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Health and Wellbeing Board

Date: **TUESDAY, 30 NOVEMBER 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

Health and Wellbeing Board Reports - Part I (Public)

Health and Wellbeing Board Reports - Part II (Private and Not for Publication)

That the reports in Part 2 of this agenda be declared not for publication because they involve the disclosure of information in accordance with Section 100(A) and Part 1 of Schedule 12 (A) to the Local Government Act 1972 (as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.

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Minutes

HEALTH AND WELLBEING BOARD

14 September 2021

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge

	Board Members Present: Councillor Jane Palmer (Co-Chairman in the chair), Caroline Morison (Co-Chairman), Councillor Susan O'Brien (Vice-Chairman), Fran Beasley, Graeme Caul, Nick Hunt, Tony Zaman and Sharon Daye **Officers Present:** Kevin Byrne (Head of Health and Strategic Partnerships), Gary Collier (Health and Social Care Integration Manager), Dan Kennedy (Corporate Director - Planning, Environment, Education and Community Services), Vanessa Odlin (Director of Hillingdon and Mental Health) and Nikki O'Halloran (Democratic Services Manager)
1.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence had been received from Richard Ellis (NWL CCG), Lynn Hill (Healthwatch Hillingdon), Eddie Jahn (Hillingdon GP Confederation), Turkay Mahmoud (Healthwatch Hillingdon), Jason Seez (The Hillingdon Hospitals NHS Foundation Trust) and Patricia Wright (The Hillingdon Hospitals NHS Foundation Trust).
2.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* There were no declarations of interest in matters coming before this meeting.
3.	**TO APPROVE THE MINUTES OF THE MEETING ON 2 MARCH 2021** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 2 March 2021 be agreed as a correct record.**
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** *(Agenda Item 4)* It was confirmed that Agenda Items 1 to 10 would be considered in public and that Agenda Item 11 would be considered in private.
	WELCOME Councillor Jane Palmer, the Co-Chairman thanked those present for attending and welcomed them to the meeting. She also welcomed Ms Caroline Morison as the new Co-Chairman of the Hillingdon Health and Wellbeing Board. Councillor Palmer advised that she would chair this meeting and the meeting in November and that Ms Morison would chair the meeting in March 2022. It was hoped that the new Board structure would enhance collaboration.

5.	**COVID 19 - LOCAL OUTBREAK MANAGEMENT PLAN AND VACCINATION UPTAKE** *(Agenda Item 5)* Mr Dan Kennedy, the Council's Corporate Director - Planning, Environment, Education and Community Services, advised that infection rates in Hillingdon had ebbed and flowed but were in line with the England average and were below the London average. It was noted that infection rates tended to be higher in those age cohorts where vaccination rates were lower which was in part because the vaccination had not been readily available to them for as long. Vaccination rates in Hillingdon had been higher than for the rest of London: 81% had had their first dose and 73% had had their second dose. This compared to 67% for first dose and 64% for second in London and 89% for first dose and 81% for second in England. With regard to the roll out of the vaccination to young people aged 12 to 15, it was noted that this had been well received by head teachers in Hillingdon. A pilot had been undertaken in one school in London and would be introduced in one school in Hillingdon. Once the learning from this one school had been analysed and implemented, the programme would be rolled out to the rest of the Borough. The roll out to this age cohort was welcomed as it would also benefit teachers. The Council had continued to engage with faith leaders and businesses to encourage the take up of the vaccination and to ensure that measures were in place to control infection rates. **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.**
6.	**SETTING DIRECTION AND LATEST DEVELOPMENTS** *(Agenda Item 6)* Mr Kevin Byrne, the Council's Head of Health and Strategic Partnerships, noted that a new approach to the operation of the Board had been agreed at the workshop held on 18 May 2021. The Board had set our its aspirations to be the leader of 'place' and the report set out the key live issues across the health and care economy. The Health and Care Bill was currently at committee stage in the Commons and would give effect to a number of changes that had been set out in the NHS Long Term Plan and the White Paper, a lot of which would be helpful to the Borough. Although not hugely prescriptive, the Bill did give a clear direction for centralisation which could take away local discretion to act in the best interests of Hillingdon residents and patients. The North West London (NWL) System Development Plan (SDP) had been submitted by the interim NWL Integrated Care System (ICS) and set out the ICS's vision and ambitions. Issues that arose from the plan included the significant £460m underlying deficit across the system. In addition, it had been proposed that one CEO representative would be on the NWL ICS Board to represent all eight local authorities in NWL and that borough delivery leads would only be represented on a much wider NWL ICS Health and Care Partnership Council. Dr Fran Beasley, the Council's Chief Executive, advised that she and Councillor Palmer attended a range of fora where they had been continuously reiterating the need for Hillingdon to have representation on the NWL ICS Board. It would be impossible for the Borough's voice to be heard if it didn't have representation around the table. To this end, it would be important for Hillingdon to be clear about its mandate. Other NWL

boroughs didn't seem to be quite as passionate about this issue which might be because they did not have the same coterminosity or have made as much progress as had been made in Hillingdon.

The Chief Executive of NWL ICS had written to all local authority Leaders confirming the intention to appoint a single Chair across the four acute trusts in NWL including The Hillingdon Hospitals NHS Foundation Trust (THH). Hillingdon's Council Leader had responded to advise that this move raised issues of concern at a Borough level and he had highlighted the key part that THH had played in developing a place based approach to health and care in Hillingdon.

Ms Caroline Morison, Co-Chairman and Managing Director at Hillingdon Health and Care Partners (HHCP), advised that Hillingdon had been going through a period of transition during the pandemic which had helped partners to collectively sharpen their aspirations for Hillingdon. Further work was needed to align strategic priorities so that these could be fed into the ICS priorities to present a clear and aligned local voice to the ICS.

Work was ongoing in relation to the balance between local and system accountability. Overall, things had been positive with HHCP acting as a well developed delivery vehicle and providing enablers for delivery.

Mr Tony Zaman, the Council's Corporate Director of Social Care and Health, advised that the current situation was evolving. Hillingdon partners wanted to set themselves up as a local system but there seemed to be a NWL push towards a superstructure rather than a series of local systems coming together. Currently, the Hillingdon Health and Wellbeing Board was the only place with senior representation to develop the strategic direction of travel. As such, it was important that the Board could demonstrate that it had the right people round the table. The membership changes that had been implemented would ensure that all partners benefited equally from attendance at Board meetings. The Co-Chairmen would need to discuss the issue of non attendance to determine how this should be addressed.

The ICS was new and had not yet had the opportunity to acclimatise to the culture of NWL. Hillingdon had had the confidence to think outside the box and had made significant progress but all NWL boroughs were being treated as though they were currently starting from the same place. Hillingdon would need to ensure that it positioned itself so that it was seen as being different to the other boroughs.

Mr Nick Hunt, Director of Service Development at Royal Brompton and Harefield NHS Foundation Trust, noted that the report had not mentioned the devolution of specialist commissioning which had been overspent by hundreds of millions of pounds. The issues around devolution of these services would need to be resolved as it was possible that the ICS would be required to find a local solution and fund it in the future.

In addition to the issues around specialist commissioning, there would already be a significant financial challenge in NWL. It would be important to ensure that Hillingdon had an understanding of the challenges that it faced as well as a clear plan on how these would be addressed. Hillingdon would need to articulate its ambition regularly and consistently across all fora.

RESOLVED: That:

1. **the issues set out in the report be noted and the Board's position on behalf of the health and care system in Hillingdon be confirmed; and**
2. **the new approach to governance and membership be noted.**

7.	**HILLINGDON'S JOINT HEALTH & WELLBEING STRATEGY 2022-2025** *(Agenda Item 7)* Mr Kevin Byrne, the Council's Head of Health and Strategic Partnerships, noted that the report had brought together the Hillingdon Joint Health and Wellbeing Strategy 2022-2025 (HJHWS) with a single performance report setting out progress in delivering the Hillingdon Health and Care Partners' (HHCP) priorities, the Better Care Fund (BCF) plan and activities set out in the draft strategy. The Board noted that the Strategy was 12 pages plus appendix. The report included the vision and priorities that had been agreed by Board members at the workshop held in May 2021. It included actions attributed to HHCP theme groups and provided a picture of the Borough going forward. It would provide a statement of place which would be shared at a North West London (NWL) level. The report provided the Health and Wellbeing Board with a delivery framework which could be used by the Board to hold itself to account. It was anticipated that it would now be the subject of a public consultation and that it would then be reported back to the Board at its meeting on 30 November 2021. It was agreed that Service (Lead) Metrics would be included for all Delivery Plan Actions in Annex 1 in relation to *Priority 6: Improving the ways we work within and across organisations to offer better health and social care*. This would ensure that partners knew when they had achieved the objective. Ms Sharon Daye, the Council's Interim Director of Public Health, noted that partners were supporting people to live well, independently and for longer yet the role of the community (and the part that they played) had not been mentioned in the plan, just services. It was agreed that further information would be included on strengthening community capacity and resilience. Ms Caroline Morison, Co-Chairman and Managing Director of HHCP, noted that more thought might need to be undertaken in relation to specialised commissioning as population health management tended to focus on the largest number affected. Ms Morison would liaise with Mr Nick Hunt, Director of Service Development at Royal Brompton and Harefield NHS Foundation Trust, to determine what action needed to be taken in relation to specialised commissioning and who should be involved. Mr Graeme Caul, Managing Director Goodall Division at Central and North West London NHS Foundation Trust (CNWL), advised that CNWL provided some specialised commissioning services in Hillingdon. He suggested that consideration be given to including information about action currently taken by partners to deliver good services and about access to these specialised services. Although it was currently unclear, there could be the expectation that specialised commissioning should be dealt with at a regional level and that London could be deemed to be one such region. Calculations would be needed to establish the current spend on specialised commissioning in NWL (and in Hillingdon) and consideration would need to be given to the improvements in the health of the local population resulting from action associated with the HJHWS. It was noted that the NHS was keen to maintain equality of waiting lists between the different Trusts. This was likely to create tension as local authorities strove to constantly improve service provision, yet this could effectively mean levelling down to

the lowest common denominator across a region/the country with regard to waiting lists.

General practice sat at a NWL level but it was delivered locally and it was expected that, over the next year or so, there would be further changes: it was anticipated that pharmacies and opticians would be devolved to an Integrated Care System (ICS) level.

Mr Gary Collier, the Council's Health and Social Care Integration Manager, advised that Appendix 2 of the report set out key issues in relation to the performance of integrated health and care. The BCF plan 2021/2022 had been directly aligned to the workstreams in the JHWS so that it was not seen as a separate piece of work. Consideration was now being given to the inclusion of adult mental health and also expanding the scope of the existing scheme that was seeking to improve care and support for children and young people.

