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Health and Wellbeing Board

Date: **TUESDAY, 14 SEPTEMBER 2021**

Time: **2.30 PM**

Venue: **COMMITTEE ROOM 6 - CIVIC CENTRE, HIGH STREET, UXBRIDGE**

Meeting Details: Members of the Public and Press are welcome to attend this meeting

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To Members of the Board:

- Cabinet Member for Health and Social Care (Co-Chairman)
- Hillingdon Health and Care Partners Managing Director (Co-Chairman)
- Cabinet Member for Families, Education and Wellbeing (Vice Chairman)
- LBH Chief Executive
- LBH Corporate Director, Social Care and Health
- LBH Director, Public Health
- NWL CCG - Hillingdon Board representative
- NWL CCG - nominated lead
- Central and North West London NHS Foundation Trust - nominated lead
- The Hillingdon Hospitals NHS Foundation Trust Chief Executive
- Healthwatch Hillingdon - nominated lead
- Royal Brompton and Harefield NHS Foundation Trust - nominated lead
- Hillingdon GP Confederation - nominated lead

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Agenda

CHAIRMAN'S ANNOUNCEMENTS

1	Apologies for Absence	
2	Declarations of Interest in matters coming before this meeting	
3	To approve the minutes of the meeting on 2 March 2021	1 - 8
4	To confirm that the items of business marked Part I will be considered in public and that the items marked Part II will be considered in private	

Health and Wellbeing Board Reports - Part I (Public)

5	Covid 19 - Local Outbreak Management Plan And Vaccination Uptake	9 - 16
6	Setting Direction and Latest Developments	17 - 22
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9	Tackling Mental Health Issues In Hillingdon	81 - 90
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Health and Wellbeing Board Reports - Part II (Private and Not for Publication)

That the reports in Part 2 of this agenda be declared not for publication because they involve the disclosure of information in accordance with Section 100(A) and Part 1 of Schedule 12 (A) to the Local Government Act 1972 (as amended), in that they contain exempt information and that the public interest in withholding the information outweighs the public interest in disclosing it.

11	Update on current and emerging issues and any other business the Chairman considers to be urgent	95 - 96

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Minutes

HEALTH AND WELLBEING BOARD

2 March 2021

VIRTUAL

	Statutory Voting Board Members Present: Councillors Jane Palmer (Chairman), Susan O'Brien (Vice-Chairman), Ian Edwards, Martin Goddard and Eddie Lavery and Dr Ian Goodman and Ms Lynn Hill **Statutory Non Voting Board Members Present**: Sandra Taylor – Statutory Director of Adult Social Services and Statutory Director of Children's Services (substitute) Sharon Daye – Statutory Director of Public Health (substitute) **Co-opted Board Members Present:** Sarah Crowther - Hillingdon Clinical Commissioning Group Richard Ellis - Hillingdon Clinical Commissioning Group (substitute) Nick Hunt – Royal Brompton and Harefield NHS Foundation Trust (substitute - in part) Dan Kennedy - LBH Director Planning, Environment, Education and Community Services Caroline Morison – Hillingdon Health and Care Partners Patricia Wright – The Hillingdon Hospitals NHS Foundation Trust (in part) **Officers Present**: Fran Beasley (Chief Executive), Kevin Byrne (Head of Health Integration and Voluntary Sector Partnerships), Gary Collier (Health and Social Care Integration Manager), Vanessa Odlin and Nikki O'Halloran (Democratic Services Manager) **LBH Councillors Present:** Councillor Nick Denys
32.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence had been received from Councillor Douglas Mills, Mr Tony Zaman (Ms Sandra Taylor was present as his substitute), Ms Robyn Doran, Mr Graeme Caul, Mr Bob Bell (Mr Nick Hunt was present as his substitute) and Mr Sheikh Auladin (Mr Richard Ellis was present as his substitute).
33.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* There were no declarations of interest.
34.	**TO APPROVE THE MINUTES OF THE MEETING ON 1 DECEMBER 2020** *(Agenda Item 3)* It was noted that the agenda for this meeting had been pared down due to the current pandemic. It was agreed to continue the delegated authority with regards to agreeing the BCF plan and that other reports would be brought to the next meeting,

	RESOLVED: That the minutes of the meeting held on 1 December 2021 be agreed as a correct record.
35.	**TO CONFIRM THAT THE ITEMS OF BUSINESS MARKED PART I WILL BE CONSIDERED IN PUBLIC AND THAT THE ITEMS MARKED PART II WILL BE CONSIDERED IN PRIVATE** *(Agenda Item 4)* It was confirmed that Agenda Items 1 to 9 would be considered in public and Agenda Item 10 would be considered in private.
36.	**BOARD MEMBERSHIP UPDATE** *(Agenda Item 5)* Consideration was given to the report and recommendations. **RESOLVED: That:** **1. the changes made at Council to the Cabinet Member membership of the Board be noted;** **2. the appointment of the Cabinet Member for Families, Education and Wellbeing as Vice Chairman of the Board be noted;** **3. the appointment of Ms Patricia Wright as The Hillingdon Hospitals NHS Foundation Trust Non-Voting Co-opted member on the Board, and the appointment of Mr Jason Seez as her named substitute, be agreed;** **4. the appointment of Mr Sheikh Auladin as the Hillingdon Clinical Commissioning Group Non-Voting Co-opted member on the Board, and the appointment of Mr Richard Ellis and Ms Sue Jeffers as his named substitutes, be agreed;** **5. Hillingdon Health and Care Partners be included as a Non-Voting Co-opted member on the Board; and** **6. the appointment of Ms Caroline Morison as the Hillingdon Health and Care Partners Non-Voting Co-opted member on the Board be agreed.**
37.	**HEALTH PROTECTION BOARD - COVID-19 RESPONSE AND RECOVERY ISSUES** *(Agenda Item 6)* Mr Dan Kennedy, the Council's Director Planning, Environment, Education and Community Services, advised that the rates of COVID-19 infection had been steadily reducing since the publication of this report and was now at 68.8 per 100k population. This had been lower than the London average of 74.6 per 100k population. Measures that had been put in place had been working but it would be important to not become complacent. Work had been undertaken to understand the trends with regard to infection rates in the Borough. It was suggested that the infection rates had slowed since the closure of schools as households were no longer mixing at the school gates. Data had indicated that outbreaks were often geographically clustered and were likely to have resulted from households mixing. The Health Protection Board continued to meet on a monthly basis. Hillingdon had achieved its vaccination target by 14 February 2021 and performance had been better than the other areas in North West London. Although the focus had been on the roll out of the COVID-19 vaccination, there had previously been a huge effort to increase the take up of the flu vaccination. Although the target had been to achieve around 70% take up, Hillingdon had achieved more

	than 95% for the over 80s. Intelligence had been received with regard to areas and groups with lower levels of take up of the COVID-19 vaccination. Action could therefore be targeted to encourage these individuals to have the vaccination. Joint working had been undertaken between health partners and the local authority with around 150 faith and community leaders. Some of these leaders had made videos for their communities to allay fears and rebut myths and some had offered their premises for use as vaccination centres. The current focus was on a speedy roll out of the vaccine. As such, the work being undertaken with faith and community leaders would be key. Community Champions were being recruited and marshals were being deployed to provide advice and guidance. Public Health had been providing advice and support and social care had also been providing support to care providers in the Borough. Contact testing and tracing had been well established in the Borough. Since it had started, the Council had tracked more than 2,000 residents to ensure that they were abiding by the guidelines. Partners had been quick to respond to outbreaks of COVID-19 across the Borough and enforcement action had been taken when needed. Meetings continued to be held three times each week with the police and approximately 100 fixed penalty notices had been issued for COVID rule breaches. Mr Kennedy advised that Healthwatch Hillingdon had undertaken a survey to understand the fears and concerns that would prevent residents from having the vaccine. The results of this survey had been shared with North West London to address these concerns and inform future publicity. For those residents who had been concerned that the vaccine was not safe, further information had been provided and the take up had increased as a result. As Sipson had been identified as an area with lower testing, a targeted letter and information drop had been undertaken in the area which had resulted in a step change increase over the previous weekend with regard to the take up of testing. Engagement and early intervention appeared to be working. **RESOLVED: That the work to date and underway by the Council and Board Members to prevent and control the spread of the COVID-19 virus be noted.**
38.	**VACCINATION PROGRAMME UPDATE** *(Agenda Item 7)* Mr Richard Ellis, Joint Lead Borough Director for Hillingdon Clinical Commissioning Group (HCCG), advised that the calibre of working relations across Hillingdon in relation to vaccinations had been very high. This joint working had included health partners, the voluntary sector and the local authority. It was noted that the report had provided a snapshot of the work that had been undertaken which continued to move forward. The target for the first four priority groups in Hillingdon had been achieved. Overall, approximately 88% of each group had been vaccinated by mid-February, including 92% of care home residents. Work had now started to roll out the vaccine to groups 5 and 6. 80% of group 5 had already been vaccinated (those aged 65-69) and about two thirds of group 6 (those aged 16-65 with underlying conditions). It was anticipated that the vaccination of these two groups would be completed in the next two weeks. A national and London steer was now awaited for the roll out to those aged 50-64 (a third of this group had already

	been vaccinated and it was anticipated that this would be completed in the next few weeks). Although it had previously been anticipated that there would be three mass vaccination centres opened in the Borough, there would only be two: Old Vinyl Factory and Compass Theatre. Although Winston Churchill Hall in Ruislip would not now be used as a mass vaccination centre, consideration was being given to it being used for something else. Since the programme had started, supplies of the vaccine had fluctuated but there had always been sufficient quantities. However, this week and next week, adequate supplies of the vaccine had posed significant challenges on a national scale so would not be comparable with previous weeks. It was anticipated that, from the week commencing 15 March 2021, vaccination centres were expecting more supplies than usual. Although there had been an initial reluctance by some parts of the community to have the vaccination, the support provided had demonstrated that this could be overcome and take up amongst these groups increased. Dr Ian Goodman, Chair of Hillingdon Clinical Commissioning Group, advised that the vaccination programme in Hillingdon had been a success story with regard to collaborative working. 73% of care home staff in Hillingdon had been vaccinated which compared very favourably with the low rates achieved elsewhere in London. It was hoped that the first dose would have been received by those in groups 1-9 in Hillingdon by 29 March 2021. It was anticipated that the second dose for these groups would then be completed by 13 June 2021. GPs would be giving the second dose to individuals and would have been involved in administering 5% of the first doses. It was noted that a vaccination centre was also being set up in Boots in Uxbridge. **RESOLVED: That the update be noted.**
39.	**KEY PARTNER UPDATES (VERBAL)** *(Agenda Item 8)* <u>The Hillingdon Hospital NHS Foundation Trust (THH)</u> Ms Patricia Wright, THH Chief Executive, advised that, in April 2020, the highest number of inpatients testing positive for COVID-19 had been 100. At its peak in January/February 2021, this figure had risen to 160-170. In the three months from December 2020, the number of critical care beds had been increased from 9 to 15. THH staff had responded magnificently despite high levels of sickness and whilst also juggling personal responsibilities such as home schooling. A programme of support had been put in place for the health and wellbeing of staff, particularly in relation to mental health. THH had built a strong relationship with Hillingdon Health and Care Partners (HHCP) and had worked closely together to improve things such as discharge planning. It was noted that the number of patients testing positive for COVID-19 had started to reduce but increased from 80 on 1 March 2021 to 89 on 2 March 2021. Ms Wright advised that she had been in post since the beginning of December 2020. Her Executive Team was now complete and had been planning to develop the recovery plan in response to recent regulatory issues and scrutiny.

It was noted that the redevelopment of Hillingdon Hospital was a three-stage process: Strategic Outline Case (SOC), Outline Business Case (OBC), Full Business Case (FBC). This process usually took about five years but was being expedited. The SOC had been signed off by the Treasury in October 2020 and it was anticipated that the OBC would be submitted in August / September 2021. 1 in 500 drawings of what the development might look like had already been produced – 1 in 200 drawings would be needed for the OBC.

Upfront funding had been secured for the provision of two modular buildings which would help with decanting patients from existing wards during the redevelopment project: Modular North would include two wards plus critical care and would be on line by the end of March 2021; and Modular South would include paediatrics and would be in place by September 2021. Once these modular buildings were functional, the existing single level huts could be cleared from the site. A programme of refurbishment was also underway in the hospital tower block.

Hillingdon Health and Care Partners (HHCP)

Ms Caroline Morison, Managing Director of HHCP, advised that the exceptional integrated working that had taken place with regard to the vaccination programme in Hillingdon had already been highlighted in the two previous reports. This had included work between the local authority and THH around the discharge hub.

Joint working had been undertaken to reach as many people as possible in the Borough as quickly as possible to administer the vaccine. Consideration was now being given to the longer term impact of COVID-19, for example mental health for children and young people, the impact on resilience and developing neighbourhood working. Work would be needed to develop the Joint Health and Wellbeing Strategy to deliver priorities and address the inequalities that had been brought to light by COVID-19. It would also be important to align the transformation programmes of each of the partners so that these were not progressed in isolation.

Hillingdon Clinical Commissioning Group (HCCG)

Mr Richard Ellis, Joint Lead Borough Director at HCCG, advised that a lot of work had been undertaken to support general practice into resuming the referral of patients into secondary and specialised care which might have been suspended during the pandemic. Primary and secondary care had been working together to reduce the number of elective referrals to THH.

Consideration was being given to long COVID and how this condition might be supported. Work would also be undertaken in partnership with organisations such as H4All regarding the social and mental health pressures resulting from the pandemic.

It was noted that, from 31 March 2021, HCCG would form part of North West London CCG (NWLCCG). Work would continue with the local authority and other partners on a place-based / Borough basis. The commissioning of dentistry, optical and pharmaceutical services would move to the CCG, elements of which would need to be considered by the Health and Wellbeing Board.

Dr Goodman stated that general practice was open for business and should not be turning patients away. An increasing number of GP consultations were being undertaken virtually / remotely and would continue. However, for things like cervical smear tests and child immunisations, these were still being done in person. Condition management appointments for things such as diabetes would resume from 1 April 2021. It was anticipated that the digital contact options that had been brought in would

remain once the pandemic was over but that face to face consultations would still be available for those who did not have access to, or were not so au fait with, technology.

