4,341 contacts from 646 families. In September there were 2,109 contacts. Chart 4 below provides a breakdown of the source of referrals.




32. **Special Educational Needs and Disabilities (SEND)**: The creation of the SEND Strategic Partnership Board co-chaired by the Council's Director of SEND and the CCG's Head of Joint commissioning has strengthened the governance of this area over the last six months. Reporting into the Strategic Partnership Board is a new operational board, which oversees five stakeholder groups that are working on the delivery of the five SEND priorities. The priorities are:

- Priority 1 – Inclusion & early intervention

- Priority 2 – Co-production
- Priority 3 – Health and social care engagement
- Priority 4 – Transition planning
  Priority 5 – SEND school places and sufficiency

33. Each of the priority stakeholder groups has an action plan and these are currently being refined and will feed into the SEND self-evaluation form (SEF). Work is underway with partners across education, health, social care and the voluntary sector to develop a SEF for SEND that has a focus on leadership and management; the identification of SEND; the monitoring and assessment of SEND and improving outcomes.

34. **Preparing for Adulthood:** In response to the needs of young people voiced at the Young People's Network about managing stress and anxiety e.g., while anticipating or attending appointments in Adult Social Care Services, a psychologist (from CNWL CAMHs) attended the network meeting in September to trial some Mindfulness support and also explore further with the young people what other strategies might help. The outcomes will be reflected in the Network's first annual report which is near completion.

**About Mindfulness**

Mindfulness is a type of meditation in which you focus on being intensely aware of what you are sensing and feeling in the moment, without interpretation or judgment. Practising mindfulness involves breathing methods and other practices to relax the body and mind and help reduce stress.

35. **16 -25 Young Adult Mental Health and Wellbeing Partnership Model:** The NWL 16-25s model was signed off at the October CNWL Young Adult Board and NWL 16-25s Steering Group. A local implementation team is currently being established to deliver the new model.

36. **CYP Dental Health:** The dental health of children in Hillingdon requires improvement with 32.5% of 5-year-olds having dental caries compared with 23% nationally. The current focus is on rolling out a supervised brushing programme in schools and three schools have now gone live with the programme. There is on-going engagement with other schools to bring them on board. Attention is also being paid to sustaining the Brushing for Life programme operating from Children's Centres and through Health Visitors.

37. **Paediatric Integrated Community Service (PICS):** Reviewing the outpatient data for children under 6 seen in the Hospital's outpatient setting using 2017/18 as the base year has seen activity reduce by 9% to 2019/20 and now sits at 59% lower in 2021/22. This shows how the PICS service has impacted on reducing outpatient attendance within the Hospital. However, some of the reduction in 2021/22 is likely due to the impact of COVID.

38. **Children and Adolescent Mental Health Service (CAMHS) Early Help and Intervention Hub**: Additional funding for the CAMHS service to facilitate achievement of the national target of 35% of CYP with diagnosable conditions having access has been agreed. Hillingdon has seen increasing access totals through the first five months of 2021/22 with each month seeing higher individual monthly access totals than in the previous year. In the 12 months to 31st August 2021, 1,694 unique Hillingdon children and young people accessed services.

39. **CAMHS Mental Health Support Team**: The role of the Mental Health Support Team (MHST) is to:

- Deliver evidence-based interventions for mild-to-moderate mental health issues;

- Support the senior mental health lead in each school or college to introduce or develop their whole school or college approach; and

- Give timely advise to school and college staff and liaise with external specialist service to help children and young people to get the right support and stay in education.

40. Recruitment is underway, with the intention that senior staff will be in post in December and for the service to be in place by the end of January 2022, initially with four schools. Information about the service has been sent out through the schools' communication networks, including the Heads Bulletin.