Since the publication of the report, the timetable for the BCF had been published. Under this timetable, the planning requirements would be published on 16 September 2021 at the same time as the October to March 2022 NHS planning guidance. Subject publication taking place in September, the 2021/22 plan would need to be submitted on 11 November 2021 and therefore delegated authority from the Health and Wellbeing Board (as set out in the recommendation) was required. A decision on whether or not the plan was assured would be received on 2 January 2022 and the final date for sign off of the Section 75 agreement would be 21 January 2022.

It was noted that Hillingdon had benefitted from pooled funding in relation to hospital discharge to meet the new and arising needs of local residents in a tangible and flexible way. Consideration would need to be given to the governance of the BCF sign off process now that Hillingdon CCG no longer existed.

Partners were asked to ensure that everything that they were doing as a system was being captured in the workstreams. For example, transformation programmes being aligned to the new Hillingdon Hospital build.

RESOLVED: That the Health and Wellbeing Board:

1. **agreed the draft strategy at Appendix 1 of the report and agreed that it be made available for public consultation and that a final version be brought back to the Board at its next meeting.**
2. **noted and commented on the single performance report provided at Appendix 2 of the report.**
3. **delegated 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.**

8. **CHILD HEALTHY WEIGHT PLAN UPDATE - SEPTEMBER 2021** *(Agenda Item 8)*

Mr Kevin Byrne, the Council's Head of Health and Strategic Partnerships, noted that the issue of obesity had been of concern to the Board for some time and that a partnership action plan had been produced. Work had been undertaken with partners in relation to breastfeeding but this had been delayed by the pandemic.

The 0-19 contract had been agreed with Central and North West London NHS Foundation Trust (CNWL) and would run until July 2022 and work was underway to rethink the programme. The service offer for 0-5 year olds had been agreed and a condensed six week My Choice programme for school aged children would take place

each term to increase throughput. The National Child Measurement Programme would start again in all schools in September 2021.

A survey was undertaken in February 2021 in relation to school packed lunches which parents often considered to be a healthier option to school catering. There had been a high level of response to this survey with many parents indicating that they never included biscuits or crisps in their child's packed lunch. It was thought that there could be an opportunity to engage further after half term when the schools would be in more of a position to engage.

The Healthy Start Scheme had been established in the 1940s and offered vouchers for vitamin supplements, milk, fresh fruit and vegetables to pregnant women and families with children aged under four who were in receipt of qualifying benefits. The scheme had been relaunched for Hillingdon in June 2021 to raise awareness and officers were monitoring take up to gauge any resultant increase.

The Council's External Services Select Committee had just completed a review of children's dental health in the Borough and its final report and recommendations would be considered by Cabinet. The report provided a blueprint of actions that would help to reduce dental decay in children. Councillors Palmer and O'Brien commended the Select Committee's report.

In February 2020, funding had been agreed for the SMILE programme to be rolled out in primary schools to teach parents and children basic cooking skills and to educate them on the impact of unhealthy choices on physical health. SMILE would be piloted in Colham Manor Primary School and rolled out once schools were open again to introducing these types of activities. Councillor Susan O'Brien suggested that consideration be given to also rolling the programme out to the Colham Manor Children's Centre which was directly next door and that the distribution of toothbrushing packs be linked into it.

Councillor O'Brien advised that she had found it difficult to find any local information about programmes being run in Hillingdon such as SMILE, My Choice and Healthy Start (a national scheme led by the NHS). This had made it difficult to promote these programmes through social media. Whilst all of these were thought to be great initiatives, it was queried whether their reach was being maximised. For example, were the neighbourhoods teams being involved and work being undertaken to include social prescribing link workers, etc?

Mr Tony Zaman, the Council's Corporate Director of Social Care and Health, advised that pockets of activity tended to happen but that Hillingdon was approaching a shift in this approach. Lots of good things had been happening but these needed to be put together and tracked against an outcomes framework.

It was suggested that Hillingdon Health and Care Partners (HHCP) had become the environment in which local health and care needs would be addressed. Public Health had been positioned well within this but, from a local authority perspective, it needed to be more centre stage and the associated budget needed to be more vigilantly tracked.

The Children and Young People theme group at HHCP would be tasked with taking the Child Healthy Weight Programme forward.

RESOLVED: That the Health and Wellbeing Board noted the progress against the earlier plan and commented on proposals for taking forward actions to support children's healthy weight across partners and in the light of the current

	pandemic.
9.	**TACKLING MENTAL HEALTH ISSUES IN HILLINGDON** *(Agenda Item 9)* Ms Vanessa Odlin, Director of Hillingdon and Mental Health at Central and North West London NHS Foundation Trust (CNWL), noted that it was good that mental health had been mentioned and supported in previous items on the agenda. Two Transformation Boards had been set up by CNWL and Hillingdon Health and Care Partners (HHCP) to provide strategic direction in relation to: 1. Mental Health, Learning Disability and/or Autism Transformation Board – a mapping exercise had been undertaken in relation to out of hospital work and rehabilitation resources / bedded capacity and changes would be needed to move this forward such as community transformation to wrap around the hub model (a community stakeholder piece had been launched). Work was underway to develop a coherent rehabilitation pathway with a crisis house approach (pre intervention) to deescalate crises. Work was also need in relation to domestic abuse and mental health crisis pathways. Although a lot of work was being undertaken in relation to autism, it was thought that even more could be done to look at the support provided; and 2. Children and Young People Transformation Board – access rate performance was thought to be on track to meet targets but waiting times for eating disorders needed to improve as there had been some recruitment issues. It would be important to align with the metrics in the Joint Health and Wellbeing Strategy. The Cove was a non-clinical crisis haven for Hillingdon residents available in the evening 365 days a year. Use of The Cove had been dropping off and it was unclear why. Staff had spoken to service users who had not been attending and feedback had indicated that the physical space had felt like an office / planned intervention rather than a crisis service. As such, investigations were underway with HESTIA to identify an open space and open door / drop in / less formal model. Mr Tony Zaman, the Council's Corporate Director of Social Care and Health advised that consideration was being given to optimising value for money across health and social care. Currently, this had been weighted to clinical interventions but consideration could be given to bringing together things like the voluntary sector grant services to make services more visible to service users. Lots of work had started and partners were now working on the detail and content. Conversations were also being facilitated between partners at the Transformation Board and metrics were available to measure performance. It was noted that CNWL was in the process of developing a new 16-25 Young Adults Service to better bridge the gap between CAMHS and adult mental health services. Ms Odlin advised that she would provide more information on this at the Health and Wellbeing Board meeting on 30 November 2021. **RESOLVED: That the report be noted.**
10.	**BOARD PLANNER & FUTURE AGENDA ITEMS** *(Agenda Item 10)* It was agreed that information on a new 16-25 Young Adult Service be considered at the meeting on 30 November 2021. **RESOLVED: That the Board Planner be noted.**

11.	**UPDATE ON CURRENT AND EMERGING ISSUES AND ANY OTHER BUSINESS THE CHAIRMAN CONSIDERS TO BE URGENT** *(Agenda Item 11)* Members of the Health and Wellbeing Board discussed working arrangements locally and in North West London. **RESOLVED: That the discussion be noted.**
	The meeting, which commenced at 2.30 pm, closed at 4.43 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.

KEY ISSUES AND DEVELOPMENTS

Relevant Board Member(s)	Tony Zaman Caroline Morison Graeme Caul
Organisation	London Borough of Hillingdon Hillingdon Health and Care Partners Central and North West London NHS Foundation Trust
Report author	Kevin Byrne - Health and Strategic Partnerships
Papers with report	None

1. HEADLINE INFORMATION

Summary	This paper presents a shortlist of current and live issues that the Board may wish to discuss and note, in addition to the more comprehensive performance report on today's agenda. It covers: • Key positions at North-West London ICS • Pharmaceutical Needs Assessment – outline process • 16-25 Mental Health Service changes • Children's Dental Health review and Select Committee recommendations • Health Inequalities and Community engagement proposals
Contribution to plans and strategies	Joint Health and Wellbeing Strategy and Hillingdon Health and Care Partners Transformation plans
Financial Cost	There are no costs arising directly from this report.
Ward(s) affected	All

2. RECOMMENDATION

That the issues at 3 below be considered and the implications for the health and care system in Hillingdon be discussed.

3. INFORMATION

Background Information

3.1. North West London ICS Changes

There have been a number of changes announced regarding the NWL ICS recently:

- NWL ICS announced on 12 November 2021 that Rob Hurd had been appointed as Chief Executive of the NWL ICS from January 2022. He will succeed Lesley Watts who has been interim Chief Executive. Rob joins from the North Central London ICS where he is on secondment from his role as Chief Executive of the Royal National Orthopaedic Hospital

NHS Trust.

- Professor Ian Goodman has been appointed as the Borough Medical Director for Hillingdon, a role that will provide senior clinical leadership to the quality and transformation of services in Hillingdon.
- Dr Mohini Parmar has announced that she will retire in March 2022. Dr Parmar is currently Chair of North West London CCG.
- Pippa Nightingale MBE, Chief Nurse for North West London Integrated Care System, has been appointed as Chief Executive for London North West University Healthcare NHS Trust.

3.2. Pharmaceutical Needs Assessment (PNA)

The statutory responsibility to publish and keep up to date a statement of the need for pharmaceutical services for the population in its area is a duty of Health and Wellbeing Boards (HWBs). The 'Pharmaceutical Needs Assessment' (PNA) assists in the commissioning of pharmaceutical services to meet local priorities. NHS England also uses the PNA when making decisions on applications to open new pharmacies. Although HWBs are required to revise their current PNA within 3 years of publication, this has been delayed due to the pandemic. For Hillingdon, a revised PNA should be published by 1 October 2022.

The process for completing a PNA is prescribed and an important part of this is wider engagement. Key partners from across sectors include The Local Pharmaceutical Committee (LPC), Healthwatch, the CCG and Public Health. Partners will be invited to support the work and to advise and develop processes to support the preparation of a comprehensive, well researched, well considered and robust PNA, building on expertise from across the local healthcare community. This is the third time that Hillingdon will be completing the PNA so there is a body of learning to draw upon. A broad timeline and project plan is in place and an update on progress will come to the March 2022 Board, with a formal public consultation exercise following over the summer of 2022.

3.3. 16-25 Young Adults Mental Health Service changes

The September 2021 Board noted that Central and North West London NHS Foundation Trust (CNWL) was in the process of developing a new 16-25 Young Adults Service to better bridge the gap between CAMHS (Child and Adult Mental Health Services) and adult mental health services (AMHS) and that more information on this would come to this Health and Wellbeing Board.