London Borough of Hillingdon (LBH)
Mr Dan Kennedy, the Council's Director Planning, Environment, Education and Community Services, advised that positive steps had been taken with regard to working with NWLCCG and opening up the conversation locally. Mr Kennedy had met with the head teachers from some of the schools in the Borough to talk about reopening plans. Testing had been organised and parents had been contacted with information about the reopening. Notices continued to be displayed in schools to remind everyone to keep their distance, wash their hands and cover their faces. The schools appeared to be well prepared for reopening on Monday 8 March 2021.

Ms Sandra Taylor, the Council's Director Provider Services and Commissioned Care, noted that the success of the roll out of the vaccination programme in Hillingdon could not have been managed so well without supportive collaboration which had reaped real rewards. It would be important to now use the learning from this experience to prevent slipping back to old ways of working and instead continue to make improvements to things like hospital discharge.

With regard to social care, the Council had not used the easements that had been open to it. Consideration would now be given to doing face-to-face assessments as soon as guidance permitted. Work would continue with regard to managing the health and wellbeing of staff and service users.

Ms Sharon Daye, Consultant in Public Health at LBH, advised that public health had been working with all partners. The whole system had been working together to contain the virus and protect the population. The partnership work undertaken in Hillingdon had been looked upon favourably by Public Health England.

Central and North West London NHS Foundation Trust (CNWL)
Ms Vanessa Odlin, Director for Hillingdon and Mental Health Services at CNWL, echoed the comments that had been made regarding the collaborative work that had been undertaken in Hillingdon. She noted that discharge had been a big issue for CNWL from a mental and physical health perspective. A pull out model had been adopted which meant that processes from physical health had been adopted in mental health. Services had been flexed to manage inpatient capacity to support patients discharged from Hillingdon Hospital including the Hawthorne Unit. Although the discharge of some patients could be complex, Ms Odlin was confident that the right people were now communicating to resolve these situations as quickly as possible. Ms Taylor advised that getting out of hospital and back into the community made a difference to patients' recovery. It would be important to ensure that the services available in the community were the right services to meet individual needs.

HHCP's high intensity user programme had been looking at putting measures in place to help these frequent service users. These measures could include interventions from the Rapid Response Team or use of the Coves crisis service for support to people in crisis.

There had been an increase in presentations to CAMHS. A triage telephone line had been set up for professionals to call and a crisis line for young people to call would soon be in place. Further details of how his crisis line would be publicised would be brought back to a future meeting. In Hillingdon, the duty team capacity had been doubled to support the response but this would be a temporary measure.

Consideration had also been given to the support that needed to be put in place for young people aged 16-25 and support had been put in place for staff, particularly for those who were working from home and perhaps shielding.

It was noted that the pandemic had created opportunities for partners to improve pathways and move forward. Mr Morison advised that it would be important that these advancements were not undone. The Integrated Care System would need to articulate what good looked like and target resources and energies into the children and young people programme as one of the top priorities. The right models would need to be in place to look at early intervention and prevention work.

Healthwatch Hillingdon (HH)
Ms Lynn Hill, Chairman of HH, advised that the survey coordinated by HH to look at the concerns of individuals regarding the vaccine had received around 5,600 responses. The feedback received had indicated that hesitancy had been in relation to a wide range of issues including: diabetes, pregnancy, DNA tampering, biological tagging, etc. As a result of this survey, work had been undertaken to dispel these myths.

Young Healthwatch had undertaken research and compiled a list of 14 information and service providers that did not require a professional referral to seek support. They had produced a short promotional video to highlight these services.

Further work would be undertaken with regard to delayed appointments and patients' inability to access dental services.

RESOLVED: That the updates be noted.

40. **BOARD PLANNER & FUTURE AGENDA ITEMS** *(Agenda Item 9)*

The Chairman noted that the proposed Health and Wellbeing Board development workshop had been deferred. It was agreed that this be held virtually and that an alternative date be scheduled in May 2021. Dates would be canvassed and Mr Tony Zaman, Ms Caroline Morison and Mr Kevin Byrne would finalise the details.

It was agreed that the next Health and Wellbeing Board meeting scheduled for 15 June 2021 would include reports on the following issues:

1. Joint Health and Wellbeing Strategy and Joint Performance report – the emerging Strategy could also form the basis of the workshop;
2. Children and Young People's Emotional Health – a joint update and situation report from HHCP and CNWL on early intervention through to CAMHS;
3. Child Healthy Weight – it was likely that the issue of children being overweight and obese would have been exacerbated during lockdown. A report was requested to reflect the work that was underway and include an updated plan with proposals. Councillor O'Brien had spoken with some infant school teachers about dental health which would be included in the Child Healthy Weight Strategy. She noted that there were issues with children not knowing how to brush their teeth properly and/or not being encouraged to brush their teeth. A previous paper had been produced in relation to this and consideration would need to be given to how this information could be distributed in schools; and
4. Hillingdon Hospital Redevelopment – as this was hight on the agenda, an update report on the way forward was requested.

RESOLVED: That the Board Planner 2021/2022, as amended, be agreed.

41.	**UPDATE ON CURRENT AND EMERGING ISSUES AND ANY OTHER BUSINESS THE CHAIRMAN CONSIDERS TO BE URGENT** *(Agenda Item 10)* There were no issues deemed to be urgent.
	The meeting, which commenced at 2.30 pm, closed at 3.59 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on 01895 250472. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

COVID 19 - LOCAL OUTBREAK MANAGEMENT PLAN AND VACCINATION UPTAKE

Relevant Board Member(s)	Councillor Jane Palmer, Co-Chairman
Organisation	London Borough of Hillingdon
Report author	Dan Kennedy, Hillingdon Council Sharon Daye, Hillingdon Council
Papers with report	None

1. HEADLINE INFORMATION

Summary	This report updates the Health and Wellbeing Board on Hillingdon's Local Outbreak Management Plan, including an update on the rollout of the Covid-19 vaccination programme in the Borough. This update is on behalf of the Covid-19 Health Protection Board. This plan sets out how the Council and partners are working with residents, businesses, schools and a wide range of other organisations to prevent and contain the spread of the Covid-19 virus.
Contribution to plans and strategies	The Covid-19 Local Outbreak Management Plan contributes to Hillingdon's Health and Wellbeing Strategy by helping to protect the health of residents.
Financial Cost	There are no direct financial costs arising from the recommendations set out within this report.
Ward(s) affected	All

2. RECOMMENDATION

That the work to date and underway by the Council and Board Members to prevent and control the spread of the Covid-19 virus be noted.

3. INFORMATION

Supporting Information

1. As at 23 August 2021, Covid-19 infection rates in Hillingdon are below the London average at 238.9 per 100k population (London average = 275.5 per capita population). Overall, the trend line in infection rates in Hillingdon has fallen during the last two months, but the position remains volatile as the following graph shows (covering the period 5 August 2021 to 25 August 2021). As at 25 August 2021, the infection rate in Hillingdon dropped further

to 234.6 per capita. The higher level of infection rates tend to be in the 10-19 and 20-29 year old age groups (the age cohorts currently with the lower levels of Covid-19 vaccinations).

Table 1 – Covid-19 Infection Rates in Hillingdon Per Capita (5th August 2021-25th August 2021).

2. As part of the national effort to reduce the spread of the Covid-19 virus, every local authority has a Local Outbreak Control Plan (LOCP) which sets out how the local authority and partners are working together to help reduce the likelihood of further outbreaks of Covid-19, particularly for some of the most vulnerable residents, such as those living in care homes. The plan presents preventative action as well as what the approach will be in the event of an outbreak. The plan has been updated for summer 2021 in line with national guidance and will be updated again for the autumn/winter.

Settings

3. In general, infection rates remain low in care settings due to most residents and staff being vaccinated and robust adherence to infection control practices. Care homes continue to have multi-agency 'wrap around' support to enable them to continue to provide safe services to the residents of Hillingdon, prevent the spread of infection and ensure that safe visiting takes place (where this has been agreed).

4. In line with latest guidance, the Council and CCG will manage the discharge of patients who have tested positive for Covid-19 from hospital to designated beds for isolation. All patients that are to be discharged from hospital to a care setting will be tested and their Covid status known. For those residents who are tested negative, they will be discharged to 'step down' facilities or to their original care home placement to enable a further period of isolation at home to continue.

5. All schools have access to a council link officer who acts as a central point of contact for Covid-19 queries to ensure they can follow the latest government guidance to help keep their schools safe. Education advisors are also on hand to support headteachers with maintaining education provision and provide additional support and guidance, should this be

required. Schools returned to classroom teaching before the end of the school term in July 2021 and are prepared for the return of pupils from the start of the term in September 2021.

6. Housing providers in the Borough have been contacted and provided with nationally published information to share with tenants living in shared housing. This sets out what they can do to keep safe and to help prevent the spread of the virus. Landlords of shared accommodation and their tenants have been written to by the Council setting out practical advice and guidance to prevent the spread of the infection.

Helping Residents to Shop Safely

7. The Council has undertaken a proactive programme of providing advice and inspections to support business to re-open to keep residents safe. Since the start of the pandemic, licensing and environmental health and regulatory officers have:
   - Completed over 10,000 business compliance visits
   - Issued over 250 written warnings
   - Issued 40 Fixed Penalty Notices for breaches

8. Council teams have been supporting businesses and venues to safely reopen:
   - 108 free pavement licences issued to Hillingdon businesses
   - 1600 advice and support visits from specially trained officers
   - Covid-19 marshal patrols in all shopping areas
   - Support to hospitality sector for the Euro Tournament
   - Licensing visits and advice to beauty and personal care businesses

Testing

9. A key element of the national strategy to reduce the spread of the Covid-19 virus is to establish a robust testing strategy, targeting specific occupations, such as care staff. Working jointly with the Clinical Commissioning Group, the Council has put in place regular testing arrangements for care settings. In terms of the broader approach to testing, in Hillingdon this has involved:
   - Mobile testing units visiting on a regular basis;
   - Access to home testing kits, available to all residents;
   - Pop-up testing sites as required;
   - Local testing sites (walk through).

10. Testing will continue to be kept under review and targeted where this is needed and arranged at the convenience for residents (e.g., promoting home testing kits).

Local Contact Tracing

11. The Council is continuing to support contact tracing by using its local knowledge to successfully trace hard-to-reach individuals. The team makes contact with these residents either by text, phone or email to enable them to capture information about their activities in the days prior to their positive result. Home visits are arranged where necessary.

Covid-19 Vaccinations

12. The NHS is continuing to offer the Covid-19 vaccine to people most at risk, in priority order.

The vaccine, like all vaccines in the UK, has been approved for use after meeting the strict standards of safety, quality and effectiveness set out by the Medicines and Healthcare products Regulatory Agency. So far, reports of serious side effects, such as allergic reactions, have been very rare. No long-term complications have been reported.

13. Hillingdon remain top in delivery of vaccines to residents in London. As at 23 August 2021, 72.8% of Hillingdon's population had received their first dose (London average = 66.7%) and 63.8% their second dose (London average = 57.2%). 16-17-year olds and those aged 12+ with a vulnerability are being supported to access the vaccine.

14. Operational guidance was issued in August 2021 to all care homes by the Care Quality Commission on the requirement for Covid-19 vaccination of staff deployed in care homes. All relevant Council staff have been issued with a letter advising them of the requirements. A vaccination webinar for Hillingdon Care Home staff took place in August to promote the uptake.

Monitoring / Surveillance

15. Covid-19 infection rates are closely monitored by the Council on a daily basis so that any patterns in infection rates are swiftly identified and responded to in order to limit the spread of the virus. Monitoring includes the following:
    - The rate of infection for Hillingdon per 100,000 population (the standard measure used by Public Health England which allows for comparison across local authorities);
    - The number of new infections registered for Hillingdon in the last 24hrs;
    - Cumulative demographic information on gender, age and ethnicity;
    - Number of tests completed and the positive infection rate;
    - Incidences of infection broken down at ward level;
    - Comparative information from geographic neighbours (West London and Home Counties); and
    - Vaccination take up.

16. In addition, officers of the Council are working closely with colleagues in the Clinical Commissioning Group and health partners to exchange information to help track changes in infection rates. Analysis and interrogation of Covid-19 related data continues to evolve and develop as the understanding of patterns of infection becomes more sophisticated and the data available to the Council improves.

17. The take up of the vaccine is being closely monitored by the NHS and the Council.

Supporting businesses

18. The Council has provided a range of targeted support and guidance to businesses throughout the pandemic, ensuring that financial assistance is given to those who are eligible. The Council has paid out grant funding as follows:
    - Local Restrictions Support Grant (£16.6 million)
    - Additional Restrictions Grant (£9 million)
    - Restart grant (£11 million)

Supporting Vulnerable Residents

19. The Council is putting its residents first during the Covid-19 pandemic and continues to coordinate support, working with partners for vulnerable residents who need to self-isolate. This helps to keep residents safe by helping to prevent the spread of the virus, particularly important for those that are clinically extremely vulnerable.

20. Hillingdon's approach to protecting and supporting residents is centred on:
    - Practising social distancing and hand and respiratory hygiene and wearing Personal Protective Equipment (PPE) where required, in line with Government guidance;
    - NHS testing for the presence of coronavirus if residents display symptoms;
    - Supporting the tracing system if residents have tested positive and have been in close contact with others; and
    - Supporting self-isolation, in line with NHS guidance.

21. During the pandemic the Council has maintained a Covid-19 Community Hub within the Council's Contact Centre to respond to Covid-19 enquiries. It is open from Monday to Friday, 9am to 5pm. The Council has a dedicated contact centre which responds to resident queries. The Council is supporting local foodbanks to provide food parcels where required and signposting residents to Hillingdon 4 All and other charities to provide support.

Communications and Engagement

22. The Council, together with partners, has and continues to be proactive in delivering health protection messages to residents using a range of communication channels.

