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Health and Wellbeing Board

Date: **TUESDAY, 29 NOVEMBER 2022**

Time: **2.30 PM**

Venue: **COMMITTEE ROOM 6 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

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 Executive Director, Adult Services and Health
- LBH Executive Director, Children and Young People's Services
- LBH Director, Public Health
- NWL ICS - Hillingdon Board representative
- NWL ICS - 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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Contact: Nikki O'Halloran
Tel: 01895 250472
Email: nohalloran@hillingdon.gov.uk

Putting our residents first

Lloyd White
Head of Democratic Services
London Borough of Hillingdon,
Phase II, Civic Centre, High Street, Uxbridge, UB8 1UW

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Agenda

CHAIRMAN'S ANNOUNCEMENTS

1	Apologies for Absence	
2	Declarations of Interest in matters coming before this meeting	
3	To approve the minutes of the meeting on 20 September 2022	1 - 8
4	To confirm that the items of business marked Part I will be considered in public and that the items marked Part II will be considered in private	

Health and Wellbeing Board Reports - Part I (Public)

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Health and Wellbeing Board Reports - Part II (Private and Not for Publication)

That the reports in Part 2 of this agenda be declared not for publication because they involve the disclosure of information in accordance with Section 100(A) and Part 1 of Schedule 12 (A) to the Local Government Act 1972 (as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

10	To approve PART II minutes of the meeting on 20 September 2022	45 - 46
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Minutes

HEALTH AND WELLBEING BOARD

20 September 2022

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW

	Board Members Present: Councillors Jane Palmer (Co-Chairman) and Susan O'Brien (Vice-Chairman), Richard Ellis, Professor Ian Goodman, Ed Jahn, Julie Kelly, Kelly O'Neill, Lisa Taylor (In place of Lynn Hill), Sandra Taylor and Tony Zaman **Officers Present:** Kevin Byrne (Head of Health and Strategic Partnerships), Gary Collier (Health and Social Care Integration Manager), Becky Manvell (NHS Health Checks - Smoking Cessation Team), Naveed Mohammed (Head of Business Performance & Insight), Dr Ritu Prasad (Chair of Hillingdon GP Confederation), Shikha Sharma (Consultant in Public Health) and Nikki O'Halloran (Democratic Services Manager)
13.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence had been received from Ms Lynn Hill (Ms Lisa Taylor was present as her substitute), Ms Vanessa Odlin and Mr Nick Hunt.
14.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* There were no declarations of interest in matters coming before the meeting.
15.	**TO APPROVE THE MINUTES OF THE MEETING ON 14 JUNE 2022** *(Agenda Item 3)* It was noted that Caroline Morison was not a Councillor. **RESOLVED: That, subject to the above amendment, the minutes of the meeting held on 14 June 2022 be agreed as a correct record.**
	On behalf of the Health and Wellbeing Board, the Co-Chairman thanked Ms Caroline Morison for the excellent work that she had undertaken in Hillingdon and wished her every success going forward.
16.	**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 11 would be considered in public and that Agenda Item 12 would be considered in private.
17.	**POPULATION HEALTH MANAGEMENT - PROGRESS AND NEXT STEPS** *(Agenda Item 5)* The Director of Public Health advised that the focus had been on Public Health

Management (PHM) being used as an enabling framework to tackle health inequalities. The work commissioned in North West London (NWL) had focussed on place based projects in relation to frailty and falls in Hillingdon. There had also been some initial focussed work on obesity and health checks.

The Board noted that Ms Caroline Morison, former Managing Director of Hillingdon Health and Care Partners (HHCP), had presented the PHM information to the Borough HPB. Consideration needed to be given to the approach that would be taken and prioritising the use of the PHM framework going forward in the Borough.

Ms O'Neill stated that the PHM work being undertaken by Optum had progressed well. However, the process had been paused to enable Healthwatch Hillingdon to support the process by engaging with residents as this intelligence had been missing. Action Learning Sets had been held and key interventions had started to be developed and implemented. It was agreed than an update on the progress of the Optum project be provided to the Board at its next meeting on 29 November 2022.

At a NWL level, £7.2m of health inequalities funding had been made available from NHS England. A three week consultation had been undertaken across NWL to identify how this funding could be used to build capacity but the outcome of the consultation had yet to be confirmed.