In 2020, CNWL and West London NHS Trust (WLT) began a programme of work to inform the design, development and mobilisation of a new mental health model of care for 16 to 25-year-olds ("young adults") across NWL. A key piece of work has been engaging 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.

A young adult ambassador group has been established which has a group of fifteen young adults from North West London in the 16-25 age group who are passionate about mental health, youth services or have a general interest in the area. A clinical senate has been established with a group of clinicians from across North West London. Utilising their insights and knowledge, they have assisted in developing the model and meet fortnightly in order to input into the model and shape the design of the model.

There will be a carer and service user group in Hillingdon and as part of the implementation group

which are being set up in November 2021.

Principles

Following the period of engagement, ten underpinning principles have been created to capture everything that young adults, professionals, parents and carers had said. These principles have formed the base for the development of the partnership model. They are:

1. All resources, where possible, provided as a co-ordinated accessible young adult friendly offer, e.g., virtual/physical hub.
2. Consistent high-quality interface between CAMHS and AMHS to reduce the focus on caseloads and more on meeting the needs of young adults.
3. Enhanced triage/referral pathway providing integrated and responsive care to ensure consistent access and assessment for all (students, disability, ethnicity, etc).
4. Delivery of evidence-based interventions that meet the young adults' developmental needs. Delivered by a workforce trained to work with young adults. This may be within CAMHS, AMHS or Young Adult offer.
5. Support is developed flexibly and tailored to individual concerns and goals of young adults. It is person centred, holistic and support is delivered closer to home. For example, transition to adult services is based on needs not age.
6. Young adult, family and friend's participation is integrated into service delivery and development.
7. New 16-25 roles, providing specialist expertise, proactive care and support across the system including to higher education, social care, primary care and youth services.
8. Local alliances between the NHS and wider community to address inequalities and better identify unmet need, improve equality of access to early intervention and navigation of services.
9. Digital support platforms joining up NHS and Non-NHS support offer to young adults including self-referral and self-management.
10. Standardising the approach, where possible across NWL, whilst tailoring services to meet the needs of 16-25-year-olds and address inequalities.

Opportunities and Data

Focussed work has been completed to identify opportunities, to understand why people are re-appearing in services and what we can do to bridge this gap. We have also studied other factors including ethnicity, at what time young people are entering services, the number of referrals into services and the number of young adults that transitioned into adult mental health service.

Type of referral	Brent	Harrow	Hillingdon	K&C	Westminster	Ealing	H&F	Hounslow
CAMHS (data 2018-19)								
Total 16-18 years new referral	355	209	309	124	181	296	165	247
CAMHS transitions to adult services	23	16	21	11	14	21	12	26
CAMHS discharged 16-18	235	176	207	84	159	289	112	240
AMHS (non-IAPT) (data 2020)								
Total 18-25 new referrals	816	575	984	292	532	954	480	802
IAPT First (data 2020)								
Total 18-25 new referrals	1751	1019	1251	790	1089	967	456	381
Monthly totals								
CAMHS referrals of 16-18s per month	30	17	26	10	15	25	14	21
AMHS referrals of 18-25s per month	68	48	82	24	44	80	40	67
IAPT referrals of 18-25s per month	146	85	104	66	90	81	38	32
CAMHS Transition to AMHS per month	2	1	2	1	1	2	1	2

Table: Young Adult (16-25) Referrals

Model Development

We need to work as a partnership to deliver what young people need. This partnership approach is on a borough-based level. In each borough, there will be development of a young adult protocol which is around how we as organisations work together to better meet the needs of young adults.

Multi-Agency Young Adult Triage Meetings

The new 16-25 triage and partnership meetings will be a central mechanism for improvement within the mental health pathway for young adults, without creating new or separate service boundaries.

Depending on need, the meetings will be at Hillingdon borough level or primary care network level. With attendees including CAMHS, AMHS, IAPT, VCS, HEI's and wider agencies as required. The principles behind the meeting include it being needs-led, not age-led with a no bounce and no threshold policy. Where disengagement and/or risks have been identified in young adults in CAMHS/AMHS, individuals can be referred into YAP to explore additional or alternative support to improve engagement or provide more appropriate care options.

Referral Pathways

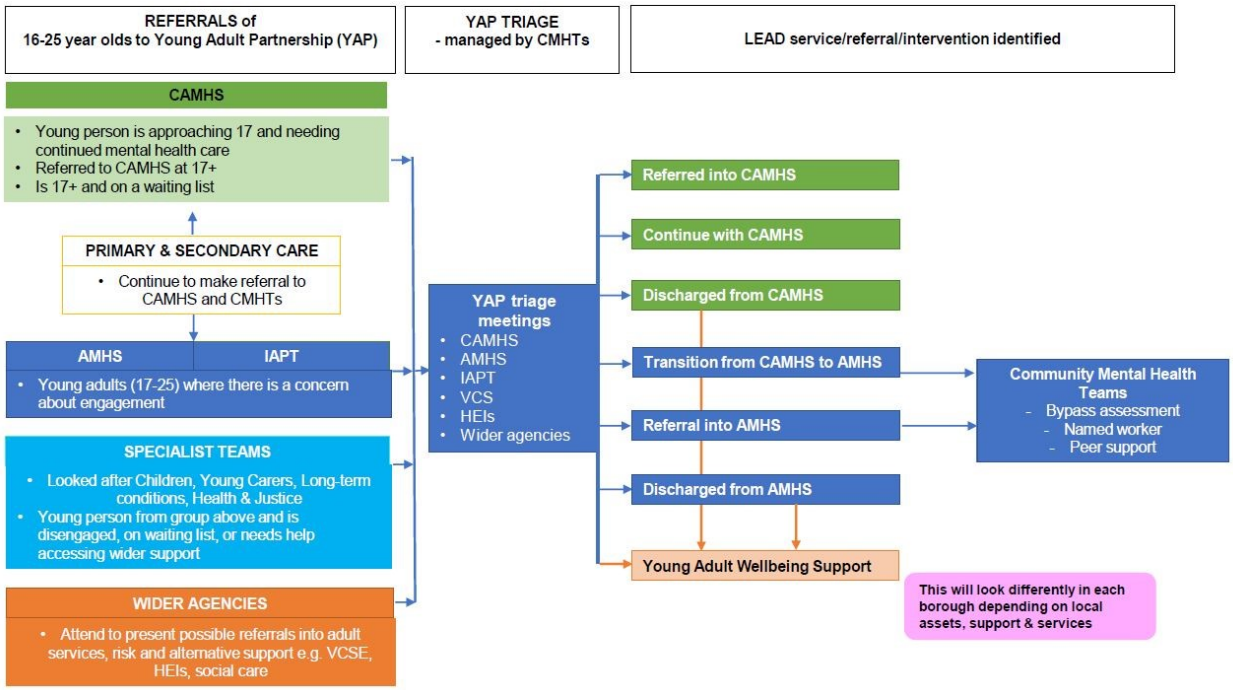

Table: Young Adult (16-25) Referral Pathways

The table above, Young Adult (16-25) Referral Pathways, provides an overview which recognises that with YAP triage meetings there will continue to be referrals going into CAMHS and AMHS directly. They would then refer into the young adults meeting where specialist teams will link into the most appropriate support such as the voluntary sector who provide a key part of the support network for young adults who are transitioning into adult mental health services.

Tailoring & Funding

As we move forward with implementation, there are parts of the model that have the opportunity to be tailored locally. We have received dedicated funding from the NHS long term plan. We need to establish a dedicated mental health practitioner who will be in the role of young adult pathway lead. Each borough will have this role and there will also be dedicated psychiatrist time to support this role.

We will also be recruiting clinicians into the mental health services to create capacity within community hubs and to support existing all ages services where high numbers of young adults are seen (e.g., Complex Emotional Needs, At Risk Mental State and CMHTs).

We aim to provide training in systemic and young adult focussed therapies (e.g., DBT & AMBIT). The aim is to establish roles around signposting with the community navigator model which will be hosted within the voluntary sector (H4All in Hillingdon).

We are developing a peer support model and working within Hillingdon partners locally on how that we can develop this, as well as University Link pilots.

There is a community grant scheme to build on some of the sets of assets that exist in Hillingdon and supporting them to address inequalities.

Considerations and Next Steps

A Hillingdon borough-based implementation group has been established that will lead locally on this work with support from the senior development lead, clinical leads and project support. We aim to go live in April 2022 with the triage and partnership meetings and fully establish the new pathway for young adults.

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.

3.4. External Services Select Committee review of Children's Dental Services

Based on concerning evidence of levels of tooth decay in young people in Hillingdon, and as part of the local authority scrutiny function, the External Services Select Committee agreed that it would undertake a review of dental services in the Borough. The review specifically focussed on service provision for children and young people and the effectiveness of preventative measures taken by partners in relation to caries and other oral health issues. The primary remit of the review was to explore the current situation within Hillingdon and consider possible areas for improvement, with a view to increasing customer satisfaction and reducing the incidences of tooth decay in the young. The review concluded earlier in 2021 and was reported to October 2021 Cabinet. The review's recommendations are:

1. That the Cabinet Member for Health and Social Care write to the Department of Health and Social Care / Secretary of State for Health and Social Care, The Rt Hon Sajid Javid MP, to request that a proportion of the Soft Drinks Industry Levy (SDIL) be ringfenced for dental health initiatives;

2. That the North West London Clinical Commissioning Group (NWL CCG) be asked to liaise with NHS England regarding the collection and carry forward of any unused Units of Dental Activity (UDAs) in Hillingdon within the year for redistribution to local dental related action programmes / initiatives such as fluoride varnishing in schools;

3. That the Cabinet Member for Health and Social Care liaise with pan London counterparts to encourage the fluoridation of water supplies across London;

4. That the Council's Early Years team liaise with private and local authority run nurseries (as well as school nurseries and Children's Centres) in Hillingdon to encourage routine supervised brushing after meals;

5. That the North West London Clinical Commissioning Group be asked to liaise with dentists locally to agree a way that children under the age of 11 can be guaranteed an appointment;

6. That the Corporate Director of Social Care & Health be asked to ensure that health visitors provide new mothers with information about free NHS dental services and brushing kits at their first contact and ask the Royal College of Paediatrics and Child Health to include oral health information in the Personal Child Health Record ('red book');

7. That Corporate Director of Social Care & Health ensure that training be made available for health professionals such as health visitors and school nurses on the promotion of good oral health;

8. That the Families, Health and Wellbeing Select Committee receives annual updates from Public Health on the performance of dental health services commissioned by the NHS in Hillingdon; and

9. That the Health and Wellbeing Board oversee a comprehensive communication and education plan on oral health coordinated by a Children & Young People's Dental Health task and finish group.