23. Since the start of the pandemic, the Council and partners have publicised key guidance to residents and businesses, ensuring that they are aware of:
    - Important health, testing and any restriction/lockdown messages.
    - The impact on Council events and services.
    - The Council support available i.e. community hub.
    - Various government campaigns.
    - The easing of restrictions and subsequent recovery of Council services.
    - Maintaining infection control practices – promoting government messaging.
    - The benefits of the Covid-19 vaccine and how to get vaccinated.

24. Coronavirus messaging has been widely communicated using all available Council channels, including the Council's website, social media platforms, media relations, regular e-newsletters, GP texting, Hillingdon People, JC Decaux boards, refuse lorries, lamp post banners, posters and signage, and internal communications.

25. Communications plans and localised assets for raising awareness of coronavirus, local outbreaks and promoting the take up of the vaccine have been produced.

26. The team is also working with a range of services to support their messaging, ensure consistency and amplify/target messages to their audiences. This has included services working with schools and universities, businesses, and community and faith groups.

27. Corporate Communications has also linked up with a variety of communications colleagues from neighbouring, pan-London and outer London local authorities, PHE and partner

agencies to share best practice and resources, and in the case of partners amplify messages via each other's channels.

28. The Council is supporting health partners and the rollout by sharing NHS information and messaging to ensure that residents are well informed about the Covid-19 vaccine. The Council is encouraging residents to have the vaccine when they are told that it's their turn so that they can protect themselves, their friends, families and local community – and keep Hillingdon safe. The Council is also working with H4All (a collaboration of local charities) to deliver the Community Champions scheme to support those most at risk from Covid-19 and boost vaccine take-up by providing advice as well as tackling misinformation.

29. The Council has already built a strong network of community, faith and voluntary sector groups since the start of the pandemic, working closely with health partners. The Community Champions scheme will further strengthen this by working with trusted local champions from faith and community groups to help reach older people, disabled residents, and people from ethnic minority backgrounds.

Targeted Actions

30. Whilst there is a degree of confidence that the action taken to date has helped to limit the spread of the Covid-19 virus in the Borough, there is no room for complacency. It is recognised, therefore, that there will be a need for a range of ongoing proactive actions to keep Covid-19 infection rates as low as possible.

Financial Implications

There are no direct financial costs arising from the recommendations set out within this report.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

Preventing and controlling the spread of the Covid-19 virus will help to keep Hillingdon's residents safe.

Consultation Carried Out or Required

The development of Hillingdon's Covid-19 Local Outbreak Control Plan has involved joint working with a range of partner organisations, including the Clinical Commissioning Group, NHS provider organisations and the Police, amongst others. The plan will continue to be kept under review and will be updated, in line with the latest NHS guidance and advice.

5. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

Corporate Finance has reviewed the report and concurs with the Financial Implications set out above, noting that there are no direct financial implications arising from the report recommendations.

Hillingdon Council Legal comments

The Borough Solicitor confirms that the Council's Local Outbreak Control Plan complies with the requirements of the Coronavirus Act 2020 and associated legislation. In addition, detailed legal advice on individual cases is provided whenever necessary to enable the Council to minimise the spread of Covid -19.

Relevant Service Groups

The development of the Covid-19 Local Outbreak Control Plan has involved all Council Directorates.

6. BACKGROUND PAPERS

Nil.

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HILLINGDON'S HEALTH AND WELLBEING BOARD: SETTING DIRECTION AND LATEST DEVELOPMENTS

Relevant Board Member(s)	Tony Zaman Caroline Morison
Organisation	London Borough of Hillingdon Hillingdon Health and Care Partners
Report author	Kevin Byrne - Health and Strategic Partnerships
Papers with report	None

1. HEADLINE INFORMATION

Summary	The Board's development workshop, held on 18 May, considered its position in taking forward health and care in Hillingdon and as the "Leader of place", especially in response to changes in the NHS and pending legislation. The workshop also proposed a number of key changes to its priorities, governance and ways of working. This report points to current live and key issues for debate by the Board to assess impact on health and care in Hillingdon and to confirm the strategic direction in Hillingdon. It also updates on the implementation of the changes agreed regarding governance and membership.
Contribution to plans and strategies	The paper seeks to reaffirm strategic direction as reflected in the draft joint Health and Wellbeing Strategy (paper 3 on agenda).
Financial Cost	There are no costs arising directly from this report.
Ward(s) affected	All

2. RECOMMENDATION

That the Board:

1. **considers the issues at 3 below and confirms its position on behalf of the health and care system in Hillingdon.**
2. **notes the new approach to governance and membership.**

3. INFORMATION

Background Information

There are a number of developments the Board may wish to consider.

3.1. Health and Care Bill

The Bill is at committee stage in the Commons. It will give effect to a number of changes set out in the NHS Long Term and the White Paper (Feb 21). These include:

- **Integrated Care Boards (ICB)** will become established with a statutory footing. The Board's will take on the commissioning functions of CCGs and some from NHS England. The ICB for Hillingdon will be North West London and it will have the ability to exercise its functions through place-based committees. It will be accountable for NHS spend and performance within the system. Meanwhile in preparation for the move to ICS, NWL is now a single CCG and as such there is no longer a Hillingdon budget for the borough.
- Each ICB and its partners local authorities will be required to establish **Integrated Care Partnerships (ICP)** which will be responsible for developing a strategy to address health and social care and the public health needs of its system. The ICB will have regards to that strategy when making decisions. In Hillingdon we have Hillingdon Health and Care Partners already established as our ICP. The Strategy is the draft Joint Health and Wellbeing Strategy as presented in paper 3.
- New powers for directions to be given to NHS England and to ICBs for the purposes of integration. This provides a **new legal basis for the arrangements under the Better Care Fund,** which had previously relied on the NHS mandate to ring fence funding. It is a technical change that has no direct impact on the operation or the policy intention of the BCF, which remains the vehicle for closer integration between health and care at place level. Hillingdon's Better Care Fund proposals are set out in appendix 2 of paper 3).
- The Bill introduces "**the Triple Aim**" and a "**duty to cooperate**", a duty on all NHS organisations to consider the effects of their decision on :
    - The better health and wellbeing of everyone
    - The quality of care for all patients and
    - The sustainable use of NHS resources
- The development of **new procurement regime** for the NHS to reduce bureaucracy and the need for competitive tendering where it adds limited or no value.
- The **CQC will have a new legal duty to review and make an assessment** of the performance of local authorities in discharging their "regulated care functions" under the Care Act 2014.
- **Hospital discharge**: the Bill revokes the procedural requirements in the Care Act 2014 which requires Local Authorities to carry our social care needs assessments before a patient is discharged from Hospital. It does not change existing legal obligations on NHS to meet health needs and LAs are still required to assess and meet needs for adult social care. This is intended to introduce flexibility locally to adopt discharge model that best meets local needs including "discharge to assess".
- The Bill will introduce a **9pm watershed for less healthy food and drink** advertising on TV and of paid-for less healthy food or drink advertising on line.

The policy intention behind the Bill is not to be prescriptive and to allow ICSs and ICBs some flexibility in the final design. This means that Hillingdon's Health and Wellbeing Board as the local leader of place has the opportunity to make the case for the maximum delegation of decision making from the NHS body to the local Health and Care partnership.

3.2. NWL System Development Plan

The NWL SDP was submitted by the interim NWL ICs as required 30 June 2021. The plan sets out the ICSs vision and ambitions, with more detail on its strategic direction, governance and on enhancing capability in the system. The proposal is that the ICS should operate in shadow form from 1 October 2021 then become fully operational from April 2022.

There are several issues which would seem to arise from this plan:

- There remains a significant underlying deficit across the system of some £460m (or about 9%) so a clear continued focus on efficiency and resource management.
- A commitment to work alongside local authorities and third sector: to assess health needs including inequalities, address social determinants of health and promote wider economic and social development.
- Revised governance is proposed with a NWL ICS Board plus a far wider NWL ICS health and care partnership Council. Local authorities would have one CEO representative on the Board for all 8 boroughs, with all CEOs on the Council. Borough delivery leads (Managing Directors of ICPs) would only be represented on the wider partnership Council.
- ICPs are referred to as Borough Delivery partnerships reporting to their local Health and Wellbeing Boards and to the ICS SRO for ICPs.
- It refers to a fair and transparent mechanism for distribution of resources as being currently developed. The plan is silent on the levels of delegation that would be made to ICPs.
- "Provider collaboratives" are described to deliver benefits with potential delegations and accountability for agreed interventions.

3.3. Appoint of single Chair for Acute Trusts in NWL

The Chief Executive of the NWL ICS wrote to Local Authority Leaders on 27 July confirming the intention to appoint a single Chair across the four acute trusts in North West London including the Hillingdon Hospitals Foundation Trust.

Hillingdon's Leader, Cllr Ian Edwards responded to say that whilst the move is understandable there are issues of concern at Borough level. He pointed to the excellent progress made across partners in developing a strategic "place based" approach to health and care in Hillingdon and that The Hillingdon Hospitals Trust has been a key part of this. The local authority remains concerned that the move towards greater unified governance and central control in the NHS will take away local discretion to act in the best interests of Hillingdon residents and patients. As THH moves forward with its new hospital build, it will be vital that we are able to work on the ground to integrate services where this makes sense and to work across Hillingdon to reduce acute admissions and bolster out of hospital services.

The authority also feels that it is imperative that the "voice of place" is able to be heard at the top ICS table so as to take the best decisions and that the local borough directors should be at that forum. In addition, as the local leader of place the HW Board must be free to have a strategic role, including directly influencing commissioning, and to be more than delivery agents of the ICS.

3.4. Actions from HWB Workshop: Membership, Governance and Ways of working

The Board's May workshop agree that to become more effective it needed to be:

- A forum to discuss openly and honestly challenges and opportunities: to assert the

view of place.

- A true partnership of equals.
- A Board with commitment from partners who viewed it as part of their governance.
- To focus on strategy rather than get bogged down in detail, with strong supporting governance to provide reassurance.

On Membership, it was proposed that the Board should consists of:

- LBH Cabinet Member for Health and Social Care - Co-Chairman
- LBH Cabinet Member for Families, Education and Wellbeing
- LBH Chief Executive
- LBH Corporate Dir. Social Care and Health
- LBH Dir Public Health
- HHCP Managing Director- Co-Chairman
- NWL CCG Hillingdon representative
- NWL CCG nominated lead
- CNWL nominated lead
- THH Chief Executive
- Healthwatch Hillingdon – nominated lead
- Royal Brompton and Harefield NHS FT – nominated lead
- Hillingdon GP Confederation - nominated lead

The workshop also felt that all members should be entitled to vote, although it was recognised that it was not expected that the Board would operate in a way whereby formal voting was generally required. In addition, the Board should take advantage of its ability to co-opt attendees at any time, for example to present issues to the Board as subject matter experts or where wider partners views on topics may be helpful. Others including the voluntary sector would also be key partners in taking forward delivery plans as part of the supporting governance.

The Board has already recognised that the HHCP Delivery Board should provide the supporting governance to the HWB and be the forum where operational issues are considered and delivery performance managed - against the aspiration that we adopt a one system approach and single performance report. The HHCP Delivery Board has in support programme boards to take forward transformation. The HWB is the statutory board which sits on top of the HHCP or place-based governance structures reporting to sovereign boards: the Council's Cabinet and to the NWL ICS. A new executive group is now in place to ensure that a tight group of key executives can meet regularly.

These proposals were agreed and the Council has now amended its constitution to bring them into effect.

4. FINANCIAL IMPLICATIONS

There are no direct financial costs arising from the recommendations in this report.

5. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

The strategy and framework proposed will enable the Board to drive forward its leadership of health and wellbeing in Hillingdon.

6. CORPORATE IMPLICATIONS

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

Hillingdon Council Legal comments

The Borough Solicitor confirms that there are no specific legal implications arising from this report.

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HILLINGDON'S JOINT HEALTH AND WELLBEING STRATEGY 2022-2025

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

1. HEADLINE INFORMATION

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. 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) • Levels of overweight and obesity in CYP at reception and Yr6. • Hospital admissions for tooth decay under 5s • Percentage of physically active CYP	• Improve take up and continuance of breastfeeding (to stage 3 of Unicef heathy baby standard) • Reduce the increase in levels of overweight or obese children under the NCMP at reception and yr 6. • 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. • Children in absolute and relative low-income families. • Age-standardised avoidable, treatable and preventable mortality rates in children and young people (aged 0 to 19 years) by sex. • Children in need due to family stress or dysfunction or absent parenting: rate per 10,000 children aged under 18. • Children in need due to abuse or neglect: rate per 10,000 children aged under 18 years. • D&A and substance misuse under 18.	• Achieve national targets for waiting times for Eating Disorder services. • Meet national targets for CYP Immunisation and vaccinations uptake rates (95% herd immunity). • 35% of CYP with diagnosed MH condition seen by NHS funded community mental health services. • % 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 • Levels of school attainment including children not in school.	• Support families sooner through new family hubs • Numbers of children out of school.

	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 • Timeliness of EHC Plans
2. Tackling unfair and avoidable inequalities in health and in access to and experiences of services. (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 • Life expectancy at Birth by Neighbourhood	• Levels of disparity in health and care services. • Levels of disparity across wider determinants of health. • 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 • The rate of unplanned hospitalisations per 100,000 by Neighbourhood by ethnic group • The rate of referrals per 100,000 moving to MH recovery by ethnic group (IAPT) by Neighbourhood.	• Develop neighbourhood plans to tackle local inequalities. • 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 • Youth violence incidents • Levels of first-time offenders/reoffenders • 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 • % of Carers on the Carers' Register. • Support for young carers

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: ➢ Cancers ➢ Cardiovascular disease ➢ Dementia ➢ Covid -19 and Long Covid ➢ Alcohol and substance misuse.	• Under 75 mortality rate from Cardiovascular Disease by Neighbourhood	• No of Emergency Admissions to Hospital Bed by Neighbourhood • 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. • Screening rates • Obesity rates • Physical activity • Smoking cessation levels • D & Alcohol misuse levels • Patient education/self help	• Elective Care: % of patients treated within 18 and 52 weeks of referral by Neighbourhood • 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 • % 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. • % of people aged 65 and over discharged to reablement still at home 91 days later. • % 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

	• Work with the voluntary and community sector to support people to live well, remain independent and to reduce loneliness.	• Falls prevention • Care homes • 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. • Life expectancy for people living with mental illness (and by neighbourhood).	• Reduce delayed transfers of care. • Reduce acute length of stay. • Increased support to self-manage. • Increased MH support in the community. • ARRS roles recruited to. • Further ARRS KPIs determined. • 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. • Increased support for people newly diagnosed with ASD. • Dynamic Support Register in place. • Reduction in hospital admissions to make medication changes. • Reduction in avoidable deaths.
	• Implement crisis and short-term intensive support teams for people with autism.		