Health Checks

Ms Becky Manvell, the Council's Public Health Manager, advised that the NHS Health Check programme in Hillingdon aimed to prevent heart disease, stroke, type 2 diabetes, kidney disease and some types of dementia. Eligible residents should receive an NHS Health Check every five years. These appointments were undertaken in all 45 general practices in Hillingdon, lasted approximately 15-20 minutes and measured height, weight, waist circumference, pulse rhythm and blood pressure. Information was also gathered in relation to alcohol consumption, physical activity and smoking status and their CVD risk was calculated and communicated and healthy life advice given or a GP referral made where necessary.

Covid had negatively impacted on the Borough's ability to meet its target for the number of Health Checks undertaken (65% / 2,700 per quarter) and there appeared to be a significant variation in achieving this at a Primary Care Network (PCN) and local practice level.

Currently, Hillingdon had worse levels of cardiovascular disease (CVD) than the London average as well as the national average. It was anticipated that an increase in the Health Checks undertaken across eligible groups would enable the identification and treatment of more people with undiagnosed CVD. Those with a higher risk of developing CVD could be supported and those with a lower-level risk could be signposted and advised. The more Health Checks that were carried out in Hillingdon, the greater their impact would be.

The Board was advised that there was some overlap between the areas with the fewest Health Checks undertaken and the areas of greatest deprivation. Consideration would need to be given to breaking down the data and providing further analysis to increase the uptake of Health Checks.

Work was being undertaken to reduce the variation in the Health Checks amongst individual general practices and on improving access via a range of community settings with appointments available at different times of the day and week, exploring the

possibility of an outreach service to complement the current general practice model.

The work that was being undertaken would improve outcomes for Hillingdon residents by increasing the uptake of preventative interventions as well as enabling higher risk groups to be targeted. A gap analysis would be undertaken to identify under served groups to then engage to understand how this disparity could be addressed. This engagement could include initiatives such as the blood pressure (BP) checks which was recently undertaken at Botwell Library. The Board welcomed this type of proactive outreach as a large number of residents would only seek out medical attention when it was an emergency.

Awareness of and the profile of NHS Health Checks would need to be raised through better communication as it was thought that patients would not actively reject the opportunity to have a Health Check. It was important that, when patients were having a Health Check, they were aware that that was what it was as it was not always being made obvious as these checks were sometimes done as part of a visit to the GP for another issue. It was suggested that the Covid Champions be used to help educate residents and promote NHS Health Checks.

In the medium to long term, a digital NHS Health Check offer was under development by NHS Digital and expected to be ready in about two years. Once this facility was available, it was expected that the age range for the programme would be expanded to include those aged 30-39 (currently around 48k residents). It was suggested that a lot more needed to be done, particularly in relation to places like Botwell and Hayes, and that waiting another two years for the digital offer to come online was unacceptable.

It was queried whether there had been a direct correlation identified between the NHS Health Checks being undertaken and positive health outcomes. Ms Manvell advised that an NHS Health Check dashboard was being developed which would hopefully address this.

Professor Ian Goodman noted that it was going to be difficult to get those who most needed help, support and advice to have an NHS Health Check. Fifty two years ago, Dr Julian Tudor Hart had recognised and referenced an Inverse Care Law whereby those who most needed medical care were least likely to receive it and those who needed it least would use health services more (and more effectively). However, these residents would be more likely to engage if the information and education about healthy lives was taken out to them in their own environment. Professor Goodman advised that he had engaged with a colleague who had spent a number of years implementing a scheme in Brazil and was now doing a similar thing in London.

35% of those in Hillingdon that were eligible had not yet had a Health Check. It would be important to target those residents that had not yet had one and to have that conversation about why it was important to identify health issues early. The uptake in the more deprived communities needed to be increased as these were the residents that were more likely to have long term conditions. Effort then needed to be made to ensure that support is available to those who needed it to reduce the risk of any conditions that were diagnosed.

It was agreed that an update on the progress of this project be brought to the Board at its meeting on 7 March 2023.

Obesity

Ms Shikha Sharma, Public Health Consultant at the London Borough of Hillingdon,

advised that the obesity rates had increased in recent years, and so had the gap in rates between the most and the least deprived people. Obesity was strongly linked to deprivation. In Hillingdon, the small areas of deprivation also had the highest obesity rates; which was of significance due to its negative impacts on health of the most vulnerable people. Nationally, hospital admissions due to obesity were shown to be 2.4 times higher in deprived areas.