The Children & Young People's Dental Health task and finish group, led by CCG (Hillingdon) and with Public Health, will review these recommendations and build actions into their delivery plan.

3.5. Health Inequalities and Community engagement proposals

The Borough's Joint Health and Wellbeing Strategy sets out the Hillingdon ambitions to:

"Tackle unfair and avoidable inequalities in health and in access to and experience of services".

The plan points to the Borough's collaboration with Brunel University to develop a more robust Joint Strategic Needs Assessment to provide an up-to-date picture of current disparities in Hillingdon and set the scene for further interventions to reduce inequalities. The epidemiology for the JSNA is near completion and it is hoped that a stakeholder workshop can be held, if possible, before Christmas to review the emerging findings and reach a clear view on next actions. It will also propose further work programmes to better understand some of the drivers behind inequalities and drill down into specific areas and to engage with residents, via a qualitative survey, to better understand their experiences and views on health and care services. This work

will be reported via the HHCP governance structure up to the HWB at its next meeting in March 2022.

In parallel to this work, the NWL ICS is embarking on a Population Health management programme to support its work in tackling health inequalities and has appointed Optum to develop this work at local level. In Hillingdon, the Hayes and Harlington Neighbourhood will be our pilot area for the Optum/NWL population health management work, with a focus on diabetes.

Work will commence through December 2021and into January 2022. Local stakeholders to be involved in the programme have been identified. The relevant people will then form part of the action learning sets as laid out on the timeline. The work will report through to the HHCP Neighbourhood Development Board so that it links directly into the Borough's transformation work.

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 Board will be able to note and consider live and current issues and drive forward its leadership of health and wellbeing in Hillingdon.

Select Committee comments

None at this stage.

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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CONSULTATION OUTCOMES: 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 LBH - Health and Strategic Partnerships
Papers with report	Joint Health and Wellbeing Strategy 2022-2025

1. HEADLINE INFORMATION

Summary	The paper summarises the results of public consultation on the Joint Health and Wellbeing Strategy 2022-25.
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 Better Care Fund (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. RECOMMENDATION

That the results of public consultation on the Strategy be noted.

3. INFORMATION

3.1 Background Information

Hillingdon's Joint Health and Wellbeing Strategy 2022 – 2025 seeks to improve the health and wellbeing of all our residents and to reduce disparities in health and care across our communities.

Public consultation on the draft Strategy took place between 1st October 2021 and 12 November 2021. The strategy was published on the Council website and circulated widely to partner and voluntary organisations in the Borough. It was also publicised via social media channels.

The Strategy describes the achievements from partnership working to date and sets out the key health advantages and challenges for Hillingdon. Consultation noted that the development of a

new Hillingdon Hospital is central to the Strategy, and that the collective response to the Covid-19 pandemic meant 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, and 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.

The Strategy seeks to deliver on six priority areas:

- **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 services through prevention and self-management.

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

The consultation sought the views of residents and organisations on these priorities and on the detail of the plans proposed to implement them.

3.2 Consultation outcomes

30 responses were received to the online consultation, 19 of which were from residents. 5 responses were received from a business or organisation, along with 4 provider responses, 1 community organisation and 1 charity. Consultation also took place with the Council's Housing Team. Based on the consultation, several amendments have been made to the text of the Strategy which is at Appendix 1. Feedback will be provided to relevant Transformation Groups to ensure that the points made are taken into account.

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

This priority area sets out how 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. It describes how multi-agency teams will support children by working in partnership in local areas, for example with a new Stronger Families service to 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.

To address levels of obesity in our young children, the Strategy sets plans to work across partners to improve diet and nutrition and to increase levels of physical activity, promote greater

uptake of breast feeding, and reduce the level of tooth decay. It also sets out work to reduce smoking in families.

80% of respondents 'strongly agreed' or 'agreed' with this priority, and 83% 'strongly agreed' or 'agreed' with the actions set out to achieve Priority 1.

The consultation invited additional comments from respondents. One respondent asked for more on education of parents and children regarding mental wellbeing and developing resilience - early prevention and intervention measures also need to be considered as well as a trauma-based service for children. One respondent felt that unpaid carers were not mentioned enough and that more needed to be done to support the health and wellbeing of carers. On child healthy weight, respondents asked for ongoing diet/cooking education for children and adults to help reduce dependence on takeaway food.

One respondent complained that the waiting time for child mental health treatment was unacceptably long.

Colleagues in the Council's Housing Team requested recognition of the importance of good housing and a stable home to health and wellbeing. Additional metrics for homelessness

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

This priority sets out how we intend to work in collaboration with Brunel University to identify inequalities in Hillingdon and engage directly with our communities to understand how we can support their health and wellbeing. We will help to improve the life chances of people with learning disabilities and/or autism through increased integration between health and social care. Working in 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.

90% of respondents strongly agreed or agreed with Priority 2, and 83% 'strongly agreed' or 'agreed' with the actions set out to achieve Priority 2.

Comments from respondents mentioned the importance of working closely with the voluntary sector. Several respondents asked for additional support for unpaid carers. One respondent requested greater flexibility to allow people with learning disabilities and their carers to drive the content of care packages. One respondent noted that waiting times for child mental health services were unacceptable.

Housing colleagues commented that the link between housing and health had been highlighted by Covid-19, revealing unequal impact related to housing circumstances, with overcrowded households particularly badly affected.

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

Priority 3 notes that 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.

90% of respondents strongly agreed or agreed with Priority 3, and 87% strongly agreed or agreed with the actions set out in the plan to achieve the objectives.

Respondents commented that promoting physical exercise, healthy diet, and opportunities to develop and sustain social networks are key areas that will improve health and reduce risks. One commented that food, smoking, and drinking were often linked to poor mental health. Another respondent wanted more specific information about the dementia pathway. There was reference made to the need for good GP services, offering face to face appointments. There was a call for more defibrillators and CPR training to be made available.

A respondent noted that some groups such as travellers do not normally access information about health and wellbeing. Using contacts with groups such as this to provide information is essential.

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

Priority 4 is focussed on the population aged 65 and over. During the lifetime of the strategy partners will further embed neighbourhood working to identify those 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 caused by 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 the 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.

87% of respondents either strongly agreed of agreed with Priority 4. 87% also agreed with the

actions identified to achieve the delivery of Priority 4.

Respondents stressed the importance of income maximisation and digital inclusion for older people to minimise inequalities and increase access to health and care services. Again the voluntary sector was seen as a crucial partner in delivering innovative services. One respondent suggested looking at the Swedish model of integrated care for people with terminal illness. Several respondents referred to the need to support unpaid carers and to provide proper support for paid carers. One organisation noted that it could be difficult to get help for older people with issues other than social isolation. More joined-up working and easier referral pathways were cited as potential solutions.

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

Priority 5 sets out our aims to ensure that people with mental health needs including learning disabilities and/or autism can live longer, healthier lives, and to work to prevent suicide. 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.

90% of respondents either strongly agreed or agreed with Priority 5 and its aims. 87% agreed or strongly agreed with the actions planned to achieve the aims. Services must work together across sectors to provide cohesive and cost-effective solutions.

Respondents commented that education and early intervention are essential to address mental health and associated costs. Care packages for people with learning disabilities need to include travel expenses for carers, and there needs to be provision for respite care. One respondent felt there was insufficient professional support available for child mental health issues, resulting in extended waiting time and worsening problems.

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

This priority is focussed on care market management and development, digital and business intelligence-led improvements, workforce development and delivery of strategic estate priorities. These are ‘enabling’ improvements which help support the delivery of the other 5 priorities.

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 including in-patient hospital services. We will embed Adult Social Care provider engagement arrangements to identify and address provider issues, including access to

guidance and sharing good practice. We will review our integrated approach to Adult Social Care provider risk management arrangements to ensure timely and appropriate interventions where required. We will secure agreement on long-term brokerage arrangements to simplify systems for providers and improve understanding of market capacity.

We will coordinate a local response to Covid-19 outbreaks in care homes and supported living schemes.

We will establish and implement lead commissioning arrangements to address local health and care system care home placement requirements.

We will make better use of data to improve understanding of need, capacity and pressure points and increasing efficiency and effectiveness using of digital assistive technologies, e.g., telecare in people's homes and remote monitoring equipment and consultation technology in care homes. We will share relevant activity data to ensure that there is understanding across the health and care system of capacity and pressure points. We will also establish a remote vital signs monitoring pilot in care homes to facilitate early intervention by health professionals.

A suitably trained workforce is crucial to the delivery of services to support the independence and wellbeing of residents both within the independent sector provided care market and within HHCP. Early warning systems will provide alerts to possible capacity issues within the independent sector and aid the development of workforce development plans. We will complete and implement a HHCP integrated community workforce plan. We will monitor staff vacancy and retention levels among Adult Social Care providers and identify possible interventions to provide support where there are issues.

Effective use of existing NHS or Council owned assets must be made to ensure we can meet the current and future health and wellbeing needs of residents. We will review Council and NHS owned assets and explore the scope for meeting current and future population and health and care system needs.

Respondents commented that resources for adult social care seemed inadequate. More information for younger care users transitioning into adult services is available. Digital services may not be accessible to all. Respondents recognised the advantages that digital services can bring, but also noted that an understanding how older people, those with learning challenges or physical disabilities use online services is information that needs to be gathered and understood as well as responded to. Direct client experience feedback is additional to 'click and complete' site monitoring.

Financial Implications

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

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

The Strategy text has been reviewed and some amendments have been made as a result of the consultation. Feedback will be provided to relevant Transformation Groups.

Consultation Carried Out or Required

This report provides details of public consultation on the Joint Health and Wellbeing Strategy 2022-2025. Consultation on the previous Strategy was carried out in 2017.

Select Committee comments

None at this stage.

5. 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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Joint Health and Wellbeing Strategy

1 INTRODUCTION

Hillingdon's Joint Health and Wellbeing Strategy, 2022 – 2025 seeks to improve the health and wellbeing of all our residents and to reduce disparities in health and care across our communities. Our strategy aims to deliver a vision shared by all health and care partners in the borough.