	• Develop a collaborative approach to improve services for people who misuse drugs and alcohol and are mentally ill.	• Streamline the MH pathway. • Adults in contact with secondary MH services living in stable and appropriate accommodation.	• Reduction in re-admissions rate. • Reduced acute MH length of stay. • 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. • 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. • monitor postvention bereavement support • 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> • Embed Adult Social Care provider engagement arrangements. • Secure agreement on long-term integrated brokerage arrangements. • Review Adult Social Care provider risk management arrangements. • Establish and implement lead commissioning arrangements to address local health and care system care home placement requirements. • 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. • Number of emergency admissions from care homes.	• Uptake of Covid vaccines in the community.
	<u>Digital and business intelligence led improvements</u>: • Maximise scope for sharing	• Number of care homes approved to use CMC.	

	activity data to ensure system wide understanding of capacity and pressure points and opportunities for early intervention. • Promote roll out of advanced planning tool Coordinate My Care (CMC) in care homes. • Embed remote consultation technology in care homes to facilitate access to timely advice from health and social care professionals. • Establish a remote vital signs monitoring pilot in care homes to facilitate early intervention by relevant health professional. • Promote use of telecare technology to support independence of residents. • Maximise opportunities for sharing relevant activity data to ensure system wide understanding of capacity and pressure points.		
	<u>Workforce development</u>: • Complete and implement the HHCP integrated community workforce plan. • 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>: • Review Council and NHS		

	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: • **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. • **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. • **Care Coordinator (CC)** – They assist the Guided Care Matron in proactive care of patients, pulling practice and system intelligence on patients and updating care plans and communicating with other providers.	Neighbourhood Teams (NTs) are multidisciplinary teams but with a core team of GPs, community staff, social care staff and health and wellbeing officers and wider third sector staff, mental health professionals, practice staff and acute consultants. There are 6 NTs in Hillingdon aligned to the PCNs. Each team is supporting a population of between 30 and 50,000. The NTs identify and manage 15% of people within their population at greatest risk of future hospital admission or attendance. At risk people are identified through: • Use of risk stratification tools. • Intelligence gathering from health and care providers. • 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. 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. 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

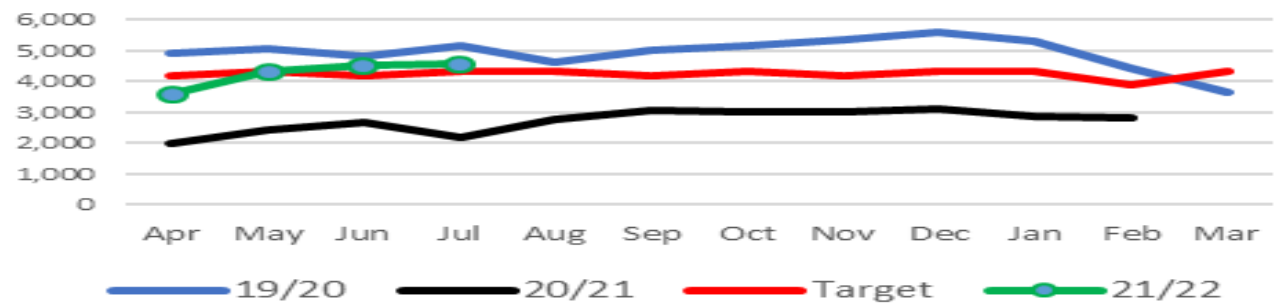
20. With the intention of addressing issues of vaccine hesitancy in care homes, the GP Confederation managed to secure agreement from Professor Sarah Gilbert to lead a webinar for care home staff. Professor Gilbert was one of the people who led the development of the Astrazeneca vaccine. The webinar 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

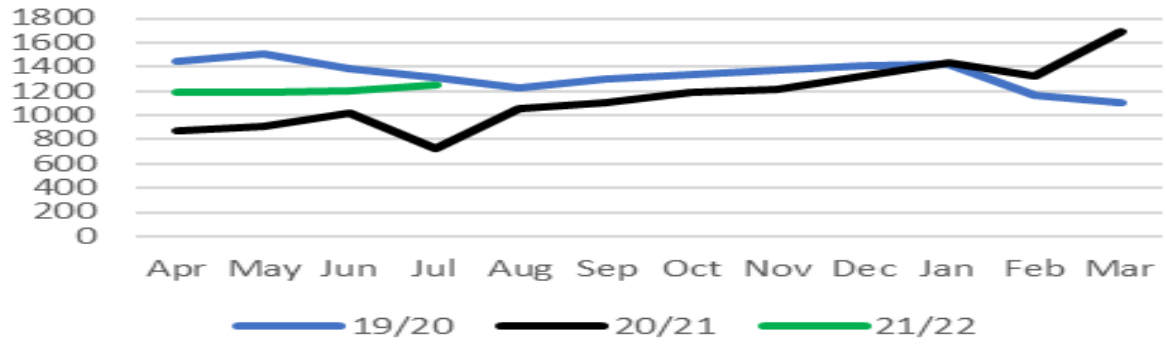


22. **Urgent Treatment Centre (UTC):** This is for residents who have an urgent or severe condition or minor injury that cannot wait for a GP appointment (usually 48 hours). Hillingdon's UTC is based on the Hillingdon Hospital main site and has seen attendances increase from an average of 256 a month 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

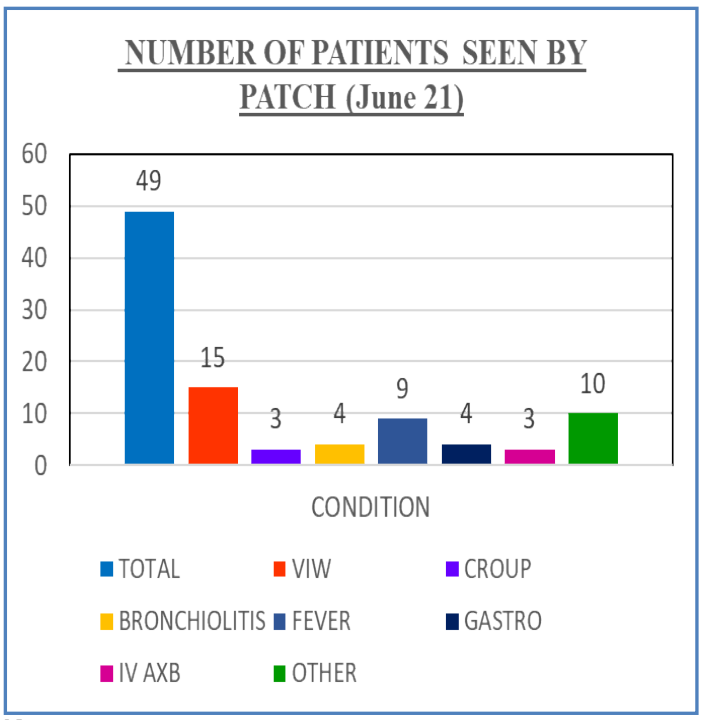
30. **Pathway redesign:** Priority is being given to gynaecology, gastroenterology and musculoskeletal (MSK), ophthalmology and dermatology to determine what activity can take place in the community rather than in hospital.

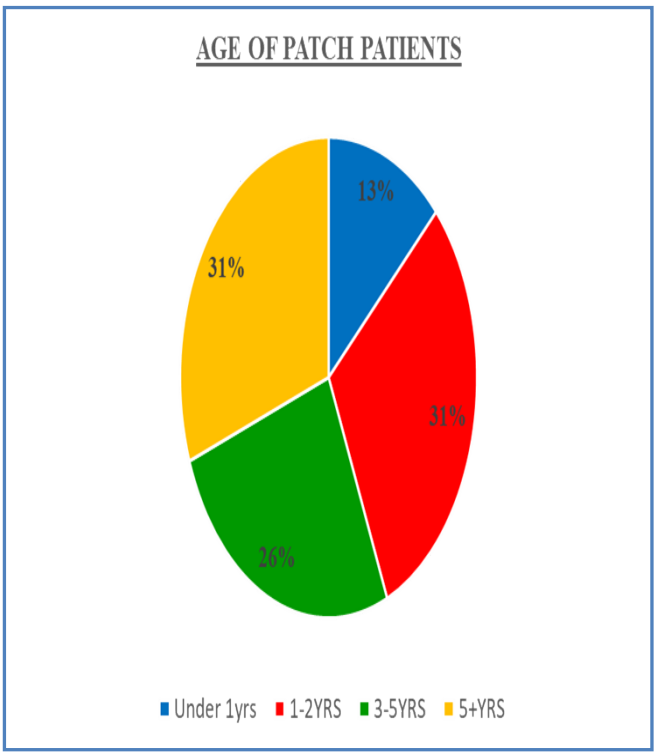
31. **Integrated Advice and Guidance Hub**: The Advice and Guidance system (A&G) went live across Hillingdon GP practices, THH, community and primary care providers in June 2020 with the intention of enabling consultants to triage requests from primary care to ensure that patients who required an outpatient 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.

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CHILD HEALTHY WEIGHT PLAN UPDATE - SEPTEMBER 2021

Board Member	Councillor Jane Palmer
Organisation	London Borough of Hillingdon
Officer Contact(s)	Kevin Byrne, Health and Strategic Partnerships Shikha Sharma, Public Health
Papers with report	Appendix 1: Child Healthy Weight action plan

1. HEADLINES

Summary	The report provides the Board with an update on actions in the Child Healthy Weight Partnership Action Plan.
Contribution to our strategies	The report delivers on a key element of the Hillingdon Joint Health and Wellbeing Strategy and the NWL Sustainability and Transformation plan.
Financial Cost	No financial cost arising directly from action plan. Costs for proposed project to promote healthy eating and physical exercise estimated at £6k for initial stage.
Relevant Ward(s)	All

2. RECOMMENDATION

That the Health and Wellbeing Board notes the progress against the earlier plan and comments on proposals for taking forward actions to support children's healthy weight across partners and in the light of the current pandemic.

3. SUPPORTING INFORMATION

The Borough's Child Healthy Weight Partnership action plan (see Appendix 1) was produced in response to the Board's request that a partnership approach be developed to tackle the main causes of excess weight in children. The plan takes a life course approach to reviewing the activities in place to support families and young people. There is no one intervention or one cause of overweight or obesity in children – interventions, therefore, need to cover a multi-faceted approach and across partners.

The Covid pandemic has undoubtedly impacted on families and children and young people. Activities in schools were put on hold and have only just been able to recommence. We do not yet have data on levels of overweight and obese children since lockdown but the situation is unlikely to have improved. The plan explains progress against each priority area and, in particular, the following actions are now in place:

- **Early Years and Maternity.** Both The Hillingdon Hospital and CNWL have achieved

Stage 2 'Baby Friendly' accreditation to support breastfeeding and mother-infant relationships. Progress towards Stage 3 has been delayed by the pandemic.

- **CNWL contract.** The 0-19 contract variation has now been agreed with CNWL and will run until July 2022. The new contract includes the 0-19 healthy child programme, ARCH substance misuse and smoking cessation, as well as a Family Healthy Weight Programme. The contract includes an approach to transformation which seeks to develop integrated interventions with measurable key performance indicators. CNWL is developing a more family-orientated approach to weight management at all universal contacts and will provide practical information including healthy eating messages, healthy lifestyle messages, and bottle to cup guidance. For children aged 0-5 the service offer will include:
  - Advice for mothers on healthy weight and weight gain during pregnancy,
  - New birth and 6-week checks, a starting solids group offered at 3 months,
  - From 8 months to one year, advice on healthy eating and activity, foods for baby and family and portion sizes, and fussy eating,
  - At 2-year review, targeted healthy eating groups in Children's Centres: 4-week programme,
  - At 3-4 years, identification of potential issues with short, targeted interventions,
  - Future work with the Primary Care Networks (PCN's) linking with social prescribers to enable them to work creatively with families.

  The offer for school-age children will include:
  - A condensed 6-week 'My Choice' programme to enable two sets of courses per term, increasing throughput and building on increased parental interest since Covid,
  - Healthy eating workshops delivered to year 6 children in schools with high rates of over-weight children.

- **National Child Measurement Programme.** Following the reopening of schools in March 2021, DHSC notified us that a 10% weighted population sample of data could be submitted due to the impact of lockdown during winter 2020-21. Hillingdon has exceeded this requirement, with one of three school nursing localities collecting data for all children. NCMP results identifying children's BMI levels are the gateway to 'My Choice' targeted intervention programme. Data has been collected and submitted for 2017 children out of 3930 Reception Year children (51.3% completion) and for 2452 out of 3849 Year 6 children (63.7% completion). A full programme will resume in all schools in September 2021, with the aim to complete at least the usual coverage of 95%.

- Follow-up actions to the child measurement programme have been completed as follows:
  - All parents were sent letters informing them of the BMI of their children and a Change for Life flyer with 'top tips' for maintaining healthy weight.
  - All parents of overweight and obese children were sent letters with offer to join 'My CHOICE' programme, an application form to join the programme and the C4L 'top tips' leaflet (as above).
  - All parents of underweight children and their GPs received letters.

- **My Choice.** The first My Choice programme commenced in January 2020 but was not completed due to the first lockdown. CNWL made efforts to engage with parents online but were not successful due (CNWL believes) to parental fatigue with online education.