Consideration was now being given to understanding the current achievements in terms of preventing obesity and to determine the impact of actions that had been undertaken and the associated learning on a local and national level. Local partners understood that obesity was a significant issue and, although there had been discussions and initiatives introduced to tackle obesity, there were still gaps. A whole system approach that involved bringing everyone together across the system to identify areas for targeting (and working together to action those), was proposed. In order for this to work, certain mindsets and behaviours would need to be promoted and adopted across the system. This would involve acting on wider environmental factors as tackling obesity was not just about diet and physical activity.

To tackle obesity, the population health management (PHM) methodology would be utilised where partners studied local data together to identify the individuals and then look at the risk factors and remove barriers. Staff working in areas such as leisure services, healthcare and social care all needed to be confident in raising the issue of weight and should have knowledge of the interventions that were available to help. It was suggested that tackling obesity was everyone's responsibility.

Ms Sharma advised that sufficient data was not currently collected in relation to who attended what activities in the Borough. As such, it would be more difficult to motivate people to use services or to identify who the non-users were, which areas people lived in and whether or not they had the skills needed to be able to lose weight. The National Institute of Health and Care Research (NIHR) had identified interventions which had been successful and, if applied locally, would need to be monitored to identify their impact and effectiveness as well as identify what didn't work.

Nationally, there had been an increase in rates of people who were overweight and obese. Although obesity rates for adults and children had appeared to have increased in Hillingdon too, due to interruption caused by COVID-19, there were gaps in the collection of local data (as in other boroughs nationally). As a result of the pandemic lockdowns and exclusion of 'bubbles', it had not been possible to measure children's heights and weights and complete data to usual levels in schools. There was further evidence in the data of lifestyles related to diet and physical activity not improving in Hillingdon. As well as physical activity levels for children and adults in the Borough being significantly low, children's dental health was poor and the uptake of 5-a-day was low. The Population Health Management model would shift the focus to treating obesity as a chronic disease involving action on upstream measures across the identified population.

Data collection needed to be improved and residents' engagement needed to be increased. To this end, workshops would be scheduled to target areas where inequalities and obesity levels were comparatively high such as Hayes and Harlington, West Drayton and Yiewsley.

The Health and Wellbeing Board was asked to provide leadership at place to implement a whole system approach for healthy weight through PHM. Partners were supportive of stakeholder professionals to be involved in the PHM process and agreed

that progress insight and recommendations for achieving whole system approach ambitions be reported back to the Health and Wellbeing Board at its meeting on 29 November 2022.

It was queried whether the action being undertaken now differed greatly to that taken five or ten years previously. Ms O'Neill advised that reducing obesity was not just about looking to reduce how much someone ate / calorie intake but was also about the infrastructure that sat behind that. The Council was deemed to be an enabler in relation to services such as planning, housing development, etc, and the NHS looked to promote health literacy, etc. This all needed to be put together to produce better outcomes, whilst also understanding the drivers of obesity and barriers to losing weight (which included the increasing cost of healthy food versus something like a relatively cheap bucket of fried chicken).

Activity that was already being undertaken to address obesity had been mapped out and gaps identified and filled. However, more strategic oversight was needed. The Council's fortnightly senior manager meetings could be used to help position Public Health better within the local authority. For example, it was recognised that housing maintenance covered a huge range of public health issues which could be included in the medium to long term transformation programme. There were some policy decisions that would need to be made to enable work to be undertaken effectively and all partners needed to work together as a beacon.

Although there appeared to be a lot of enthusiasm for the proposed way forward, concern was expressed that enthusiasm had not previously been enough to produce results. Consideration would need to be given to what had worked before and prioritise what would give the biggest return and prove the most robust when evaluated. Professor Goodman advised that colleagues at Brunel University were able to evaluate health interventions and would likely be happy to be involved.

Councillor Sue O'Brien noted that the schools had a range of resources that could be used to tackle obesity such as Multi Use Games Areas (MUGAs). She also queried what action Hounslow had taken that had resulted in significant improvements to obesity levels there. Ms O'Neill advised that Hounslow had made a significant investment in tackling obesity. Dedicated leads had put together ambitious plans that were then promoted to the LGA and London Councils to secure funding, which then attracted additional funding.

It was agreed that an update on the progress of this project be brought to the Board at its meeting on 7 March 2023.