## Key Performance Indicators

41. The following indicators have been agreed for workstream 5:

- **Education, Health and Care Plan (EHCP) Assessments**: The target for completion of assessments following referral is 20 weeks. The April to September 2021 average for the percentage of assessments completed within 20 weeks is 83% compared to 34% for 2020/21. The Board may wish to note that it was 94% in Q2. Improved performance can be attributed to strong oversight from managers and the recruitment of a permanent team. In addition, the provision of statutory advice from partners, i.e., therapists, within the mandated 6-week timeframe is supporting delivery of the 20-week target.

- **CAMHS referral to treatment:** The Hillingdon target for CYP receiving treatment within 18 weeks of a referral is 85%. For the period April to September 2021 the average achieved was 94%. '*Treatment*' is defined as including two contacts, the first to undertake an assessment and the second to provide treatment.

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

## Workstream Highlights

42. **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.

43. **Older Adults Memory and Assessment Service:** Additional funding has enabled the Older Adults Team to recruit to a full-time post. This person started in October and will be in place for six months to assist with reducing waiting times within the service.

44. **Crisis pathway:** Research on best practice shows that if Hillingdon had services including a Crisis Café, Crisis House, Hospital at Home and Street triage we would see significant system savings, reduction in acute admissions and better outcomes for people living with mental health conditions. Partners are continuing to look at the modelling options and the intention is to complete analysis so that decisions can be made in Q4.

45. **Crisis cafē**: As part of the crisis pathway work referred to above, from Monday 29th November local Hillingdon residents aged 18 and above who need support with their mental health will be able to access a free walk-in mental health support service at the Hillingdon Cove Café and there will be no need for a referral or an appointment. The service is co-located at Haya House Community Centre, 90A East Avenue, Hayes, UB3 2HR and will be run by Hestia. Mental health recovery workers will support attendees to build on their resilience, develop coping strategies and self-management techniques around their mental health.

46. **Drugs, Alcohol and Mental Health:** ARCH (please see below) and the Community Mental Health Teams (CMHTs) are trialling joint conversations on a fortnightly basis to discuss complex cases and new referrals. This approach will be reviewed in January 2022 to check that it is producing the intended outputs and outcomes.

**About the Addiction Recovery Community Hillingdon (ARCH) Service**

This is a free and confidential service that is available to young people and adults who live in Hillingdon or are registered with a Hillingdon GP. The service employs nurses, doctors, recovery workers, social workers, occupational therapists and clinical psychologists and services offered include:

- Assessment and individual personal recovery plans
- Advice and information on reducing harm.
- Needle exchange.
- Specialist psychosocial interventions.
- Specialist pharmacological treatments for help with drug and alcohol problems (to manage withdraw cravings etc).
- Specialist detoxification programmes to manage withdrawal symptoms and safely wean you off drugs and alcohol.
- One-to-one and group therapies aimed at getting to the core of the problem, coming up with ways to deal with cravings and avoid repeating past mistakes.
- Motivation and support from those that have previously had problems with alcohol or drugs and who have successfully overcome them.
- Group activities and social networks, including men and women's groups, relapse prevention and life skills advice.
- Joint working with employment agencies, training providers and housing associations to help you get back on track.
- Evening and weekend social drop-in and activities with the opportunity to volunteer and build new social networks to help your recovery.

47. **Rapid Engagement Support Team (REST) model**: Funding has been secured to trial a model that has worked effectively in Milton Keynes and entails working with stakeholders and community organisations to:

- Reduce the length of stay on acute mental health wards.
- Provide admissions avoidance support.
- Wrap around addiction specialist support.
- Be a gateway between the substance misuse and the mental health services.

48. The work undertaken as part of the model includes specialist comprehensive assessment, clinical advice and psychosocial and peer support. The model will be delivered by a team of seven with additional peer support from experts by experience. The teams will work

across NWL as a trial of concept to the end of March 2022. It is envisaged that the model of delivery with evolve over time in response to operational experience.

## Enabling Workstreams

49. 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

50. This section provides the Board with updates on implementation of the enabling workstreams where there have been developments during the review period.

51. **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

52. **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. Hillingdon Hospital's Head of Integrated Discharge regularly joins the care home calls as discharge from hospital is a standing agenda item. Care Home Matrons and a representative from The Confederation usually attend the care home provider forum calls.