Our shared vision is that by 2025 most people who live in Hillingdon are able to say:

- "I am helped to take control of how my own health and social care needs are met"
- "I only have to tell my story once and my details are passed on to others with an appropriate role in my care"
- "If I do need to go to hospital, they start to plan for my social and health care in the community from day one of my stay"
- "Social care and Health Services help me to be proactive. They anticipate my needs before I do and help me to prevent things getting so bad that I need to stay in hospital"
- "I am treated with respect and dignity, according to my individual needs"
- "It doesn't matter what day of the week it is - as I get the support appropriate to my health and social care needs"
- "Systems are sustainable and money that once might have been spent on hospital care for me is now spent to support me at home in my community"

The purpose of the Joint Health and Wellbeing Strategy is to show how health and care partners will work together between 2022 and 2025 to deliver this vision.

Supporting Principles

Our approach to delivering the vision will be governed by the following principles:

- Our residents will be at the centre of everything we do and will enable people to take more control over their own health and wellbeing.
- We will be driven by evidence and data, and we will work to reduce disparities in levels of health and care.
- We will be innovative, ambitious and brave in our approach.
- We will work with the voluntary and community sector and make best use of what it has to offer.
- We will integrate teams and systems amongst partners where this will deliver better outcomes for residents.
- We will move resources to where they can deliver the best outcomes for residents
- We will support a thriving and sustainable local workforce.

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 dominated by 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 develop 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. We know that 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

- Over the next 5 years 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 a quarter 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 sufferers of the longer-term effects of Covid.

Social determinants of health

- There is also a range of non-medical factors that influence health outcomes. These include education, employment, income, housing, transport and a healthy environment. By working with partners to influence these factors, we can also impact on health and wellbeing outcomes.

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 was to bring organisations together to improve efficiency and effectiveness through a reduction in duplication and better use of resources in order to produce better outcomes for residents and 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 that has assisted in maintaining key services during the pandemic.

- **Reformed "intermediate tier" services** – These services support timely discharge from hospital and the prevention of admission and the last twelve months has seen the following changes 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 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. A good quality and stable home is very important to getting a good start in life.

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

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 prevent diabetes and support people with 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, while recognising that most older people will remain in mainstream housing.

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 in hospital are able to do so.

Priority 5: Improving mental health 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 available to support mental health including at GP practice level through development of new roles.

We will continue to 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.

  Examples of what we will do include:

  - We will embed Adult Social Care provider engagement arrangements to identify and address provider issues, including access to guidance and sharing good practice. Provider fora and weekly newsletters are examples of how this will be done.

- We will review our integrated approach to Adult Social Care provider risk management arrangements to ensure timely and appropriate interventions where required.

- We will secure agreement on long-term brokerage arrangements to simplify systems for providers and improve understanding of market capacity.

- We will coordinate a local response to Covid-19 outbreaks in care homes and supported living schemes.

- We will establish and implement lead commissioning arrangements to address local health and care system care home placement requirements.

- *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 assistive technologies, e.g., telecare in people's homes and remote monitoring equipment in care homes.

  Examples of what we will do include:

  - We will maximise opportunities for sharing relevant activity data to ensure that there is understanding across the health and care system of capacity and pressure points and required interventions.

  - We will promote the roll out of the nationally recognised advanced planning tool Coordinate My Care (CMC) in care homes.

  - We will embed remote consultation technology in care homes to facilitate access to timely advice from health and social care professionals.

  - We will establish a remote vital signs, e.g., blood sugar level, blood pressure, respiratory rate, temperature, etc., monitoring pilot in care homes to facilitate early intervention by the relevant health professionals.

  - We will promote the use of telecare technology to support the independence of residents.

- *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.

  Examples of what we will do include:

  - We will complete and implement a HHCP integrated community workforce plan.

- We will monitor staff vacancy and retention levels among Adult Social Care providers and identify possible interventions to provide support where there are issues.

- *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.

  An example of what we will do is:

  - We will review Council and NHS owned assets and explore the scope for meeting current and future population and health and care system needs.

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 Appendix 1. The boards also have responsibility for monitoring performance against the metrics shown in Appendix 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 Appendix 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.

Appendix 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. • Number of children in emergency accommodation.	• 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 drive up levels of attainment.	• Pupil absence • Levels of school attainment including children not in school. • *Indicator on positive activity?*	• Support families sooner through new family hubs • Numbers of children out of school. • 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 • Number of homeless people with substance misuse and / or mental health needs	• Homelessness Strategy Action Plan
	• 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	• 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

		• Smoking cessation levels • D & Alcohol misuse levels • Patient education/self help	
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 10 days by Neighbourhood
	• Work with the voluntary and community sector and housing providers to support people to live well, remain independent and to reduce loneliness.	• Falls prevention • Care homes • Re-admission rates to hospital by Neighbourhood • Housing standards	• Hillingdon Housing Strategy

5. Improving mental health, learning disability and autism services through prevention and self-management. (Learning disability issues covered in priority 2)	• 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.

		• Homelessness approaches that include substance misuse and mental health as support needs	
	• 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.
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 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.	• Systematic sharing of system capacity data in place. • Number of care homes approved to use CMC. • Number of care homes utilising remote consultation technology. • Provider reported outcomes from pilot. • Numbers using telecare equipment per 100,000 75 and over population.	
	<u>Workforce development</u>: • Complete and implement the HHCP integrated community workforce plan. • Monitor vacancy and retention levels among Adult Social Care	• HHCP community workforce plan in place. • Adult Social Care vacancy and retention rates below or equal to	

	providers and identifies possible interventions to provide support where there are issues.	averages for benchmarking group of councils.	
	<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.	• Develop partnership approach to management of assets.	

2021/22 INTEGRATED HEALTH AND CARE PERFORMANCE REPORT

Relevant Board Member(s)	Councillor Jane Palmer Caroline Morison
Organisation	London Borough of Hillingdon Hillingdon Health and Care Partners
Report author	Gary Collier - Social Care and Health Directorate, LBH Sean Bidewell - Integration and Delivery, NWL CCG
Papers with report	None

HEADLINE INFORMATION

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

RECOMMENDATIONS

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

INFORMATION

Strategic Context

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

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

3. The report is structured as follows:

A. Key Issues for the Board's consideration

B. Workstream highlights and key performance indicator updates

A. Key Issues for the Board's Consideration

Winter Planning

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

Mandatory NHS and Social Care Staff Covid-19 Vaccinations

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

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

Business Intelligence

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

B. Workstream Highlights and Key Performance Indicator Updates

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

Workstream 1: Neighbourhood Based Proactive Care

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

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

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

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

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

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

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

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

Table 3: Covid-19 Vaccinations by Priority Group

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

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

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

Table 4: Covid-19 Vaccination Rates by Care Settings						
Vaccine Recipient	**Hillingdon**		**North West London Average**		**London Average**	
	Dose 2	**Booster**	**Dose 2**	**Booster**	**Dose 2**	**Booster**
Care Home Residents	92%	76%	92%	69%	92%	65%
Care Home Staff	[redacted]	27%	[redacted]	19%	[redacted]	19%
Homecare Staff	63%	2%	67%	2%	66%	2%

Source: Capacity Tracker 10/11/21

14. **Additional Roles Reimbursement Scheme (ARRS):** This scheme is designed to expand the primary care work force and enable more proactive, personalised and integrated health and social care. Through the scheme, Primary Care Networks (PCNs) are entitled to access funding to recruit staff for additional roles that will provide multi-disciplinary support according to local needs. In Hillingdon the scheme is being used to develop an additional 39 posts across the PCNs that include clinical pharmacists, dieticians, mental health practitioners and physiotherapists. The project to establish these roles in Hillingdon is being jointly managed between The Confederation and CNWL with the goal of having posts filled by the end of 2021/22.

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

Key Performance Indicators

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

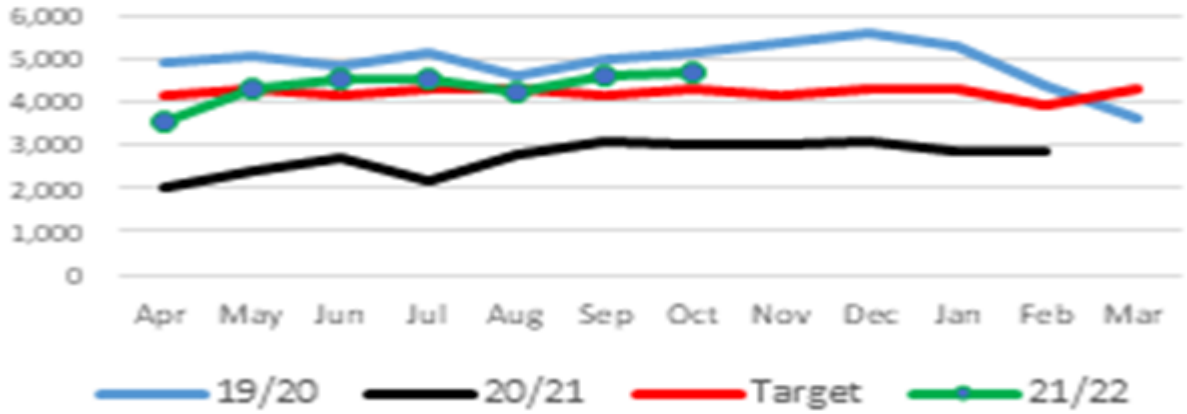
16. The data for this new BCF metric will be provided by the Better Care Support Team as it is based on population level information rather than NHS trust or GP. The Q3 position will be reported to the Board at its March 2022 meeting.