RESOLVED: That the following be noted:

1) **the current status of the place-based PHM programme on falls and frailty commissioned by NWL in the Borough;**
2) **discussions at the Health Protection Board that proposed:**
   a) **how we embed population health management in wider projects;**
   b) **how this approach can more efficiently become a systematic tool for improving outcomes in defined communities; and**
   c) **how we can best use the opportunities presented as part of the NWL ICB consultation on investing in PHM to tackle health inequalities at Borough level;**
3) **two examples of public health focused work that were starting to use PHM as an approach to achieving improved outcomes and offer a different approach to two long-standing health needs to achieve more impact;**

	4) an update on the progress of the Optum project be provided to the Board at its next meeting on 29 November 2022; and **5) updates on the progress of the obesity and Health Check projects be considered by the Board at its meeting on 7 March 2023.**
18.	**2022/23 INTEGRATED HEALTH AND CARE PERFORMANCE REPORT** *(Agenda Item 6)* Mr Gary Collier, the Council's Health and Social Care Integration Manager, advised that the mental health Crisis House was now operational and people had moved in. The Crisis House was able to help different categories of guests and, therefore, evidence needed to be provided on a quarterly basis to determine whether or not the criteria needed to be altered. As there had been some developments in relation to the Cove Café, Mr Collier would ask Ms Vanessa Odlin to circulate the information to members of the Board. Although there was reference made to the Better Care Fund (BCF) in this report, it was noted that it had not been possible to include the BCF report on this agenda. It was likely that guidance in relation to the post April 2023 BCF arrangements would not be forthcoming until after November 2022. **RESOLVED: That:** **1. Ms Vanessa Odlin be asked to provide the Board with information in relation to developments at the Cove Café; and** **2. the report be noted.**
19.	**2022/23 BETTER CARE FUND PLAN - VERBAL UPDATE** *(Agenda Item 7)* Mr Gary Collier, the Council's Health and Social Care Integration Manager, advised that it had not been possible to provide a report on the 2022/23 Better Care Fund (BCF) Plan. As such, it was agreed that authority to approve the plans and amendments from the assurance process with NHS England be delegated to the Council's Executive Director, Adult Services and Health in consultation with the Health and Wellbeing Board Co-Chairman, the Joint Borough Director, NHS North West London and the Chairman of Healthwatch Hillingdon. This would be reported back to the Board's subsequent meeting. **RESOLVED: That:** **1. formal approval of the submission documentation be delegated to the Executive Director, Adult Services and Health in consultation with the Health and Wellbeing Board Co-Chairman, the Joint Borough Director, NHS North West London and the Chairman of Healthwatch Hillingdon, on behalf of the Board; and** **2. on behalf of the Board, authority to approve amendments to the 2022/23 plan in response to feedback from NHS England be delegated to the Executive Director, Adult Services and Health in consultation with the Health and Wellbeing Board Co-Chairman, the Joint Borough Director, NHS North West London and the Chairman of Healthwatch Hillingdon.**
20.	**PHARMACEUTICAL NEEDS ASSESSMENT UPDATE** *(Agenda Item 8)* Mr Naveed Mohammed, the Council's Head of Business Performance and Insight, advised that consultation on Hillingdon's Pharmaceutical Needs Assessment (PNA)

	had been undertaken between 21 June 2022 and 19 August 2022. A separate consultation had been undertaken with partners. As it was thought to be a niche topic, there had not been a huge number of comments received during the consultation period. However, an amendment to the opening hours had been made following feedback from one respondent. In addition, on 12 September 2022, NHS London had raised ten issues and questioned the localities that had been chosen. A response was being put together. Professor Ian Goodman noted that Primary Care Networks had been funded to employ community pharmacists that were now in great demand and short supply. He queried whether the PNA covered future workforce planning. Mr Mohammed would get back to Professor Goodman outside of the meeting. It was agreed that the inclusion of further amendments to Hillingdon's PNA 2022 and publication be delegated to the Council's Director of Public Health and Head of Performance and Insight. **RESOLVED: That the Health and Wellbeing Board:** **1. agree the final version of Hillingdon's Pharmaceutical Needs Assessment (PNA) including the recommendations and inclusion of summarised comments from the statutory 60-day consultation.** **2. agree that the PNA be published by 1 October 2022.** **3. agree to delegate further amendments to Hillingdon's PNA 2022 prior to publication to the Head of Performance and Insight and Director of Public Health, should further changes be required.**
21.	**ADULT SOCIAL CARE FUNDING REFORMS UPDATE - VERBAL UPDATE** *(Agenda Item 9)* Ms Sandra Taylor, the Council's Executive Director Adult Services and Health, advised that the Council had been working with care home providers about the fair cost of care. Consideration needed to be given to how this was being addressed and assessed and the eligibility for financial assessment before the care cap became effective in October 2023. Eligibility thresholds had increased from £23k to £100k. It was noted that the Council would be able to start undertaking fair cost of care assessments from February 2023. In the meantime, the authority would need to produce a market position statement by 23 October 2022 on the fair cost for care home placements and domiciliary care. An update would be provided to the Board at its meeting on 29 November 2022. **RESOLVED: That:** **1. Ms Sandra Taylor provide the Board with an update on the fair cost of care at its meeting on 29 November 2022; and** **2. the update be noted.**
22.	**ICS STRATEGY - VERBAL UPDATE** *(Agenda Item 10)* Mr Richard Ellis, North West London Integrated Care System (NWL ICS) Joint Borough Lead Director, advised that, although he had been unable to attend the revised meeting date, the Director of Strategy and Population Health at NWL ICS had been keen to talk to the Health and Wellbeing Board about the ICS strategy. Mr Ellis noted that the NWL ICS had been committed to working in partnership with