However, one to one contact was offered, and support maintained to encourage families to utilise what they had learned during the course. Subsequent contact with identified overweight children during the school closures was offered to parents on a one to one basis by letter and in some cases this support was accepted.

- Efforts have been made to resume My Choice since the Spring, but with leisure centres not accommodating groups, CNWL have looked to the schools for support. Unfortunately, they have only had the support of one of the three selected schools in each of the localities, to facilitate a session with parents and children. This too has been met with obstacles with parental declining to attend the course citing "embarrassment from the child" to "other family commitments". In order to address the increasing numbers of over-weight children, 3 schools in the south of the borough with the highest numbers of identified overweight children were chosen by the school nurses to deliver a healthy eating workshop session to each year 6 class group. This will be to the whole class and will cover the key elements of healthy food choices and activity. It will be reviewed by feedback questionnaire to the pupils and teachers. During the summer CNWL will plan for the delivery of three My Choice programmes - one in each locality - for September, in either leisure centres or schools. CNWL is now also planning to deliver My Choice over two terms to avoid fallout and increase capacity to run more courses.

- **School Packed Lunches Survey for Parents & Carers.** A small steering group comprised of Headteachers, the catering lead from Colham Manor Primary school, staff from the NHS, Public Health and Education Improvement has been set up to review school and packed lunches. This followed feedback and concerns raised by paediatric staff at THH regarding levels of diabetes. A survey in February with school leaders looked at school catering - portion sizes and whether sugary desserts are provided to children as part of their hot lunches, for example. The survey received over 1300 responses and showed that children in younger age groups were more likely to take a packed lunch, which parents often considered to be a healthier option. Vegetables, salad, and fruit were frequently included in lunches. Many respondents said they never included crisps or biscuits, but there was support for more guidance on the nutritional content of packed lunches.

- **Healthy Start scheme.** The programme offers vouchers for vitamin supplements, milk, fresh fruit and vegetables to pregnant women and families with children aged under 4 who are in receipt of qualifying benefits. Take-up in Hillingdon has been around 54% which is similar to the London and regional averages. The scheme was relaunched in June with an on-line training and awareness event attended by 46 front line professionals from Children's Centres, GP practices, maternity services and libraries. New promotional leaflets and posters have been distributed. The take up will be monitored to gauge improvement.

- **Child dental health.** The numbers of children aged 3 with poor dental health remains a red indicator for Hillingdon as measured by Public Health Profiles. Roll out of the Supervised Brushing Programme was delayed due the closure of schools during the pandemic, but there has been continued engagement with schools. Oral health has been promoted through a monthly newsletter for parents, carers and professionals; oral health themed holiday activity packs for children; and regular training and awareness sessions. The Brushing for Life initiative is key in promoting good oral health targeting young children and parents. It provides brush for life packs and free-flow beakers to give out at

weaning workshops and bottle exchange activities. The programme is supported by Health Visitors and Early years staff in Children's centres.

The Council's External Services Select Committee is revisiting the concerns about children's dental health previously considered by the Social Services, Housing and Public Health Policy Overview Committee in 2015. The Committee's preliminary view is that there may be a localised issue affecting North West London, with some evidence that long-term bottle use and consumption of sugary drinks is driving high levels of decay. The Committee will look at causes and at the availability and accessibility of services.

- **Physical activity and open spaces.** Hillingdon is home to excellent green and open spaces, but official survey evidence shows relatively low rates of adult physical activity, which may in turn affect children's activity rates. Hillingdon's 'Our Parks' programme involved commissioning 5 activity sessions per week over 50 weeks targeting areas of lower physical activity. During the pandemic, sessions moved online but saw a 50% increase in take-up, with large numbers of new users. Work is underway with London Sport to draft a new Strategy and action plan using the recommendations from the recently commissioned *London Sport Insight Report: Hillingdon* to address physical inactivity levels, and particularly after COVID, across all age groups within the borough.

- **Healthy Schools.** The Healthy Schools programme offers a framework for schools to develop and implement healthy eating and exercise action plans. Hillingdon has a higher level of active primary aged school children (57%) than London and England. (Active Lives Survey). Hillingdon also has a higher level of 5-16yr olds active for 30 minutes a day in school (51%) than London and England. Analysis of PE and Sport Premium action plans suggests that 'active play' is the main contributor to this in primary schools. Work is being undertaken with London Sport to examine how the Primary PE and Sport Premium is spent in and to review the impact from the pandemic in secondary schools.

- **SMILE programme.** Funding was agreed in February 2020 for a programme in primary schools to teach children and parents basic cooking skills, increase knowledge about foods high in sugar, salt and fat, learn how unhealthy choices impact on physical health and understand the relationship between food and physical activity. The programme is now planned to pilot in one school (Colham Manor) in September 2021, followed by a rollout to 6 other schools. A service level agreement has been drawn up.

- **Restricting advertising less healthy food and drink**. The Health and Care Bill is proposing a 9pm watershed for less healthy food or drink advertising on TV and a prohibition of paid-for less healthy food or drink advertising on line. Subject to parliamentary approval the ban would take effect from end of 2022.

Financial Implications

The 'SMILE' project has previously been agreed by the Leader of the Council. The initial pilot programme is anticipated to cost approximately £5.8k. Should the pilot be successful, it is then proposed to commission Colham Manor School to roll out the programme to 6 schools. This would come at a total cost of approximately £16.2k.

4. RESIDENT BENEFIT & CONSULTATION

The benefit or impact upon Hillingdon residents, service users and communities?

The purpose of the Child Healthy Weight Plan is to reduce the levels of obesity and overweight children in Hillingdon.

Consultation carried out or required

None needed.

5. CORPORATE CONSIDERATIONS

Corporate Finance has reviewed this report and concurs with the financial implications of this report, noting that the 'SMILE' project meets the Public Health objectives for Hillingdon and, as per the previous agreement, will be funded from the Public Health reserve.

Hillingdon Council legal comments

The Borough Solicitor confirms there are no specific legal implications arising from this report.

6. BACKGROUND PAPERS

Child Healthy Weight Action Plan

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HILLINGDON HEALTHY WEIGHT ACTION PLAN v 2.1 September 2021

Priority	What is the aim?	What will success look like? (outcomes)	What will we do? (outputs)	Status	Lead contact
1. EARLY YEARS & MATERNITY					
1.1. Ensure UNICEF 'Baby Friendly' standards apply across maternity, neonatal, health visiting and children's centres	Baby Friendly standards support mothers to breastfeed and make informed decisions on healthy infant nutrition.	There is a clear understanding of the accreditation levels achieved across maternity and neonatal services, health visiting and children's centres.	Map and document the accreditation levels achieved.	*Complete* THH & CNWL have achieved Stage 2 BF Standards. The intention is to progress to Stage 3, this has been delayed by the pandemic. Children's Centre staff are all trained in line with UNICEF guidelines	Anita Hutchins THH Claire Fry LBH
1.2. Increase levels of breastfeeding	Increase the number of babies being partially or completely breastfed at 6-8 weeks.	More babies are being breastfed at 6-8 weeks. Parents are readily able to access advice and support to breastfeed in their community. Unicef Baby Friendly Accreditation at stage 3 for Health Visiting and Maternity services.	Education on the benefits of breastfeeding through antenatal classes and contacts. Provide breastfeeding support groups and specialist clinics in Children's Centres. Midwifery, Health Visiting and Children's Centre staff trained to support responsive feeding.	*In progress* The Breastfeeding Strategy Group meets quarterly and reviews data on BF at ward level. Data provided for levels of BF initiation and then sustained after 6 weeks at ward level.	Sally Crowther (CNWL)/Julia Masdin (THH)

1.3. Increase levels of physical activity for children aged 0-5 in line with NHS guidelines	Ensure opportunities for physical activity are available to young children.	Clear information on opportunities for physical activity is readily available. Information is included in development of child obesity pathway. Information given to parents at HV health reviews at 8 month and 2 years.	Produce clear mapping of physical activity sessions across children's centres and early years settings including: ● Xplorer ● Scootercise ● Forest school ● Daily activity guidelines ● BHF Early Movers. ● 'Tummy time' <u>Early Years Settings and Childminders</u> • Centralised training on the revised Early learning goal for physical development • Good practice guidelines for gross motor development published • Outdoor play and learning training - making use of Ruislip Lido - following forest school ethos. Building upon the previous LBH healthy EY accreditation - 20 childminders and 6 PVI settings to achieve level one of the Mayor Of London's Healthy Early Years London scheme, over the next year, with a view to building upon this in the following years.	*In progress* Mapping of location of sessions and numbers participating to be produced. Baseline and targets to be set with aim to raise participation.	Claire Fry LBH Sue Hynds LBH

1.4. Increase awareness of and access to healthy food and snacks for young children	Ensure information and advice on healthy nutrition is made available to parents and children.	Clear information on healthy diet is readily available. Information is included in development of child obesity pathway.	Produce clear mapping of healthy eating information and advice including: ● Getting Ready for Food weaning groups ● Bottle to cup parent workshops ● Cooking activities ● Adult Education courses ● Sugar Swap ● Brush for Life ● Eat better Start better ● Guidelines for EY settings ● Healthy Early Years London programme ● Free Adult Education classes for parents around healthy eating <u>Early Years Settings and Childminders</u> • Centralised training on the revised Ofsted guidelines in relation to mealtimes and food • Good practice and guidelines disseminated on portion size and nutrition information for PVI settings • Building upon the previous LBH healthy EY accreditation - 20 childminders and 6 PVI settings to achieve level one of the Mayor Of London's Healthy Early Years London scheme, over the next year with a view to building upon	*In progress* Produce a clear picture of the nature, location and attendance at groups and workshops. Produce description of activities and courses and their availability Produce description of implementation of national healthy eating and other campaigns. Campaigns such as Brush for Life & Sugar Swap are an integral part of Stay and Play activity sessions	Claire Fry LBH Sue Hynds LBH

			this in the following years.		
1.5. Improve children and young people's oral health	Address the link between obesity and poor oral health	Improvements in brushing techniques and reductions in fillings and extractions	Explore scope and opportunity for interventions such as supervised brushing	*In progress* Roll out of the Supervised Brushing (SB) Programme has been delayed due the closure of schools with COVID19 lockdown however Hillingdon's Oral Health Promotor continues to engage with schools and provide training in preparation. Schools lined up to take part include: Pinkwell, Colham Manor, Rabbs Farm, West Drayton Academy, Minet, Belmore and Yeading and Nestle's avenue early years setting. Other on-going oral health promotion activities continue e.g. a monthly newsletter containing information for parents, carers, and professionals; oral health themed holiday activity packs for children; and there are training and awareness raising sessions offered regularly. A competition for National Smile Month ran from mid-May to mid-June, the brief chosen locally was: Let's fill Hillingdon with Healthy Smiles. Submissions were received either as independent entries or via schools and a prize giving event took place on 8 Oct. via MS Teams. Another key initiative in promoting good oral health is Brushing for Life (BfL) targeting younger children and supported	Carol McLoughlin HCCG

				by Health Visitors and Early years staff in Children's centres.	
1.6. Increase awareness and uptake of Healthy Start Scheme	To ensure more women eligible to receive HSS vouchers are enabled to receive HSS vouchers to obtain fresh/frozen fruit and vegetables, cows' or formula milk, and vitamin coupons.	Increased take up of scheme. Increased awareness of scheme among front-line midwifery and other services.	Task and Finish Group identified key partners and developed strategic marketing plan and organised a training/relaunch event.	*In progress* On line launch event held 28th June with 46 attendees to reinvigorate the scheme so that front line staff are trained to make every contact count. Marketing materials also distributed. Take up will be monitored.	Sharon Daye/Viral Doshi
2. ACCESS TO GREEN SPACES AND SUPPORTING MORE PHYSICAL ACTIVITY					
Priority	**What is the aim?**	**What will success look like? (outcomes)**	**What will we do? (outputs)**	**Status**	**Lead contact**
2.1. Increase physical activities in local sports and leisure and open space facilities	Integrate physical activities into Children's Centre programmes	Increase levels of physical activity by young people and families via Children's Centres	Promote Outdoor play through Children's Centre led park visits, Playday and library storytime sessions 10 Fun things to Do outside integrated into Children's Centre timetables.	*In progress* Not progressed during 2020	Julia Heggie Claire Fry
	Increase regular use of outdoor gym facilities	Measurable increase in use of outdoor gym facilities.	Commission local exercise instructors and promote outdoor gym programme in Hillingdon People, through social media and LBH website.	*Complete* 3 sites have system installed. Programme ran April-Sept. 165 sessions with 275 attendances. Popular sites were delivered in the north of the borough. Instruction Programme now concluded. Facilities remain in place	Julia Heggie
	Increase community tennis provision in local parks	Measurable increase in use of facilities.	Install gate access system, provide Tennis For Free sessions	*In progress* Tennis has remained a popular activity during 2021. A gate access system has been installed in 5 parks to	Priscilla Simpson

			Promote *Nature Valley* Big Weekend events	date. A further 5 sites will have a gate system installed. Registration system monitoring usage. Between September 2019 – June 2021, 25,546 court hours were booked using 'Clubspark' through 30,972 bookings. This is an impressive number given the experience of three lockdowns. **Walking Tennis** (for families) started in June 2021: 1 session 14 participants held at Hillingdon Court Park tennis site. **Tennis for Free** – Coach led activity 247 bookings April – June 2021 (age is 12+ and will include adults) **SERVES LTA** programme – non traditional venues in areas of deprivation 8-18 years) Hayes Muslim Centre: 132 attendances over 8 sessions (started SERVES will be delivered in Young People Centres from Sept 2021.	
	Increase community Cricket provision in local parks	Measurable increase in use of facilities.	Install NTP and nets at Cowley Rec and Grassy Meadow. Develop activation plan with MCC	*In progress* Discussions with ECB to install two non-turf pitches at Grassy Meadows and Cowley Rec Ground for children and families.	Julia Heggie