Workstream 2: Urgent and Emergency Care

Workstream Highlights

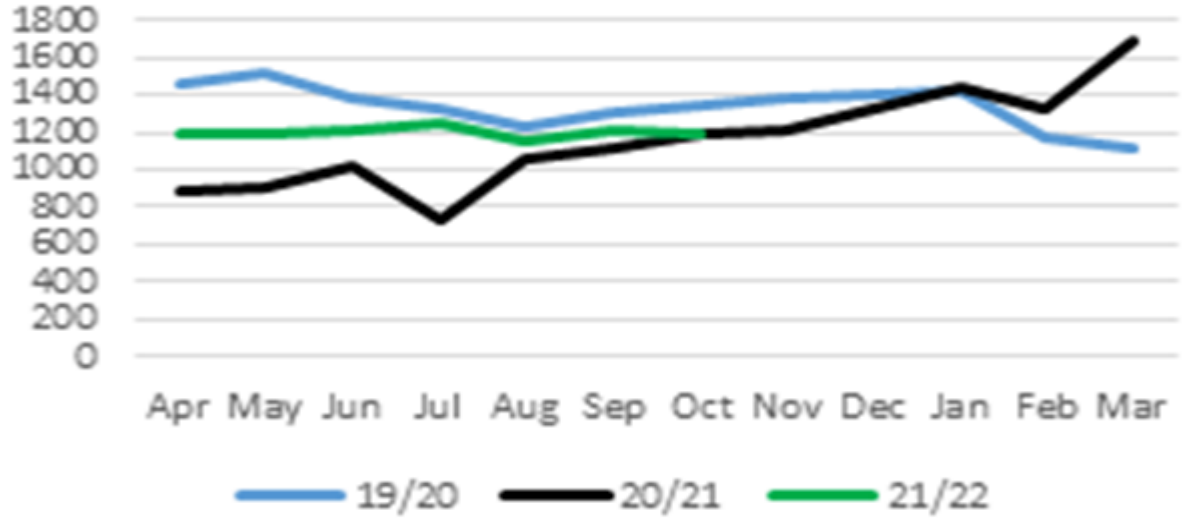
17. **A & E Attendances:** Graph 1 below shows that attendances from the Hillingdon population have been increasing since April. The trend reported to the September Board of attendances just over the 140 a day target has continued. The Board may wish to note that 72% of attendees are people registered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

Graph 1: A & E Attendances – Hillingdon Hospital Only

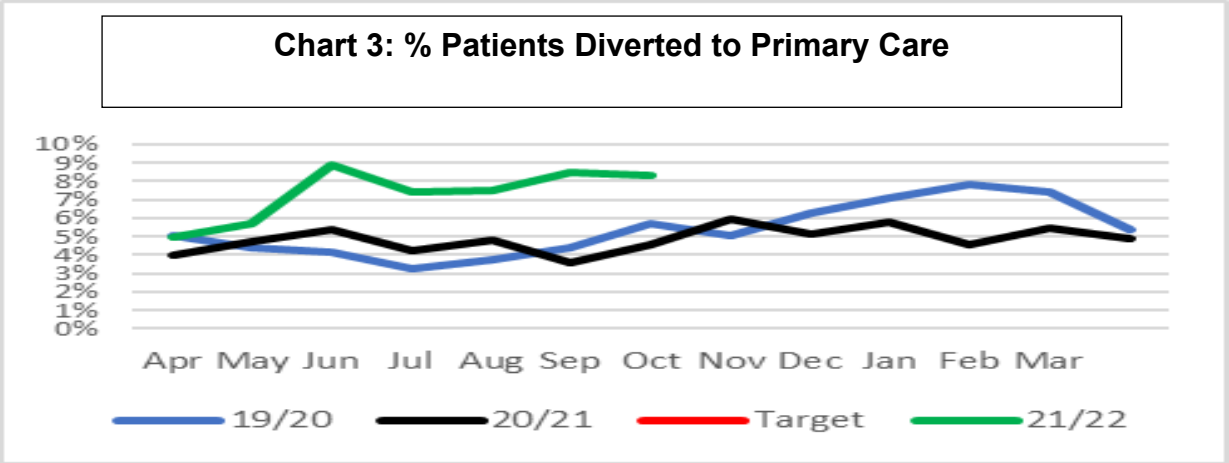


18. **Emergency Admissions:** Graph 2 below shows that there has been a levelling off in the number of emergency (also known as non-elective or NEL) admissions during Q2 compared to Q1 and that activity is aligning more to 2020/21 levels.

Graph 2: Emergency Admissions – Hillingdon Hospital



19. **Urgent Treatment Centre (UTC):** This is for residents who have an urgent or severe condition or minor injury that cannot wait for a GP appointment (usually 48 hours). Hillingdon's UTC is based on the Hillingdon Hospital main site. A key objective of the service is to redirect people to primary care who do not need inpatient treatment at Hillingdon Hospital. The redirection rate has increased from 7.4% in July to 8.6% in October 2021. Chart 3 below illustrates progress during 2021/22 in comparison with previous years.



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

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

Discharge to Assess Pathways Explained

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

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

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

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

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

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

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

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

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

23. **Urgent Care Nurse Practitioner Service:** This service provides advice and can offer treatment for minor injuries or illnesses. It is led by Hillingdon Hospital and is based at Mount Vernon. The service operates 8am to 7pm seven days a week and bookings are via the UTC or GP practice staff. Appointments are initially by telephone with a face to face follow up if appropriate. Since the service opened in April 2021 4,858 people have been treated of which 2,116 (44%) were registered with Hillingdon GPs. The most common reason for people attending is for minor injuries.

Key Performance Indicators

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

- ***Daily bed occupancy rate at Hillingdon Hospital:*** The current bed occupancy target should be at no more than 90%, i.e., 31 bed capacity at the start of each day. *Slippage*: Q2 average was 96%.

- ***Length of stay of seven days or more (Hillingdon Hospital):*** This metric measures the percentage of people in hospital with a length of stay of seven days or more (known as '*stranded patients'*) should be no more than 30% of the bed base, i.e., 94 people based on 313 core beds. *Slippage*: Q2 average was 56% (175 people based on 313 core beds)

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

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

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

- ***Out of hospital capacity:*** Health and social care step-down capacity should be at no more than 90% utilisation. This includes bedded services such as the Hawthorn Intermediate Care Unit (HICU), Park View Court step-down flats and beds in three care homes, as well as services such as the Rapid Response D2A service and District Nursing. *On track:* The Q2 average was 79%, therefore suggesting that there was sufficient community capacity to meet demand.

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

Workstream 3: End of Life Care

Workstream Highlights

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

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

Workstream 4: Planned Care

Workstream Highlights

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

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

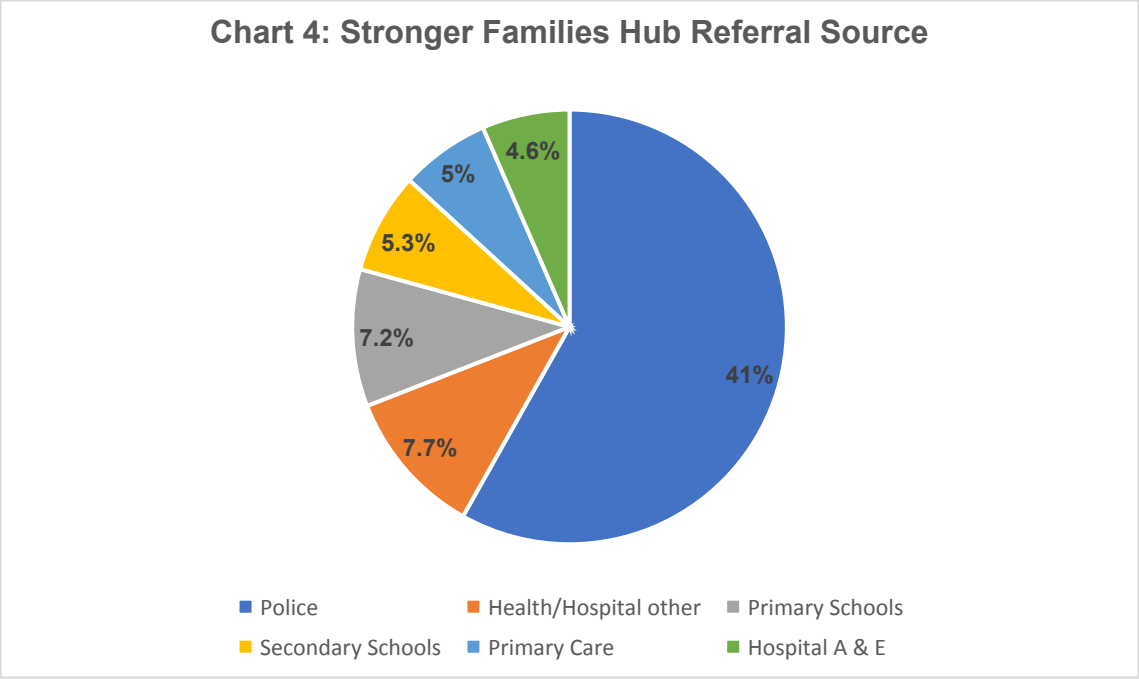
who required an outpatient appointment were prioritised. Data suggests that the service is being effective in reducing unnecessary referrals to the Hospital. For example, the period April to October 2021 has seen a 39% reduction in referrals by GPs on the same period in 2019/20, which equates to 6,800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

Workstream 5: Children and Young People (CYP)

Workstream Highlights

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

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



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

- Priority 1 – Inclusion & early intervention

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

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

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

About Mindfulness

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

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

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

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

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

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

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

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

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

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

Key Performance Indicators

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

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

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

Workstream 6: Mental Health, Learning Disability and Autism

Workstream Highlights

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

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

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

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

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

About the Addiction Recovery Community Hillingdon (ARCH) Service

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

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

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

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

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

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

Enabling Workstreams

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

1. Supporting Carers.
2. Care Market Management and Development.
3. Digital, including Business Intelligence
4. Workforce Development
5. Estates

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

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

Workstream Highlights

52. **Provider Engagement Plan**: Conference calls with care home managers take place fortnightly and with homecare providers monthly and involve partners across the Council and HHCP in order to support the local care market. Hillingdon Hospital's Head of Integrated Discharge regularly joins the care home calls as discharge from hospital is a standing agenda item. Care Home Matrons and a representative from The Confederation usually attend the care home provider forum calls.

53. In addition to the provider fora, weekly newsletters for CQC registered providers are produced by the Council, i.e., there are targeted newsletters for care home, home care and supported living providers. The newsletters provide an opportunity for key messages from the Council and HHCP to be targeted to the appropriate recipients. These also provide a single location for updates to national guidance.

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

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

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

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

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

Workstream Highlights

57. **Remote monitoring:** NWL has commissioned a company to deliver a system that will monitor vital signs in care homes. Vital signs include oxygen saturation, heart rate, respiratory rate, temperature, blood glucose level, blood pressure and weight. Provider workshops on the operation of the monitoring equipment and related support took place during August and September but implementation is being focused on two large nursing homes with high rates of hospital admissions. Information sharing agreements are currently in the process of being signed and the goal is for equipment to be deployed early in December.