	local authorities. To this end, a number of workshops had been set up (including one in October 2022) for partners to attend. Invitees had included Councillor Palmer as well as the Council's Chief Executive, Executive Director Adult Services and Health, Executive Director of Children and Young People's Services and Director of Public Health. Those that had been invited to the workshops were encouraged to engage. The NWL Integrated Care Board (ICB) had developed four objectives to tackle issues such as health inequalities similar to those discussed earlier on the agenda. Furthermore, NWL aimed to replicate the joint working achieved through the Hillingdon Health and Care Partners (HHCP) which had worked across health, social care, voluntary sector and local authority. NWL ICB had developed nine deliver programmes to look at: mental health; acute care; workforce development; research; maternity; children and young people; cancer; support for people with long term conditions; and older people. Mr Ellis noted that Hillingdon had overachieved in some of these areas. **RESOLVED: That the update be noted.**
23.	**BOARD PLANNER & FUTURE AGENDA ITEMS** *(Agenda Item 11)* Consideration was given to the Board Planner. It was noted that the following items be included on the agenda for future meetings: • an update on the progress of population health management interventions to gain residents' insight be provided to the Board at its next meeting on 29 November 2022. • an update of the fair cost of care be provided to the Board at its meeting on 29 November 2022. • an update on the uptake and outcomes of health checks be brought back to the Board at its meeting on 7 March 2023. **RESOLVED: That the Board Planner, as amended, be agreed.**
24.	**UPDATE ON CURRENT AND EMERGING ISSUES AND ANY OTHER BUSINESS THE CO-CHAIRMAN CONSIDERS TO BE URGENT** *(Agenda Item 12)* Consideration was given to the make up of the North West London Integrated Care Board (NWL ICB) and NWL Integrated Care System (ICS). **RESOLVED: That the discussion be noted.**
	The meeting, which commenced at 2.30 pm, closed at 4.37 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.

POPULATION HEALTH MANAGEMENT (PHM) UPDATE

Relevant Board Member(s)	Councillor Jane Palmer Keith Spencer Kelly O'Neill
Organisation	London Borough of Hillingdon North West London Integrated Care Board (NWL ICB)
Report author	Kelly O'Neill, LBH Melanie Foody, NWL ICB
Papers with report	None

HEADLINE INFORMATION

Summary	This report provides an update on: 1. Progress towards implementing the population health management process, focusing on the: - Optum falls and frailty project - Whole-System Approach (WSA) to Obesity - Building PHM capacity and capability 2. planning for the London Borough of Hillingdon allocation of the NHS England (NHSE) Health Inequalities funding 2022/23 and 2023/24
Contribution to plans and strategies	• The Joint Health and Wellbeing Strategy • HHCP Delivery and Health Protection Boards • NWL ICS Health Inequalities Strategy • Proactive Population Health Management and Inequalities Programme
Financial Cost	Investment of NHSE Inequalities funding allocated to the London Borough of Hillingdon: • Non-recurrent: £358,824 • 2022/23: In year: £256,303 • 2023/24: FYE: £ 615,127
Ward(s) affected	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

1. **notes the progress of the Falls and Frailty project and the Whole System Approach to obesity (presented to the Board in September 2022);**
2. **is aware of the current training focused on building of capacity and capability across HHCP organisations; and**
3. **recognises the opportunities of ongoing investment for current projects and future planned projects that meet the criteria for NHSE health inequalities funding.**

INFORMATION

1. Current PHM Projects:

1.1 **Falls and Frailty:** The Optum supported PHM project focused on reducing frailty-associated falls is in the process of implementing interventions and confirming monitoring and evaluation measures to determine impact. The slide deck of current focus is embedded and was used as part of the final action learning set.