				In July'21, Middlesex Cricket set up 'Dynamos' and 'All Stars' cricket for 5-11-year-olds at 3 local parks. 6 schools have also been approached to receive cricket equipment from ECB to set up games and training within their schools. Data due autumn 2021.	
	Provide multi-activity programme of free and low-cost activities in local parks.	A diverse and accessible programme of activities is available and promoted.	Commission Our Parks programme A programme targeting areas of low physical activity offering free activities aimed at inactive people.	*In progress* Online sessions rose by 50% (April – July). 312 people attended (April – July), In some cases whole families are taking part as well as the registrant. Most new user accounts are people doing less than 30 minutes per week of activity. There have been 300 attendances across 3 park sites. Projects on open spaces for young people only started in June 2021. 41 attendances to date. Couch to Fitness, an online 9-week, 3 x 30m programme started in November 2020 with referrals from Hillingdon Hospital weight management, diabetes team and consultants. The project ran for 30 weeks 12 engaged; 10 inactive, 9 female, 1 male, 4 BAME - 79 attendances. A new online programme, free to access and promoted through Hillingdon People and Hillingdon Hospital. Both programmes are 4-week, 3 x 10 minutes.	Julia Heggie

				To date there are 1226 active participants.	
	Provide children with disabilities with access to weekly exercise instructor-led multi-sports sessions.	Increase in numbers of children with disabilities taking up weekly exercise.	Commission disability sport programme at leisure centres.	*In progress* All leisure facilities -when open - are accessible to enable disabled people to take part in activities including swimming lessons, health and fitness gyms and sports hall activities such as badminton. The Hillingdon LeisureLink scheme provides savings on leisure activities to concessionary groups including people with disabilities, 16 plus students and looked after children. Disability sports club at Queensmead Sports Centre on a Saturday afternoon for 8 to 19 years old. Activities include trampolining, football, table tennis and volleyball. **Active Londoners Application**: completed and submitted application for funding November 2020 to support children and young people with autism and their carers to participate in regular multi-sport activities three times a week.	Nicky McDermott LBH
	Provide multi-activity programme of free and low cost activities to targeted groups	Increase in participation of inactive young people	Implement 9 London Sport Commissioned projects (to run over 30 weeks) • See Our Parks above, plus • YMCA - free football at Botwell for 14-16 yrs	London Sport Funded projects YMCA - After 20 weeks: 42 (36 BAME) participants, 677 attendances, 50% inactive. Project due to end at the end of Sept.	Julia Heggie

			• P3 young people experiencing anxiety, depression, poor mental health • YOS - Boxing project for young people at risk of offending Universal Youth Service • This Girl Can – peer activities and coach led provision • Sports Leaders - train up to 20 young people to support planning and delivery of physical activity in settings	P3 – After 20 weeks: 12 participants - 83 attendances 10 female, 10 inactive. YOS – After 10 weeks: Project ended – only 1 referral This Girl Can After 10 weeks: Started May '21 – 223 attendances	
	Children and families are encouraged to try new sports and sign up to become members of sports clubs.	Increase in numbers of new registrations at sports clubs.	Make links with local sports clubs and promote Sports Taster weeks throughout the year.	*In progress* Twice a year clubs are asked to run taster sessions Sports Taster - Planned for Aug 2021 to coincide with Olympics. Survey planned to understand the challenges clubs face post-Covid – to be sent out when there is stability in the sector.	Priscilla Simpson
	Children aged 7-17 are able to participate in a range of competitive sports.	High levels of participation from target age group.	Deliver the London Youth Games programme. Deliver the Mini Marathon trials and event.	*Ongoing* Due to Covid only outdoor sports took place at London Youth Games 2021 (ages 10-16). Hillingdon had representation in 12 sports. Finals this year held at Brunel University at the end of August.	Mekaya Gittens

2.2. Physical activity programmes targeted at those most inactive	Develop targeted programmes to increase physical activity amongst inactive people	High levels of participation from target groups.	Examine scope for and design of targeted programmes: *Active Hillingdon*	In progress Active Hillingdon programme will bring together new and existing activities. Work is underway with London Sport to draft a new Strategy and action plan to address physical inactivity, particularly after COVID, across all age groups within the borough. It is anticipated that a draft of the Strategy will be completed by December 2021.	Julia Heggie

3. SCHOOLS

Priority	What is the aim?	What will success look like? (outcomes)	What will we do? (outputs)	Status	Lead contact
3.1. Improve links with schools	Identify ways to build and maintain links with schools	Healthy Schools London programme promoted as a tool for evidencing Personal Development requirements in Ofsted 2019 inspection framework Number of schools who have Healthy Schools London: ● Foundation level ● Silver Awards for healthy eating or physical activity. ● Gold Awards for healthy eating or physical activity.	Promote Healthy Schools London award to School Improvement Service. Provide free Healthy Schools London award training as part of LBH Learning and Development Offer to schools. Provide a quality assurance function to assess HSL applications Map healthy eating and physical activity involvement in schools (through submission of HSL Foundation level).	Engagement with schools is a key challenge. More schools need to move to silver/gold levels by developing and implementing action plans on healthy eating and exercise. Healthy Schools rating scheme to be reviewed to map school engagement. HSL project to reduce levels of fat, sugar and salt in lunch boxes. Only 1 school actively participated in the HSL project (Hayes Park) Gold award achieved. Engagement likely to remain low but also opportunities to promote ways to achieve 30:30 in schools.	Julia Heggie

				Hillingdon has a higher level of active primary aged school children (57%) than London and England. (Active Lives Survey) Hillingdon also has a higher level of 5-16yr olds active for 30 minutes a day in school (51%) than London and England. • Active Play is likely to be the main contributor to this in primary schools (from an analysis of PE and Sport Premium action plans) and protected timetabled PE in secondary schools Working with London Sport to look at how Primary PE and Sport Premium is being spent as well as how provision in secondary schools is being affected by Covid. It has been agreed that the focus should be on community provision to increase activity.	
3.2. Increase physical activity through 'Daily Mile'	Develop programme with schools to increase participation in Daily Mile activities	Schools are registered on The Daily Mile (TDM) website Schools cite TDM in Healthy Schools London (HSL) awards Schools engage in annual TDM events	Include an information session on how to implement and the benefits of The Daily Mile in the Learning and Development training programme for schools. Encourage TDM to be an activity schools implement for HSL awards.	As above engagement is a key challenge. Daily Mile activity could be part of an HS action plan. Links exist with London Marathon Trust who have partnered with The Daily Mile. Promotion of England does The Daily Mile (Feb) in School Leaders Briefing – now postponed to 30th April. 31 schools registered with The Daily Mile.	Julia Heggie

			Promote TDM events in Head Teacher briefings and forums.		
3.3. Improve school healthy food provision	Increase availability and take up of healthy food in schools. Decrease availability of unhealthy food	Good availability of fresh water to replace sugary drinks Good access to and awareness of healthy food	Introduce water fountains into schools Through Healthy Schools London programme: Increase School Meal uptake Develop School food staff training Implement 'Sugar Smart' campaign School Packed Lunches	*In Development, subject to agreement* Consider project to coordinate, support and interventions with, firstly, primary schools. Survey work with schools has shown extensive use of packed lunches and a high degree of parental interest in healthy packed lunch guidance. Further work is needed to take this forward.	TBC
3.4. Extra-curricular activities	Facilitate extra-curricular physical activity sessions	Primary PE and Sport Premium funding is used to improve physical activity offer in schools: ● Providing 30 minutes in school each day ● Increased participation in sport and physical activity	Undertake a review of school action plans and see how funding is being used and how funding is allocated. Share examples of activities that have had a positive impact on increasing participation in physical activity throughout the school day.	*In Development, subject to agreement* Consider project to coordinate, support and interventions with, firstly, primary schools.	TBC
3.5. Increase Active Travel to and from school and outside of school time	Encourage more schools to undertake TFL STARS (School Travel Accreditation awards)	More schools STARS accredited. More schools encouraging and increasing active travel. Improved school provision of secure cycle storage.	Investigate scope to promote STARS awards scheme to schools Provide Bikeability training to 2300 pupils (in years 6/7)	*In Progress* 16 schools signed up to STARS so far. Bikeability training to 2128 pupils in 2018/19	Lisa Mayo Transport Team

	More schools enable active travel including cycling More children are equipped to cycle safely to school and outside school time.	Regular programme of cycle training for schools.	Provide Practical Pedestrian Training to 10,200 pupils at infant and junior schools Map and encourage school cycle storage facilities		
3.6. Explore additional intervention with schools	To consider developing a nutrition and physical activity programme for schools and families	Clear programme with costings for consideration. Agreement with schools and families on content Development of sustainable funding model	The 'Smile' programme has been developed to provide courses for children and parents. Funding has been agreed. The proposed courses are intended to equip families to: • Learn basic cooking skills • Increase knowledge about foods high in sugar, salt and fat • Learn how unhealthy choices impact on physical health - obesity, diabetes, dental health • Understand the relationship between food and physical activity.	*In progress* The intention is to hold pilot sessions in 1 school following the autumn half-term 2021 – a 4 week programme, followed by assessment in Nov/Dec assess their needs in terms of space, equipment, address any concerns and get them ready. Considering production of videos of 4 sessions to enable wider participation - cost estimate is £2k - professionally produced videos using a demonstration kitchen.	Kevin Byrne

4. ACCESS TO HEALTHY FOOD

Priority	What is the aim?	What will success look like? (outcomes)	What will we do? (outputs)	Status	Lead contact
4.1. Increase availability of Healthy food	Current activity at 1.4 and 3.3. above.	Increased availability of healthy food, especially in areas where healthy food is less accessible.	Investigate scope for developing work in this area.	Subject to business case development	TBC

4.2. Increase availability of information on healthy eating and increase family cooking skills		Range of sessions available to increase healthy home cooking	Deliver course via adult education function	Cooking activities are taking place in some children's centres A trial programme in development for children's centres Adult learning offer courses to promote healthy eating at children's centres including: ● Food to Make You Feel Good ● Nutrition and Balance ● Healthy lifestyles	TBC
5. PUBLIC AND COMMUNITY SETTINGS					
Priority	**What is the aim?**	**What will success look like? (outcomes)**	**What will we do? (outputs)**	**Status**	**Lead contact**
5.1. Council and NHS buildings offer healthy nutrition and promote physical activity	Develop a consistent approach to food provision and promotion of physical activity	Healthy food readily available across public and community settings	Review the current approach and consider the scope for improvements	*in progress* Early Years Centres contract includes requirements to follow Healthy Eating Guidelines: new menus developed Leisure Centres Management contract is being re-tendered from Feb 2020. Contractor asked to provide a healthy, balanced menu. At least 20% of the items provided in vending machines must be healthy options.	Claire Fry Children's Centres Nicky McDermott Leisure Centres
6. WEIGHT MANAGEMENT SERVICES					
6.1. Weight management services or pre-school via children centres and EY settings	support children and families to ensure best start through health eating	Fewer numbers of children reporting at reception as overweight or obese.	Consider developing proposals for intervention for this cohort, e.g. successor to Mini MEND scheme	*In Development, subject to agreement* Healthy eating course for parents will be piloted in spring	Claire Fry
6.2. Ensure 100% of children measured overweight/obese by NCMP are referred to weight	All parents of children measured as overweight/obese are referred to weight management services	More referrals translate into full participation in weight management programmes	Review the referral pathway from NCMP to weight management services	*In Progress* Review letter wording and follow-up process	Shikha Sharma

management programme					
6.3. Weight management services as part of pathway for overweight/obese children	Review MEND programme and develop new programme	Increased take up of participants and reduced levels of overweight and obesity at year 6	Revised programme is developed and implemented with measurable outcomes	*In development subject to agreement-* New 'MyChoice' programme in commenced from Jan 2020 but impacted by loackdown. Evaluation underway utlising Brunel students	Shikha Sharma / Nicola Nuttall / Claire Fry
6.4. Increase take-up of weight management programme	Higher proportions of referrals convert to participation in programme	0-19 KPI currently 74% against target 75%	Review the referral pathway from NCMP to weight management services Review KPI target and performance	*In progress* Current scheme running at full capacity. Review programme capacity and referral pathway	Shikha Sharma / Nicola Nuttall / Claire Fry
6.5. Increase numbers of children completing weight management programme		0-19 KPI currently around 77% against target 80%	Review KPI target and performance	*In progress* Monitor participation and increase completion rate	Shikha Sharma / Nicola Nuttall / Claire Fry
6.6.	Ensure NHS Tier 3 intensive clinical support is available for severely obese children		Review demand for and availability of Tier 3 provision	*In progress*	Carol McLoughlin
7. EVALUATION, CAMPAIGNS, MESSAGING AND COMMUNICATIONS					
7.1. Strengthen evidence base	To ensure there is clear and detailed information about local needs	Clear and detailed evidence is available to inform interventions	Complete a need analysis	*To be developed*	Sharon Daye LBH
7.2. Investigate and develop child obesity pathway	Frontline staff in NHS, Council services and schools are equipped to engage with families of overweight/obese children and can provide information and refer to appropriate services.	Training exists for frontline staff and schools and there is a clear pathway to a range of services, targeted and universal, to address excess weight in children	Scope and develop a child obesity pathway	*In progress* TBC	Kevin Byrne LBH
7.3. Increase public awareness through promotion of 'Change for Life' Messages	Consistent messages on diet and nutrition are promoted and targeted information is provided	Increase understanding and awareness of healthy weight messages amongst target group and families	Develop Health Weight communications plan	*In progress* Draft in place	LBH Comms

7.4. Agree monitoring and reporting framework to measure impact and ensure delivery of agreed actions.	There are clear mechanisms for measuring and reporting progress	Regular performance reporting on progress regarding workstreams	Reports to Group and HWB	*In progress*	Kim Overy LBH

TACKLING MENTAL HEALTH ISSUES IN HILLINGDON

Board Member	Graeme Caul, Managing Director, CNWL
Organisation	Central and North West London (CNWL) Hillingdon Health and Care Partners (HHCP) NWL CCG – Hillingdon
Officer Contact(s)	Vanessa Odlin, Director for Hillingdon & Mental Health, CNWL
Papers with report	Not applicable

HEADLINES

Summary	This report provides the Board with the latest update on the progress towards tackling adult, children and young people's mental health in Hillingdon.
Contribution to our strategies	This contributes to the Health and Wellbeing Strategy, NWL Clinical Commissioning Group (CCG) Operating Plan and individual organisational strategies for Hillingdon Health and Care Partners (HHCP).
Financial Cost	Not applicable
Relevant Ward(s)	All Wards

RECOMMENDATION

That the report be noted.