53. In addition to the provider fora, 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.

54. **Infection Control and Testing Fund and Workforce Recruitment and Retention Fund:** Since the performance update to the September Board a further round of the Infection Control and Testing Fund has been announced for the period from 1st October 2021 to 31st March 2022. There are now three distinct components of the grant and these are Infection Control, Vaccines and Testing. The respective allocations are shown below and with the mandated provision for care homes in brackets. Distribution of the funding to providers is currently in progress.

- Infection Control: £841,767 (£417,707)
- Vaccines: £93,661 (£29,375)
- Testing: £453,505 (£296,801)

55. The Council has also been allocated £704,917 for the Workforce Recruitment and

Retention Fund. Unfortunately, the late publication of the grant conditions and the short-term nature of the funding – it covers the period between 21st October 2021 and 31st March 2022 – reduces the extent to which it can assist in addressing workforce capacity issues in Hillingdon at this time.

56. **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**

57. **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 took place during August and September but implementation is being focused on two large nursing homes with high rates of hospital admissions. Information sharing agreements are currently in the process of being signed and the goal is for equipment to be deployed early in December.

58. **Telecare:** There is a rolling project intended to replace existing analogue telecare equipment in residents' homes with new digital units. This is contributing to achieving the 2025 replacement target. Over 6,000 residents have telecare equipment and currently 10% have received the new digital units, which means that this is a significant task.

**Finance**

59. Table 5 below provides a summary of the financial contributions to the 2021/22 BCF plan. More detail about this is provided in a separate report on the Board's agenda.

**Table 5: BCF FUNDING SUMMARY 2020/22**

| Funding Breakdown | 2020/21 (£,000) | 2021/22 (£,000) | % Difference |
|---|---|---|---|
| **MINIMUM CCG CONTRIBUTION** | **19,401** | **20,485** | 5.6 |
| **Required Spend** | | | |
| • Protecting Social Care | 7,075 | 7,470 | 5.6 |
| • Out of Hospital | 5,513 | 5,821 | 5.6 |
| • Other minimum spend | 6,813 | 7,194 | 5.6 |
| | | | |
| **MINIMUM LBH CONTRIBUTION** | **12,359** | **12,359** | **0** |
| **Required Spend** | | | |
| • Disabled Facilities Grant (DFG) | 5,111 | 5,111 | 0 |
| • Improved Better Care Fund (iBCF) | 7,248 | 7,248 | 0 |
| | | | |
| **MINIMUM BCF VALUE** | **31,760** | **32,844** | **3.4** |
| • Additional CCG Contribution | 28,608 | 28,642 | <1 |
| • Additional LBH Contribution | 43,089 | 44,968 | 4.4 |
| | | | |
| **TOTAL BCF VALUE** | **103,457** | **106,454** | **2.9** |

60. Table 6 below summarises the proposed contributions by the Council and HCCG in 2021/22 compared with 2020/21.

| Table 6: Financial Contributions by Organisation 2020/21 and 2021/22 Compared | | |
|---|---|---|
| **Organisation** | **2020/21** ***(£,000s)*** | **2021/22** ***(£,000s)*** |
| CCG | 48,009 | 49,127 |
| LBH | 55,448 | 57,327 |
| **TOTAL** | **103,457** | **106,454** |

61. There are no direct financial implications of this report.

## CORPORATE IMPLICATIONS

### Hillingdon Council Corporate Finance Comments

62. Corporate Finance has reviewed this report and concurs that there are no direct financial costs contained within the recommendations.

### Hillingdon Council Legal Comments

63. There are no direct legal implications arising from this report.

## BACKGROUND PAPERS

*2021 to 2022 Better Care Fund policy framework (DHSC 19/08/21)*
*Better Care Fund planning requirements, 2021/22* (DHSC 30/09/21)
Draft *Joint Health and Wellbeing Strategy, 2022 - 2025*