V1 Final System ALS 5 PHM PLACE HHCP

1.2 **Whole System Approach (WSA) Obesity:** A project reference group and operational task and finish group have been established to develop the foundations of the PHM project. The process of project initiation and profiling is nearly complete.

PID Template WSA V1 (002).docx

WHOLE SYSTEMS APPROACH TO OBES

2. Progress towards building PHM capacity and capability:

Outside of the experience learning from the Optum project, there has been focused GP Confederation training led by Public Health (PH) and the GP Confederation training team. The title of three sessions were:

1. What is PHM? 29 September 2022
2. PHM, your PCN priorities: 6 October 2022
3. Sharing ideas and know-how: 13 October 2022

PHM Training 29 09 22.pptx

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PHM Training 13 10 22 - FINAL.pptx

PH has also started officer training in the team to develop specialist skills to support HHCP projects.

3. Investment of the Hillingdon allocated NHSE Health Inequalities funding 22/23 and 23/24

In previous meetings, we have discussed the NHSE funding to tackle inequalities and, for NWL ICS, this is a recurrent annual investment of £7.022M additional resource of which, through regional agreement, 60% will be allocated directly to borough-based partnerships, 15% for cross system infrastructure, and 25% is for flexible use for additional schemes. The level of funding is stated to be based on population size and need and business cases need to be submitted either by 5 December or 9 January that meet the criteria below.

Business cases demonstrate	PPHMI Principles	NHS England Requirements
• Use of local evidence • Strategic fit with BBP priorities • Fit with PPHMI principles and NHSE requirements • Clear intended impact • Commitment to share learning	• Aligned to three pillars: 1. Identifies and tackles inequalities, 2. PHM building blocks, 3. Partnership working on wider determinant • Aligned to three categories: 1. Infrastructure, 2. Innovative partnerships, 3. Coproduction • Clear strategic ownership: at System, Borough and Neighbourhood level • Leverage existing funding opportunities and assets by mapping, integrating, and enhancing existing capabilities (this is for multiyear schemes) • Accelerate delivery of existing priorities aligned to Core20plus5 and inequalities priorities • Clear and proportionate accountability for expected outcomes, spend, and **reviews of impact** • Clear governance to manage conflicts of interest • Commitment to share learning (ensuring any small-scale initiatives lead to system improvement, rather than wider variation and inequality of care)	Show whether the investment/ spend supports: • Development of the NWL ICB health inequality framework and ambitions • Delivery of interventions as part of Core20plus5 • Improvement in population health management approach capabilities (engagement, analysis, methodical coproduction facilitation, health economics) • Improvement in preventative care • Improvement in equity in health service restoration • Building of qualitative evidence (case studies, experiences of residents, patient journeys)

The allocation from the £7,022M allocated to the London Borough of Hillingdon is based on a non-recurrent allocation (the process to access this funding is yet to be confirmed), an in year 2022/23 investment and then a recurrent allocation:

Non-recurrent	£358,824
2022/23	£256,303
2023/24	£ 615,127

The process taken to date to determine how this funding is prioritised is an iterative one. A small senior group of the Health Protection Board initially met to develop a long list, and a discussion paper was presented to the Health Protection Board on 15 November 2022. A further informed plan was discussed at the HHCP Delivery Board on 17 November 2022. In the interim, a meeting has been set up with Brunel University Health Economics Research Group to determine whether there are opportunities to use an economic basis to prioritise whether some projects could achieve greater inequalities outcomes and financial impact.

A task and finish group of HHCP partners will work together on the business cases. Initially discussed areas include:

- Health of asylum seekers and focused health resilience and improvement of other vulnerable communities
- Maintaining momentum and focus on the falls and frailty PHM project and the neighbourhood project in Hayes and Harlington focused on mental health and obesity and broadening that project to other areas

- Mental health of the 16–35-year-old population
- Improving oral health
- Whole system approach to obesity
- Reducing acute urgent presentations of working aged men with chest pain

There is a clear understanding that these projects need to link with the Health and Wellbeing principles of improved access to services, and experience from services, and outcomes achieved.

It is expected that, by April 2023, every system should have in place the technical capability required for population health management. This should have longitudinal linked data available to enable population segmentation and risk stratification, using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.

Systems are encouraged to work together to share data and analytic capabilities – we have the opportunity for shared projects based on shared risks.

4. Finance

The financial implications of this report are associated with the NHSE investment into the borough-based partnership.