EXECUTIVE SUMMARY

The aim of this paper is to update the Health and Wellbeing Board on the current developments on tackling mental health in Hillingdon. The paper highlights key areas of development and updates on previously reported initiatives. Updates on:

- **First Response Service** offering 24/7 assessment to our residents, wherever they are in the community
- "**The Cove**" crisis haven for Hillingdon population, 365 days a year for non-clinical evening offer
- **Central Flow Hub** will find a suitable bed in a timely way and is supporting the elimination of the use of beds out of area through external providers (Out of area placements – OAPs) via improved flow management
- Inpatient admission is supported by new investment embedding **Trauma Informed Approach** and the **See, Think, Act Framework** on wards
- Develop and improve our **Home Treatment Team** (HTT) model
- **Expansion of Primary Care Mental Health Teams**
- **Development of a Complex Emotional Needs Service (CENS)**

- Enhance the **older adult mental health services** through the community framework
- Develop a **0-25 pathway**
- Enhance the **High Intensity User (HIU) Service**
- Enhance the early intervention and early support offer for children and young people (CYP)
- Access to Child and Adolescent Mental Health services

Working with the Hillingdon Health and Care Partners (HHCP), CNWL is leading on transformation programmes consisting of Mental Health, Learning Disability and/or Autism and Children and Young People.

Key Matters for the Board

- The Board is asked to note the strategy and updates on mental health services in Hillingdon, which are outlined in this paper.
- Note how the findings of the Integrated Early Intervention prototype pilot are being embedded within new Service models.
- Note the establishment of the Children and Young Peoples Dynamic Support Register (DSR) and the collaborative approach to supporting young people with Autism, Learning Disability and both Autism and a Learning Disability in crisis.
- Note the increasing presentations of CYP with mental health conditions and the steps being taken to support the increase in access to support.

Background and Overview

Since the December Board, a number of services were discussed using Long Term Plan and locality investment, these have continued to be developed in spite of further lockdowns as a result of the COVID pandemic.

We are continuing to see an impact on the population with regards to mental health issues. We are reviewing the current situation and are considering how we move forward with developments in a way that delivers best value and meets the needs of the population.

We continue to see heightened periods of activity across Hillingdon Mental Health services but we are able to see benefits from the provisions and services we are putting in place.

Local Vision and Clinical Objectives

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 work with partners to prevent the numbers of suicides in Hillingdon and to offer support to those who are bereaved.

CNWL and the HHCP have established two transformation boards in order to provide strategic direction. There is good representation on board memberships from across the system. The transformation boards are gaining ground and are now secure and stable.

Transformation Boards:

- HHCP Mental Health, Learning Disability and/or Autism.
- HHCP Children and Young People

CNWL recognise the impact that COVID has had on the system and the transformation boards commenced to provide oversights and push forward with the transformation of mental health in Hillingdon.

CNWL has conducted a community strategy review since March 2021. There was a need to look at the long-term plan in the respect of COVID. There is a need for better integration of community health services and mental health services. CNWL is committed to building family centres from PCN's and neighbourhoods.

CNWL and the HHCP are using Long Term Plan and locality investment to take forward:

- New **First Response Service** offering 24/7 assessment to our residents, wherever they are in the community which enables quicker access to support
    - The first response service remains a new service currently.
    - We have been coming through the COVID pandemic and activity remains erratic. We are currently analysing the patterns to see how these change over time.
- "**The Cove**" crisis haven for Hillingdon population, 365 days a year for non-clinical evening offer (as above)
    - The coves are now open and actively receiving referrals.
    - The data shows that the coves, from the current position, the utilisation is dropping off and it is not clear why. We are currently investigating the root cause for this and will take appropriate action.
- If a bed is required, a new **Central Flow Hub** will find a suitable bed in a timely way and is supporting the elimination of the use of beds out of area through external providers (Out of area placements – OAPs) via improved flow management:
    - We can see that bed usage is reducing, in line with the number of referrals decreasing. DTA is consistently being recorded and the average time from DTA to admission is reducing.
- Inpatient admission is supported by new investment embedding **Trauma Informed Approach** and the **See, Think, Act Framework** on wards. This will support the clinicians' understanding of the patient's life, emotions and psychology to shape and influence safe individualised co-produced care and treatment within the hospital.
    - The See, Think, Act framework has been piloted at the Riverside centre.
    - The framework has been successfully implemented and embedded with a sustainability plan in place.
    - CNWL continues to review the data and ensure quality governance.
    - Internal audits continue on a fortnightly basis and this model has been a success and will now be implemented in other areas of CNWL.
- Develop and improve our **Home Treatment Team** (HTT) model to:
    - Refocus function to ensure fidelity to a recommended model that offers a genuine alternative to admission, 24/7, 365 days a year.
    - Make HTT responsible for staying within their local bed allocations and enabling HTT to in-reach to wards to facilitate early discharge.

    - Data shows us that, in the last 26 weeks, 70% of inpatients have been discharged to HTT with a 97% follow up in 72 hours.
    - 72% of patients were gatekept face to face, with an average of 7 contacts per episode.
- **Expansion of Primary Care:** The Primary Care Mental Health Team has been expanded to enable alignment to the PCNs. The team is made up of Registered Mental Health Nurses (RMNS), senior support workers (SSW) and Occupational Therapists (OTs). The team will take over all initial assessments for routine non-complex mental health referrals (this means that the patients' needs as such require an assessment within 28 days (20 working days).
- **Complex Emotional Needs Service (CENS):** It has been increasingly recognised that patients who have a primary diagnosis of Personality Disorder do not always receive the right care and treatment from mental health services. As a result, Hillingdon Mental Health Services are moving forward with a new model of care. This will include individual and group work; psychological therapies tailored to specific needs and are drawn from empirical research and an increasing evidence base.
- **Community MH Transformation / ARRS**
    - This project will oversee the reconfiguration of the Adult Community MH Teams model to better align services to PCNS. There are two workstreams one is the Community Model and two is developing and embedding the ARRS (Additional Roles Reimbursement Scheme) roles working in integration with Primary Care
- **High Intensity Users:** To build on the High Intensity Users (HIU) service in Hillingdon to support people who are presenting to A&E on multiple occasions
    - After reviewing the current remit of the HIU (High Intensity Users), the decision has been made to progress with the British Red Cross Model to align with other parts of the Central and North West London NHS Foundation Trust.
    - This model has multiple purposes to focus on the High Re-admission Group, prevent someone from becoming part of the HRG, to assist with the section 136 and to support High Intensity Users.
- **Older Adults (OA) Mental Health (MH):** Building on investment in partnership working in 2021/22 for the OA, the aim is for OAMH services to PCNs, work more collaboratively with the VCSE sector to enhance the offer for older people. There are three key workstreams to this:
    - Optimising Inpatient Care, CNWL have recruited a discharge co-ordinator and continue to recruit to VCSE posts.
    - Crisis and Inpatient Alternatives.
    - Integrated working with Physical Health and Care Homes, we are currently implementing the people safely home pilot.
    - CNWL is currently utilising additional Memory and Assessment Service funding to recruit a fixed term contract to support waiting times within this service.
- **16-25 Improvements:**
    - CNWL is in the process of developing the new 16-25 Young Adults Service, to better bridge the gap between CAMHS and adult mental health services.
    - The requirements and scoping phase is now complete. There has been engagement with a range of stakeholders from different sectors such as local authorities, the voluntary sector, education, care leavers and service users from both CAMHS and AMHS. We have also now employed the operational and clinical lead doctor for the service.
    - Next steps will be the design of a service model, first draft due for discussion at the YA Mental Health Programme Board on 30 August 2021.
    - The new model includes multi-agency YA triage meetings with a flexible interface

between services tailored to need not age led, support for young adults moving from CAMHS to AMHS, extension of support to 25 for LAC and Health & Justice, Young adult focused therapies and an improved wellbeing and recovery support for young adults on waiting lists and post-treatment.

Hillingdon Health Care Partners and London Borough of Hillingdon

Working with the Hillingdon Health Care Partners (HHCP) and the London Borough of Hillingdon CNWL is chairing the HHCP Mental Health, Learning Disability and/or Autism Transformation Board consisting of four key workstreams:

1. Early Intervention & Support
2. Community Transformation
3. Urgent & Emergency Care
4. System Integration / Alignment.

Highlighted Projects:

- **Community MH Transformation / ARRS**
  - This project manages the reconfiguration of the Adult Community MH Teams model to better align services to PCNS. There are two workstreams one is the Community Model and two is developing and embedding the ARRS (Additional Roles Reimbursement Scheme) roles working in integration with Primary Care.
- **Physical Health in Serious Mental Illness**
  - Improve the Physical Health of patients with Serious Mental Ill-health and Complex Common Mental Health problems.
  - Provide proactive case management for these patients, supported by an Annual Bio-Psycho-Social 'Recovery & Staying Well Plan' with patient contact throughout the year to review progress.
  - Ensure that the patient benefits from high quality care, delivered as close to their home as the stability of their mental health allows.
  - Prevent or reduce unnecessary referrals and admissions to specialist services and Secondary Care.
  - Address health inequalities and recovery needs that have arisen from the COVID pandemic.
- **Drugs, Alcohol and Mental Health**
  - Vision is to offer a joined-up approach for people with drug, alcohol and mental health problems which is collaborative and facilitates shared treatment and care plans and joint management when appropriate.
  - The approach will facilitate a shared understanding of a person's needs, and lead to increased service user support.
- **System Wide Resource Mapping, Status Review**
  - In May 2021, the CNWL Rehabilitation Services launched a transformation programme to focus on pathways and its critical role in the wider system.
  - It was recognised that the changing commissioning landscape, transformation of Acute and Community pathways and the move to Integrated Care Systems provided an opportunity to take stock and consider how the services can continue to meet the needs of local patients, in the least restrictive environment.
- **Crisis Pathway**
  - We are currently undertaking review to look to see if we need to adapt the model that we have got on offer in Hillingdon to better meet the needs of the people.
  - We have taken stock of some of our approaches, and we are recognising the need to rethink our crisis work.

- The aim is to provide support to the population in Hillingdon, reduce admissions to the acute, provide service users with more appropriate resources and ensure that we are servicing mental health demands in the community.
- We are looking at evidence based best practice and performing outreach to other parts of England. Exemplary crisis models have been seen in Northamptonshire and Kingston.
- Best practice crisis model suggest significant system savings are to be gained.
- This work links with the One Stop Shop and Coves already mentioned as well as scoping the opportunity for a Crisis House in Hillingdon and piloting an innovative project – Wellbeing Wheels. The aim for this would be to provide mobile outreach to the population, enabling wellbeing access for people across the borough.

Children and Young People Mental Health and Emotional Wellbeing

Since the Board last met, the HHCP CYP Transformation Board has been established and met monthly since late 2020/21. This Board is co-chaired by the Director of Social Care and Health (LBH) and the HHCP Lead Director in recognition of the shared aspiration to develop a system that brings together Education, Health and Social Care to give a single approach for CYP and their families. This paper will update on the CYP MH performance and projects previously brought to the Board which are being brought together under the remit of the Transformation Board.

Early Intervention and Prevention

The Early Intervention Multi-Agency care and support pilot brought together CAMHS, P3 (a voluntary group) and the Multi-Agency Safeguarding Hub (MASH) to provide advice to the professionals involved and triage of cases, using multi-disciplinary assessment. The pilot ran from May 2020 to June 2021.

During that period, monthly complex case meetings were held and:

- A total of 394 referrals were discussed.
- 30 referrals (7.6%) were accepted by Specialist CAMHS following additional information being provided by the network.
- 28 referrals (7.1%) were accepted by Early Intervention CAMHS (e.g., Child Wellbeing Practitioners, Goal Based Interventions [GBI] via Healios, etc) (these services have now ceased).
- A total of **336 referrals were signposted to other agencies**, in most cases to more than one organisation.

The work to include GDPR statements on referral forms stalled due to the pandemic so families haven't been able to consent to the sharing of information with other agencies as required.

There have been a number of significant changes since December that have impacted on the project; the wellbeing practitioner service ended (the national Mental Health School Team model will take on this role from Feb 2022). The Local Authority has redesigned its early help and prevention offer and is implementing a collaborative multi agency approach, this has seen Local Authority teams involved in the prototype being refocused and staff roles changing. The six Primary Care Networks (PCN), with the support of the GP confederation, are now established and taking on their roles and responsibility in the Borough, and NWLCCG came into being on the 1 April 2021.

To ensure that the achievements and learning from the prototyping are adopted into the new and

emerging local system and structures, a number of developments have taken place. The group continue to meet monthly and triage and review cases. The project lead has recently joined the Safeguarding Board Early Help group and will work with the group to determine how to offer early mental health and wellbeing support to support the local aspiration of having a complete and joined up suite of services across Early Help, through education, health and social care.

PCN Children and Young People Virtual MDT's have now been held in 2 PCNs, these bring together members of the prototyping group with a wider group of professionals to review cases. It is envisaged that these will continue to take place in all PCNs to support practitioners working with CYP and families.

Children and Young People in Crisis - Dynamic Support Register

Hillingdon has seen a significant increase in the number of Children and Young People in crisis presenting to A&E and/or seeking urgent support from the Local Authority and the NHS to maintain their placement.