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

Finance

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

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

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

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

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

CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance Comments

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

Hillingdon Council Legal Comments

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

BACKGROUND PAPERS

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

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2021/2022 BETTER CARE FUND PLAN

Relevant Board Member(s)	Councillor Jane Palmer Caroline Morison
Organisation	London Borough of Hillingdon Hillingdon Health and Care Partners
Report author	Tony Zaman, Social Care and Health Directorate, LBH Sue Jeffers/Richard Ellis, Joint Borough Directors, NWLCCG Gary Collier, Social Care and Health Directorate, LBH
Papers with report	None

HEADLINE INFORMATION

Summary	The Better Care Fund (BCF) is a Government initiative intended to improve efficiency and effectiveness in the provision of health and care through increasing integration between health and social care. This report sets out the financial arrangements for the 2021/22 BCF plan, which the Board needs to consider and approve to satisfy the national conditions for the BCF.
Contribution to plans and strategies	The Better Care Fund is a key part of Hillingdon's Joint Health and Wellbeing Strategy and meets certain requirements of the Health and Social Care Act 2012.
Financial Cost	The recommended total amount for the BCF for 2021/22 is £106,454k made up of Council contribution of £57,327k and a CCG contribution of £49,127k.
Ward(s) affected	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

a. approves the 2021/22 Better Care Fund Plan as described in the report, including the proposed financial arrangements and proposed targets for the national metrics.

b. delegates to the Corporate Director, Social Care and Health to formally approve the submission template and supporting narrative on behalf of the Board.

c. delegates authority to approve amendments to the 2021/22 plan in response to feedback from NHSE to the Corporate Director, Social Care and Health, in consultation with the co-chairmen and the Board representative of the North West London Clinical Commissioning Group and reports back in due course.

d. notes the position regarding the refresh of Equality and Health Impact Assessments as set out in the report.

INFORMATION

Strategic Context

1. The policy framework that set out broad principles to be followed for the 2021/22 Better Care Fund (BCF) Plan was published on 19 August 2021. The detailed planning requirements were then published on 30 September 2021 and mandated that health and wellbeing board areas submit their BCF plan on 16 November 2021.

2. At its meeting on 14 September 2021 the Board approved an outline for the 2021/22 and agreed to delegate approval to the Council's Director for Social Care and Health in consultation with the Board Chairmen, the North West London Clinical Commissioning Group (CCG)'s Board representative and the Healthwatch Hillingdon Chair. The late publication of the BCF planning requirements and the deferment of the plan submission date means that the approval decision can be considered by a scheduled meeting of the Board. There is scope within the BCF planning requirements to allow for HWB approval post submission.

3. In accordance with national requirements, the Council's Chief Executive and CCG Accountable Officer approved the 2021/22 plan prior to submission. The Hillingdon Health and Care Partners (HHCP) Delivery Board also considered the detail of the plan at its meeting on 11 November 2021. Hillingdon's plan was formally submitted on 12 November 2021.

2021/22 BCF Plan and National Requirements

4. Since its introduction by the Government in 2014/15 the approach taken in Hillingdon has been to achieve ever closer alignment between the BCF and the broader health and care integration programme. Discussions have taken place between officers, the CCG and Hillingdon Health and Care Partners (HHCP) about the scope of the 2021/22 BCF plan within the context of the proposed changes to the NHS architecture expected to take effect from 2022/23, subject to the Health and Care Bill becoming law. As a result of these discussions, it is proposed that there will be full alignment between budgets and the health and care transformation programme within the BCF legal framework from 2022/23 and that the 2021/22 plan will be an incremental progression towards achieving this goal. This approach also takes into consideration a review of NHS investment in mental health provision across NWL that is currently in the progress, the outcome of which will help to shape the BCF from 2022/23.

5. The increased alignment between the BCF and transformation workstreams referred to in paragraph 4 is illustrated in table 1 below.

Table 1: Alignment of Transformation Workstreams and BCF Schemes

Transformation Workstream	BCF Scheme
Workstream 1: Neighbourhood Based Proactive Care.	***Scheme 1:*** Neighbourhood development.
Workstream 2: Urgent and Emergency Care.	***Scheme 4:*** Urgent and emergency care.
Workstream 3: End of Life Care.	***Scheme 3:*** Better care at the end of life.
Workstream 4: Planned Care.	No related scheme.
Workstream 5: Care and support for Children and Young People.	***Scheme 7:*** Integrated care and support for children and young people.
Workstream 6: Care and support for People with Mental Health challenges	***Scheme 6:*** Living well with dementia. ***Scheme 8:*** Integrated care and support for

(including addictions) and/or People with Learning Disabilities and/or Autism.	people with learning disabilities and/or autism.

6. The alignment between the BCF and the transformation workstreams is reflected in the integrated performance report submitted to the Board for its consideration.

National Conditions

7. Table 2 below summarises the national conditions confirmed in the DHSC's December 2020 policy statement. The table describes the local position.

Table 2: National Conditions and Local Response	
Condition	**Local Response**
1. **A jointly agreed plan** - A plan that has been agreed by the HWB.	This is dependent on the recommendation being agreed.
2. **The contribution to social care from the CCG via the BCF is agreed and meets (or exceeds) the minimum expectation** - The Protecting Social Care funding is passported to Social Care with the inflationary uplift (£7,470k in 2021/22).	This is included within the CCG's minimum contribution.
3. **Agreement to invest in NHS-commissioned out of hospital services to meet or exceed the minimum ring-fence** - Investing a ring-fenced sum (£5,821k in 2021/22).	This is already addressed through the funding committed to the CCG's community contract with CNWL and the Neighbourhood Teams.
4. **A plan for improving outcomes for people being discharged from hospital** – The local approach to managing discharges from hospital.	This is in place and is described in **Appendix 1**.

National Metrics

8. There are five mandatory metrics and these are:

- ***Discharge indicator*: Reducing the length of stay in hospital**. *Commentary*: The measure is the number of hospital inpatients who have been in hospital for longer than 14 and 21 days.

- ***Discharge indicator*: Improving the proportion of people discharged to their usual place of residence**. *Commentary*: The discharge destinations not included as '*usual place of residence'* are set out in data issued by NHSE. A spell in a step-down facility before returning to their usual place of residence would be excluded.

- **Avoidable emergency admissions:** *Commentary*: This new metric is intended to measure a reduction in people admitted to hospital for ambulatory care sensitive conditions. The conditions within the scope of this metric include acute bronchitis, angina, heart disease, heart failure, dementia, emphysema, epilepsy, high blood pressure, diabetes, chronic obstructive pulmonary disease (COPD) and fluid on the lungs (pulmonary oedema).

9. NWL has coordinated the approach to the above metrics, which only apply to people aged 18 and above and has provided targets based on 2019/20 activity in line with the 2021/22 Operating Plan. The targets, supporting rationale and identification of schemes that will contribute to delivery are set out in **Appendix 2**. This information is reflected in the submission template. For the Board's assurance, the approach taken with all targets is that they should be achievable, especially taking into consideration the point we are at in 2021/22.

- **Permanent admissions 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.

- **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 at home 91 days after discharge. The aim is for the percentage to be as high as possible and it has also been a BCF metric since its inception.

Submission Requirements

10. Hillingdon's 2021/22 BCF submission consisted of the following:

- A narrative summary of the 2021/22 plan (attached as **Appendix 1**). This includes the priorities for 2021/22 by scheme.

- A completed template detailing financial arrangements and the local targets for the national metrics and supporting rationale, which is reflected in **Appendix 2**. Table 5 summarises the financial investment by the Council and the CCG by scheme.

11. Prior to submission officers made use of the opportunity for NHSE's Better Care Support Team to review the draft narrative plan to ensure that it addressed the key lines of enquiry in the planning requirements. The content of the submitted narrative plan reflected the feedback provided.

Next Steps

12. Hillingdon's submitted plan will be subject to an assurance process involving NHSE, the Local Government Association, the Ministry for Levelling Up, Housing and Communities and the Association of Directors of Adult Social Services (ADASS). Notification of the results of the assurance process should be known the week starting the 11th January 2022. The outcome of the process will be that the plan will either be '*assured*' or '*not assured'*, although if the latter is likely we would expect to be advised of this before Christmas.

13. Once assured status has been obtained it will be possible for the Council and the CCG to enter into an agreement under section 75 (s75) of the National Health Service Act, 2006, that will give legal effect to the partnership and financial arrangements within the BCF plan. Although the target date for this being signed is the 31st January 2022, the process for securing local approval of the agreement means that it will not be possible for the agreement to be signed until the end of February. NHSE has been made aware of this and there are no detrimental implications.

Risk Share Arrangements

14. The arrangement for previous iterations of the plan has been that each organisation manage its own risks and it is proposed that this will continue for 2021/22. The detail of risk share arrangements will also be reflected in the s75 agreement referred to previously.

Equality and Health Impact Assessments

15. Much of the 2021/22 plan represents a roll over from the 2020/21 plan, which was largely a continuation of the 2019/20 plan. Equality and health impact assessments (EIA & HIA) were undertaken for the latter. Under the circumstances it is the view of officers that a refreshed EIA and HIA is not required. This will be considered for the plan covering the period from 2022/23.

Post April 2022 Arrangements

16. Officers understand that there is an aspiration for planning requirements for 2022/23 to be published in February 2022, but this is likely to be influenced by the publication of the health and social care integration white paper. Partners therefore intend to continue discussions about the full alignment between budgets and transformation workstreams within the BCF legal framework in order to address the needs of Hillingdon's population. The outcome of those discussions as agreed by the Board will then be fitted into the required BCF planning structure once published.

Financial Implications

Financial Uplift

17. The following tables show the split of the 2021/22 BCF allocations. Table 3 below provides a breakdown of the mandated financial requirements for 2021/22.

Table 3: BCF FUNDING SUMMARY 2020/22

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

18. Table 4 below summarises the proposed contributions by the Council and HCCG in 2021/22 compared with 2020/21.

Table 4: Financial Contributions by Organisation 2020/21 and 2021/22 Compared		
Organisation	**2020/21** ***(£,000s)***	**2021/22** ***(£,000s)***
CCG	48,009	49,127
LBH	55,448	57,327
TOTAL	**103,457**	**106,454**

19. Table 5 below summarises the Council and HCCG contributions for 2021/22 by scheme and compares these with the 2020/21 position.

Table 5: HCCG and LBH Financial Contribution by Scheme Summary							
Scheme		**2020/21**			**2021/22**		
		LBH (£,000)	**CCG (£,000)**	**TOTAL**	**LBH (£,000)**	**CCG (£,000)**	**TOTAL (£,000)**
1.	Neighbourhood development	3,759	2,661	**6,420**	4,015	3,053	**7,040**
2.	Supporting carers	899	94	**993**	864	101	**965**
3.	Better care at end of life	0	819	**819**	0	1,983	**1,983**
	Covid Hospital discharge	2,411	845	**3,256**	0	0	**0**
4.	Urgent and emergency care	2,142	16,808	**18,950**	4,120	17,772	**21,693**
5.	Improving care market management and development.	7,598	17,011	**24,609**	7,598	13,875	**21,473**
6.	Living well with dementia	30	349	**379**	0	2,836	**2,836**
7.	Integrated care and support for children and young people.	501	2,306	**2,807**	2,567	2,384	**4,951**
8.	Integrated care and support for people with learning disabilities and/or autistic people.	38,108	7,029	**45,137**	38,163	7,034	**45,198**
	Programme Management	0	87	**87**	0	89	**89**
	TOTAL	**55,448**	**48,009**	**103,457**	**57,327**	**49,127**	**106,454**

20. For ease of reference, the main financial changes are:

- **Additional LBH contribution:** The following new items are included:

- *Scheme 1*: *Neighbourhood Development:* Voluntary sector capacity building grant (£40k).
- *Scheme 7*: *Integrated care and support for CYP*: LBH contribution to CYP safeguarding (£1,883k); Homestart grant (£120k) and Relate, P3 and Uxbridge Child Centre grants (£57k).