2022/23 INTEGRATED HEALTH AND CARE PERFORMANCE REPORT

Relevant Board Member(s)	Councillor Jane Palmer Keith Spencer
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 ICS
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 Joint Health and Wellbeing Strategy. This report also includes an update on actions within the scope of the draft 2022/23 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 value for the BCF for 2022/23 is £109,080k made up of Council contribution of £58,033k and an NHS contribution of £50,947k.
Ward(s) affected	All

RECOMMENDATION

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 Joint Health and Wellbeing Strategy for the July to September 2022 period (referred to as the '*review period'*), unless otherwise stated.

2. This 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

2022/23 Better Care Fund Plan

3. The draft 2022/23 Better Care Fund plan was submitted on 26 September 2022 in accordance with national requirements, and the Board's sign-off under delegated arrangements was confirmed to NHS England on 17 October. This means that Hillingdon is compliant with the BCF national conditions, and the outcome of the assurance process is awaited. This is expected between 28 November and 9 December 2022.

4. The 2022/23 BCF plan submission documents can be found via the following link Better Care Fund - Hillingdon Council.

5. The approval process for the agreement under section 75 (s75) of the National Health Service Act, 2006, that will give legal effect to the financial and partnership arrangements within the plan, is in progress. The intention is to secure the necessary approvals so that it will be possible to meet the national target of having the s75 signed by 31 December 2022 should confirmation of assured status be received in time.

6. Regarding the post April 2023 requirements, it is understood that the Government's intention is still that there will be a two-year plan and that the policy framework and planning requirements will be published in Q4.

Winter Demand Planning

7. The Director of Public Health has coordinated version 1.0 of an overarching Hillingdon Health and Care Partners (HHCP) winter action plan that brings together plans that a range of partners have been responsible for. It sets out prevention, early intervention and response actions that aims to protect vulnerable residents to stay healthy and develop response mechanisms to intervene early or mitigate demand on NHS and social care services in response to illness. The plan is iterative and includes oversight and monitoring mechanisms. Operationally, it is overseen by the HHCP Senior Operational Leads Team (SOLT) and strategically by the Health Protection Board.

8. The plan aims to create resilience of the health and social care system over the challenging winter period that includes Easter 2023 (1 November 2021 to 8 April 2023) and is already operational. These plans are in addition to the existing services and capacity in place and cover 4 themes:

- **Prevention:** This mainly consists of the roll out of the annual flu vaccination programme, the Covid booster programme and public communications about alternatives to attending A & E, e.g., use of NHS 111, pharmacy, A &E/UTC, support to parents this winter, self-care and how to access weekend and evening GP appointments. In addition, there is a robust winter communications plan, that directs residents to where they can access help and support, including a network of warm spaces located around the Borough.
- **Demand Management:** This entails increasing the capacity of some existing services to enable them to operate seven days a week, e.g., Community Adult Rehabilitation Service (CARS), end of life support, additional frailty assessment staff within the Rapid Response Team and Age UK's Take Home and Settle Service.
- **Flow:** This includes creation of additional capacity within the hospital such as a 6 bedded frailty assessment unit to reduce unnecessary admissions, 35 additional medical beds, establishing a 7-day therapy service and increasing CNWL's discharge to assess capacity from 48 to 60 slots per week.

- **Mental Health**: This includes establishing a mental health crisis assessment service in conjunction with Adult Social Care to support diversion from A&E; additional support to urgent care services and community alternatives to inpatient provision led by the North West London Children and Adolescent Service (CAMHS) Provider Collaborative; and improvements in the rehab pathway to support the flow in rehab and acute wards

NWL Children and Adolescent Service (CAMHS) Provider Collaborative Explained

The collaborative is made up of West London NHS Trust (the lead provider) and CNWL as the two mental health Trust's in North West London (NWL) and is responsible for the budget for CAMHS inpatient admissions. The main objective of the collaborative is to ensure that children and young people have safe, high quality mental health inpatient stays and are also cared for in the most appropriate environment. Through investing in urgent care schemes, it is able to either avoid inpatient stays, or reduce the length of time children are inpatients for.

Since the collaborative started in 2018, it has been able to open the first adolescent inpatient unit in NWL (previously all children were sent all around the country for admission) and significantly increased urgent care provision in the NWL sector, which has significantly reduced the number of children requiring admission to hospital.