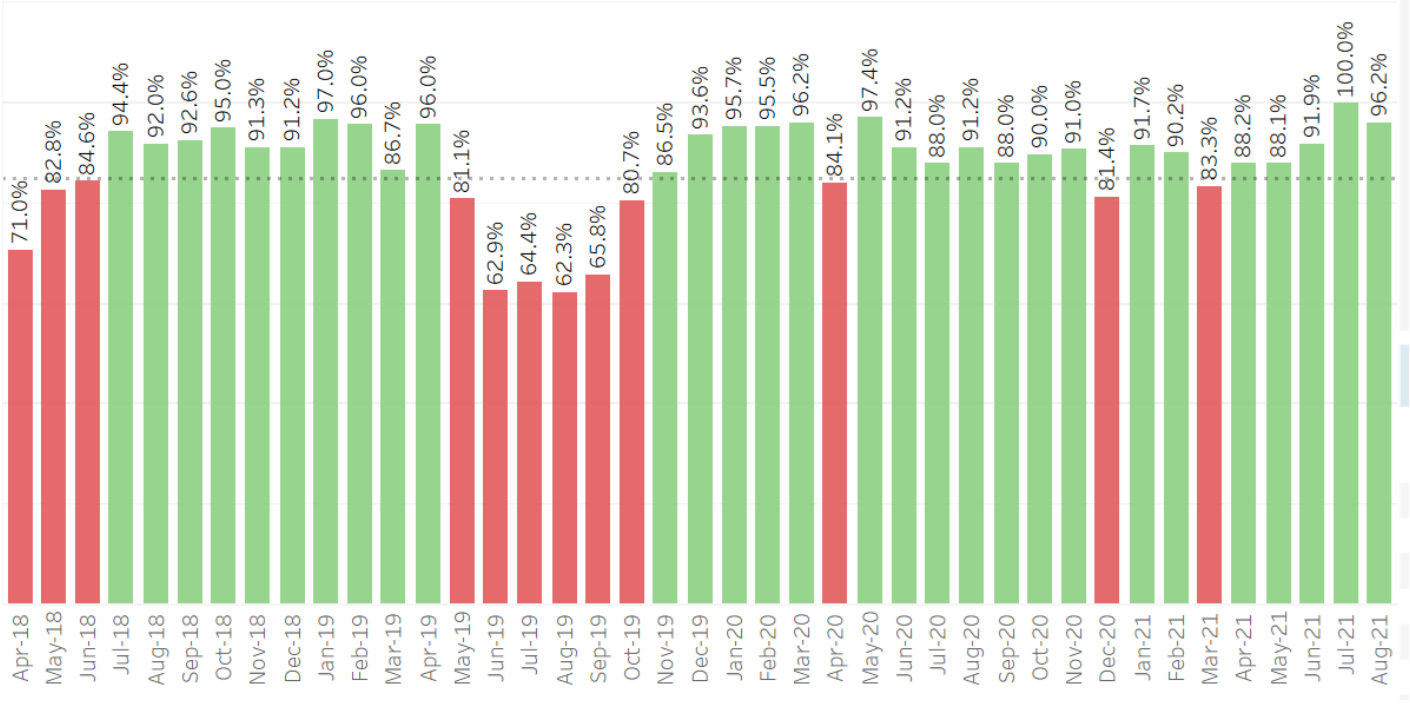
The Dynamic Support Register for CYP with a Learning Disability, and Learning Disability and Autism was set up in 2019. This group is a multi-agency group that meets to agree how to coordinate the best support for young people in Hillingdon who have additional needs and are at risk of their placement at home or school breaking down. Responding to the increase in the number of CYP with Autism in crisis and in recognition that there are different teams involved with these CYP, an 'Autism only' DSR was established in March this year. Although the group has supported earlier identification of cases and collaborative approaches to support families and CYP, there is more work to be done to raise awareness of the DSR across all relevant teams and services.

The DSR is rag rated with red rating identifying those at greatest risk of placement breakdown. Currently there 20 young people on the DSR (18 Autism Only) and two Young People rated as Red, (both Autism only) at high risk of placement breakdown. The DSRs are relatively immature and the NWL CCG Hillingdon Borough team continue to work with partners to supporting their development.

Kooth, the online counselling support and advice service for 11 – 19-year-olds continues to grow from strength to strength. The new NWL CCG contract, of which Hillingdon is a party, is currently being mobilised. This will see the local service continue with additional communication and awareness raising activity across the Borough including websites, communications, and schools.

Hillingdon Core CAMHS Service

As reported nationally and reflected by the work of the DSR, the 'Core' CAMHS service has seen significant increase in referrals and crisis presentations. The services received additional funding to support the delivery of the Long Term Plan, i.e., to increase in access to 35% of CYP with a diagnosable mental health condition being seen within 18 weeks. The funding has been used to expand the capacity of the CAMHS team and this is having a positive impact on performance. The table below shows the 18 week access target performance achieved from Aug 2020 to July 2021. Early signs are that the service is on track to deliver and sustain the target.



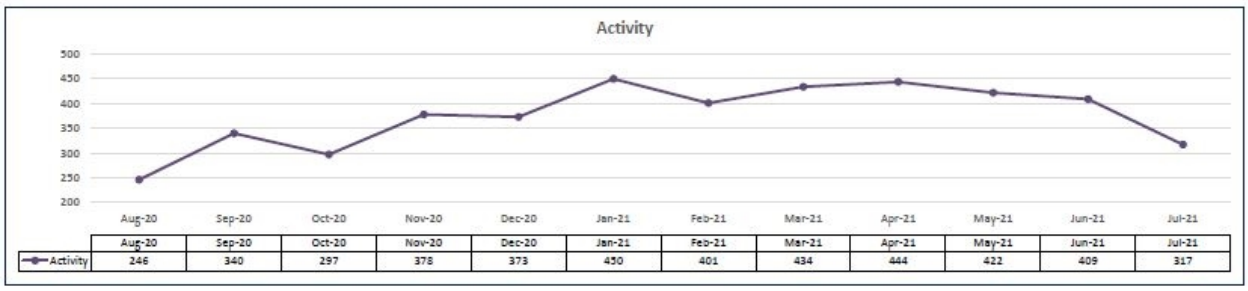
Graph 1: RTT 18 week performance

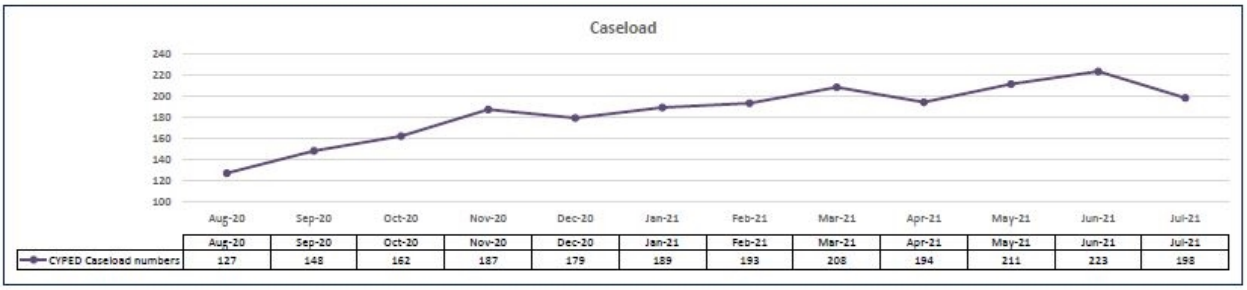
The Core Teams caseload has increased from 977 in August 2020 to 1,391 in July 2021; we will continue to monitor this closely and work with partners through the HHCP CYP Transformation Board to offer a comprehensive pathway of support for CYP and their families.

The Eating Disorder service performance shows that: we are not currently reaching targets, there has been a significant increase in referrals and the waiting list; additional resources have been made available however staff turnover and staff recruitment taking longer than anticipated has impacted on the waiting times.

CAMHS ED Waiting Times

Target Description	Target	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Waiting times - Routine	95%	87%	84%	90%	85%	84%	42%	69%	72%	38%	94%	85%	80%
Waiting times - Urgent	100%	100%	89%	100%	100%	70%	80%	100%	100%	33%	88%	75%	57%





Graph 2: CAMHS ED performance – Activity and Caseload

Via the CAMHS Provider Collaborative, CNWL is in the process with West London NHS Trust to jointly develop an ICS wide model of Intensive Community Eating Disorder Treatment for children and young people (delivered by both Trusts). The service will offer a holistic approach and will work with highly complex young people (and their families) at risk of admission or who need additional support to facilitate step down and prevent relapse. The key outcomes of this service are reduced admissions and LOS/OBDs and developing further capability and capacity to provide more intensive care outside of hospital. The plan is to have the service in place in January 2022.

Provider Collaborative CYP Mental Health Crisis Expansion

CNWL and West London MH Trust work together as the NWL provider collaborative to support children who needs are above that supported by Core CAMHS. The collaborative was awarded funding for the remainder of 2021 to 2023 from the CAMHS Provider Collaborative to expand several services to meet increased demand, acuity and qualitative targets across the Crisis & Urgent are pathway. Anticipated go-live when posts are recruited for each scheme is January 2022.

ACTS the community complex MH team. The proposed service expansion allows for 3 additional posts across a range disciplines which will impact positively system wide with benefits realised by partners and stakeholders in other sectors such as social care and education.

- Improved patient and carer experience.
- Reduction in admission rate and fewer out of area admissions with CYP.
- Support for timely discharge of young people from inpatient units (Reduction in length of stay, fewer bed days in GAU).
- Improved school reintegration coordination and planning held in the community.
- Improved relationship with system partners such as local authority, education and acute trusts and integration around safeguarding issues with greater opportunity to share and learn from joint working.
- Reduction in staff turnover and improved job satisfaction.

UCT The expansion of the CNWL Urgent Care Team will enable recruitment of an additional CAMHS professional in each borough (with the exception of Hillingdon which will benefit from two) and fits to meet the Trust's, North West London Provider Collaborative & National Priorities by:

- Avoiding T4 admissions and reducing length of stay for YP admitted to T4 beds.
- Building capacity and capability for CAMHS clinicians to manage YP in crisis in the community and, if necessary, admitting YP close to home.
- Offering more intensive community input to prevent deterioration in mental state
- Decreasing the number of young people detained under the MHA.
- Decreasing the number of emergency presentations (particularly for young people known to CAMHS).

Outcome Measures

A collaborative effort by HHCP partners has enabled the ongoing development of key outcome metrics for the joint health and wellbeing strategy. This enables us to ensure that we evidence the impact of initiatives and projects. KPI's and metrics enable us to see progress and ensure that trends and analysis are escalated appropriately and overseen by the respective transformation boards. The key outcome metrics are going through finalisation through the transformation boards.

Considerations and Next Steps

CNWL seeks close working and support from membership of the Health and Wellbeing Board as we move forward with the described approach. This will include a continuation of the transformation work outlined above and close working with the GP confederation, Primary Care Networks, London Borough of Hillingdon, The Hillingdon Hospital, Hillingdon Health Care Partners and Hillingdon CCG.

BOARD PLANNER & FUTURE AGENDA ITEMS

Relevant Board Member(s)	Councillor Jane Palmer Caroline Morison
Organisation	London Borough of Hillingdon Hillingdon Health and Care Partners
Report author	Nikki O'Halloran, Corporate Services and Transformation
Papers with report	Appendix 1 - Board Planner 2021/2022

1. HEADLINE INFORMATION

Summary	To consider the Board's business for the forthcoming cycle of meetings.
Contribution to plans and strategies	Joint Health & Wellbeing Strategy
Financial Cost	None
Relevant Select Committee	N/A
Ward(s) affected	N/A

2. RECOMMENDATION

That the Health and Wellbeing Board considers and provides input on the 2021/2022 Board Planner, attached at Appendix 1.

3. INFORMATION

Supporting Information

Reporting to the Board

The draft Board Planner for 2021/2022, attached at Appendix 1, is presented for consideration and development in order to schedule future reports to be considered by the Board. Members may also wish to consider any standing items (regular reports) and on what frequency they are presented.

The Board Planner is flexible so it can be updated at each meeting or between meetings, subject to the Co-Chairmen's approval.

Board agendas and reports will follow legal rules around their publication. As such, they can usually only be considered if they are received by the deadlines set. Any late report (issued

after the agenda has been published) can only be considered if a valid reason for its urgency is agreed by the Co-Chairmen.

Advance reminders for reports will be issued by Democratic Services but report authors should note the report deadlines detailed within the attached Board Planner. Reports should be presented in the name of the relevant Board member.

With the Co-Chairmen, Democratic Services will review the nature of reports presented to the Board in order to ensure consistency and adequate consideration of legal, financial and other implications. It is proposed that all reports follow the in-house "cabinet style" with clear recommendations as well as the inclusion of corporate finance and legal comments.

The agenda and minutes for the Board will be published on the Council's website, alongside other Council Committees.

Board meeting dates

The Board meeting dates for 2021/2022 were considered and ratified by Council at its meeting on 25 February 2021 as part of the authority's Programme of Meetings for the new municipal year. The proposed dates and report deadlines for the 2021/2022 meetings have been attached to this report as Appendix 1.

Financial Implications

There are no financial implications arising from the recommendations in this report.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

Consultation Carried Out or Required

Consultation with the Chairman of the Board and relevant officers.

5. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

There are no financial implications arising from the recommendations in this report.

Hillingdon Council Legal comments

Consideration of business by the Board supports its responsibilities under the Health and Social Care Act 2012.

6. BACKGROUND PAPERS

NIL.

APPENDIX 1

BOARD PLANNER 2021/2022

30 Nov 2021 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Select Committee (SI)	LBH	**Report deadline:** 3pm Thursday 18 November 2021 **Agenda Published** 22 November 2021
	Hillingdon's Joint Health and Wellbeing Strategy 2022-2025	LBH	
	Covid 19 - Local Outbreak Control Plan And Vaccination Uptake	LBH/HHCP	
	Board Planner & Future Agenda Items	LBH	
	PART II - Update on current and emerging issues and any other business the Chairman considers to be urgent	All	

8 Mar 2022 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Select Committee (SI)	LBH	**Report deadline:** 3pm Thursday 24 February 2022 **Agenda Published:** 28 February 2022
	Hillingdon's Joint Health and Wellbeing Strategy 2022-2025	LBH	
	Covid 19 - Local Outbreak Control Plan And Vaccination Uptake	LBH/HHCP	
	Board Planner & Future Agenda Items	LBH	
	PART II - Update on current and emerging issues and any other business the Chairman considers to be urgent	**All**	

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of the Local Government Act 1972 (as amended).

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