- ***Protecting Social Care***: Service lines are mainly a roll over from 2020/21 and most of the additional funding is being used to support inflationary pressures within the care market. New items include:
  - Production of written information to support Carers.
  - Additional capacity within the Quality Assurance Team to provide support to providers undertaking activities regulated by the Care Quality Commission (CQC).
  - Additional social work capacity to undertake reviews in response to concerns raised about or by providers.
  - Contribution to funding intermediate care provision at Park View Court extra care scheme.

- **Additional CCG contribution**: The following new items are included:
  - *Scheme 1*: *Neighbourhood Development:* Weekend Visiting Service (£370k).
  - *Scheme 4*: *Urgent and emergency care*: Winter pressures - 6 block step-down beds (£109k); Pathway 3 Brokerage Coordinator post (£27k); and additional D2A Bridging Care capacity (£63k).
  - *Scheme 7*: *Integrated care and support for CYP*: Children's safeguarding contribution (£64k) and Homestart contribution (£9k) and £6k increase to cost of Designated Clinical Officer post to make it full-time.

Covid-19 and Hospital Discharge

21. The Board may wish to note that in 2020/21 areas were required to establish a dedicated Covid-related hospital discharge scheme. This is not a requirement for 2021/22 and funding that was contained within the Covid-hospital discharge scheme in 2020/21 has been moved into scheme 4: *Urgent and emergency care* for this year.

22. Under the *Hospital and Community Support: Policy and Operating Model* (DHSC 21/08/21 & 19/10/21) funding for new or additional care following discharge from hospital was funded by the NHS for a period of up to six weeks for the period 1 April to 30 June 2021. This has reduced to four weeks from 1 July 2021 and will remain in place for the remainder of 2021/22. These funding arrangements are outside of the BCF.

Improved Better Care Fund Grant (iBCF)

23. The iBCF in 2020/21 includes the winter pressures funding that was identified as a separate grant in 2019/20 and required separate reporting. The £7,248k iBCF funding is paid directly to the Council under Section 31 of the Local Government Act 2003, with specific grant conditions, including a requirement that the funding is pooled in the BCF.

24. *iBCF* - The grant conditions for 2020/21 are the same as for the last two years, namely that the funding is used for:

- Meeting adult social care needs;

- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and/or

- Ensuring that the local social care provider market is supported.

25. As for the last two years, the Council is intending to use all the funding to support the local care market. This will fund the annualised effect of the fee uplifts as well as additional fee increases to reflect increased staffing costs to maintain and secure residential and nursing care home placements and homecare provision. As in 2020/21, the Council intends to use the winter pressures aspect of the iBCF funding to cover the cost of new placements and packages of care for people aged 65 and over.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

26. The recommendation will ensure that Hillingdon complies with the BCF national conditions, which impacts on access to £20,485k additional funding via the NHS as well as £12,359k that is paid directly to the Council by the Ministry of Levelling Up, Housing and Communities (MLUHC).

Consultation Carried Out or Required

27. HHCP representatives were involved in the development of the 2021/22 plan. The timescale for submitting the BCF plan restricted the scope for consulting with stakeholders about the plan's content and the point within the financial year and the fact that it is largely a roll over from previous 2020/21 also limited the value of doing so. The intention is to consult more broadly on the content of the plan from April 2022.

Select Committee comments

28. None at this stage.

CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance Comments

29. The financial comments as set out in the report are agreed.

Hillingdon Council Legal Comments

30. 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 the MLUHC, to make directions in respect of the use of the funds and/or impose a spending plan and give directions on the content of any imposed plan.

BACKGROUND PAPERS

2021 to 2022 Better Care Fund policy framework (DHSC 19/08/21)
Better Care Fund planning requirements, 2021/22 (DHSC 30/09/21)

THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST: KEY DEVELOPMENT UPDATE

Relevant Board Member(s)	Patricia Wright, THH Chief Executive
Organisation	The Hillingdon Hospitals NHS Foundation Trust
Report authors	Jason Seez, Deputy Chief Executive/SRO for Redevelopment, THHFT
Papers with report	Report on performance and presentation on redevelopment attached.

HEADLINE INFORMATION

Summary	To provide an update to the Health and Wellbeing Board on a number of developments at the Trust, to include: • Redevelopment of Hillingdon Hospital • Performance update
Contribution to plans and strategies	• Recovery and Improvement plans • Clinical strategy • Quality and Safety strategy
Financial Cost	N/A
Relevant Policy Overview & Scrutiny Committee	External Services Select Committee
Ward(s) affected	All

RECOMMENDATION

That the Health and Wellbeing Board discusses and notes the update.

PERFORMANCE UPDATE

Introduction

This report aims to provide the Health and Wellbeing Board with an update on performance at the Trust over the last 9 months. It focuses on areas where progress has been made and ongoing and emerging challenges for the Trust in 2021/22 and looking forward to 2022/23.

Progress

1. Quality and access

1.1 Quality

There has been a steady and consistent improvement in quality as evidenced through our routinely reported quality metrics and presentations to the Trust Board and we continue to make progress with the Quality priorities for 2021-22:

Priority 1: Improve the experience of patient discharge
Priority 2: To work in partnership with our patients and carers to deliver high quality patient experience
Priority 3: Improvement to prevention and management of VTE for our patients
Priority 4: Provide a framework for enhancing quality and safety for patients whose clinical condition may be deteriorating

As a result of the focus on quality over the last 12 months, the Section 29 and 31 licence conditions imposed by the CQC in 2020 were lifted in July 2021.

1.2 Access

The national focus since April 2021 has been on Elective Recovery. The Trust continued to provide elective care during the second wave of the pandemic from its 'green' day case facility at Mount Vernon and following the move of ITU to a new facility in Modular North has been able to support complex surgery on the Hillingdon site. We have seen a steady improvement against agreed trajectories and have a plan to reduce and eliminate long waiters by agreed dates in 2022-23.

Pressure on Urgent and Emergency Care (UEC) has been increasing since April 2021 and the Trust is seeing unprecedented numbers of patients in the Urgent Care Centre (run by Totally) and A&E. This has resulted in variable performance on a day to day basis and an overall deterioration in performance against the 4 hour target. A programme of improvement work, supported by Hillingdon Healthcare Partners, reviewing the whole UEC pathway is underway alongside a transformation programme being led by the A&E team.

2. People

There is recognition at a national and local level of the strain staff have been under over the last, almost, two years. Our People are the Trusts greatest asset and in response to this, we have published a People Strategy with the four pillars set out in the picture below.

Programmes of work have commenced to address each of these areas including:

- Developing an enhanced health and wellbeing offer for staff
- Appointing an Equality and Diversity lead
- International nurse recruitment

Ongoing and emerging challenges

1. **Finance and use of resources**

In August 2021 the Trust was placed in category 4 of the national System Oversight Framework due to concerns about the financial position in the short and longer term. As a result, the Trust is receiving support from the NHSie Recover Support team and is working with them to develop a 2-3 year Financial Recovery Plan to ensure that the Trust returns to a sustainable position.

2. Quality, access and outcomes

Alongside the focus on use of resources we will continue to prioritise quality, elective recovery and emergency access.

Conclusion

The NHS continues to experience significant pressures across all services and although the number of inpatients with Covid-19 is slowly dropping, the Trust remains vigilant and prepared for any upsurge in cases. Over the last 9 months, despite these pressures we have continued to focus on quality improvement with obvious benefits, although we recognise there is still a long way to go. Financial performance is a concern but with the support of the national team, good progress is being made.

NHS
The Hillingdon Hospitals
NHS Foundation Trust

The new Hillingdon Hospital

Update

Health and Wellbeing Board report
1 December 2020

cares communication attitude responsibility equity safety

The New Hillingdon Hospital

Areas to cover

- Where we are in the process and highlights so far
- What the new hospital will look like
  - Master plan
  - How the new hospital will be better for patients and staff

Timeline

Health Infrastructure Plan	Clinical services strategy	Strategic Outline Case	Outline Business Case	Full Business Case	Main construction
• **Late 2019** • This was the government's original 40 hospitals announcement which included Hillingdon	• **2020** • We are currently refreshing in line with learning from Covid pandemic and the updating of the NW London acute strategy	• **2020** • Approved locally and nationally • Sets out why a change is needed, reviews the options and sets out the preferred way forward.	• **We are here** • Demonstrates that the chosen option is affordable and value for money.	• **Timings subject to NHP approvals** • Final stage that provides detail on procurement and delivery.	

Highlights over the last year

- We've made a great deal of progress over the year including:
    - Strategic outline case approval
    - Finalising the 1:500 plans that set out the general layout of the floors and departments
    - Running our public exhibition around our planning application

The masterplan

The new hospital		Central open space	
Rooftop healing garden		Homes	
Multi-storey carpark		Eastern civic square	

Design




The new hospital design includes a high degree of standardisation.

We will use Modern Methods of Construction (MMC) to ensure effective and fast track delivery of a high-quality building.

Design

View from Crispin Way to new hospital

View of the new hospital main entrance

View from Crispin Way of current hospital

View of the new hospitalmain entrance

Better for patients and staff

- Urgent and emergency care on a single floor with integrated diagnostics
- A co-located midwife led unit
- A larger critical care unit located next to our high dependency unit
- Outpatients designed to improve patient and clinical experience while supporting better integrated and digitallyenabled care. Features include:
  - Large multi-functional treatment rooms for consultations
  - and day case procedures for a range of specialities. More radiology diagnostics which will support one stopvisits.

Better for patients and staff

- We have increased the working hours for elective services from 40 to 48 hours a week.
- Current plans would see the new hospital have about 40 per cent more floor space.
- This is an increase from around 55,000m^2 to approximately 75,000m^2
- There will be a small increase in beds numbers - 489 beds compared to 484 currently (this doesn't include beds at Mount Vernon)
  - With a larger number of single rooms (>70% overall) and approximately one full isolation suite per eight beds
  - Critical care unit: 20 beds, split into 2 clusters of 10 (each cluster has a 4 bed bay and 6 singles)

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

	Business / Reports	Lead	Timings
8 Mar 2022 2.30pm Committee Room 6	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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