9. The Board may wish to note that there are a number of factors are likely to make the coming winter more challenging and these include:

- *High occupancy levels in the care home market*: Occupancy levels within the local care home market are consistently sitting at around 93%. A reluctance on the part of providers to accept placements of people with more complex needs is a trend in Hillingdon that is being reflected across NWL. Recruitment and retention of staff, particularly in respect of nurses, is an important factor contributing to this trend.
- *Block contracts mobilisation:* A competitive tender to secure a combination of nursing and residential care beds primarily to support hospital discharge for the next four years resulted in an award of contract for the nursing beds but not the residential. Mobilising the nursing beds has proved challenging due to issues with availability and these are expected to come on stream incrementally. The residential care beds have been sourced from a local provider. However, the high levels of occupancy within the care home market mentioned above means that the scope to move people on to permanent placements where necessary to meet long-term care needs could prove challenging.
- *Hospital discharge funding arrangements*: The national decision to discontinue funding discharge to assess (D2A) has resulted in all local authorities within North West London withdrawing support for the D2A model. As a consequence, assessments under the Care Act to determine whether a person will be required to make a financial contribution to meeting their assessed care needs have now been reinstated in a hospital setting.

10. Details of allocation arrangements to Hillingdon from the £500m national Adult Social Care Hospital Discharge Grant announced by the Secretary of State for Health and Social Care on 22 September 2022 is awaited. The funding allocation was announced on 17 November 2022. Hillingdon has been allocated £867.5k and the NWL ICS has been allocated £8,910k. The Board will be advised of the grant conditions if published by the time of its meeting.

B. Workstream Highlights and Key Performance Indicator Updates

11. This section provides the Board with progress updates for the six workstreams, where there have been developments.

12. This section also provides updates on those of the five enabling workstreams where there has been progress since the report to the September 2022 Board meeting.

Workstream 1: Neighbourhood Based Proactive Care

Workstream Highlights

13. **Population health management:** This is addressed in a separate report on the Board's agenda (Public Health update).

14. **Health checks for people with learning disabilities and health action plans**: As of 31 October 2022, Hillingdon has completed 41% of the health checks for the people with learning disabilities on GP registers. This is a significant improvement compared to last year when Hillingdon was at 24% at the end of Q2. The national annual target is 75%. 40% of people with learning disabilities on GP registers also had an up-to-date health action plan. The national annual target is also 75%.

Health Action Plans Explained

A health action plan identifies a person's health needs, what will happen about them (including what the person needs to do themselves), who will help and when this will be reviewed.

15. **Health checks for people with severe mental illness (SMI) and people with diabetes:** Data integrity issues related to coding on the GP patient database system (EMIS) means that it is not possible to update the Board on delivery of health checks to people living with these conditions at this stage.

16. **Community development:** The Board may recall from its September meeting that six engagement roadshows were held earlier in the year with each roadshow designed to have a specific health focus based on a priority need with a particular PCN. Following success of these roadshows, system partners have come together to plan another round of roadshows later this year. The dates and venues are currently being finalised, but the first roadshow took place on 10 November 2022 for Hayes and Harlington Collaborative PCN. The roadshows will focus on winter wellness and cost of living crisis which will cover both health and social issues. Each roadshow will have a broad range of information for residents, including stands from:

- Housing and accommodation services;
- Citizens Advice;
- Foodbank;
- Community Pharmacists; and
- Cove Café.

17. The recruitment of community champions continues with currently 58 who are aligned to Neighbourhood Teams to help engage the local community in key priority areas specific to that neighbourhood. Their activities include sharing key health messaging and attending outreach events such as the recent roadshows. The focus of the community champions in Q3 and 4 will be supporting the H4All Wellbeing Service to manage increased demand over the winter period.

About Community Champions

Community champions are volunteers who work with existing networks to identify barriers to accessing accurate information and to provide tailored support, such as phone calls for people who are digitally excluded, helplines, and linking to GP surgeries.

Vaccinations: Phase 5 of the national covid booster programme started on the 5th September. There are 13 pharmacies in the borough and a roving team is delivering jabs in care homes and to residents who are unable to leave their homes due to infirmity. The first care home residents received with their covid booster on the 6th September.

18. **Vaccination programme:** With over 50,000 flu and 54,000 Covid booster immunisations given to date to the priority population groups, Hillingdon is in the top two boroughs of NWL in terms of performance and coverage.

19. **Primary Care in Partnership Programme:** Colne Union PCN have been selected to be part of a NWL programme called Primary Care in Partnership. The programme is led by an organisation called Co-Create who will work with pilot PCNs across the eight boroughs in NWL to support good engagement with residents in their neighbourhood.

Key Performance Indicators

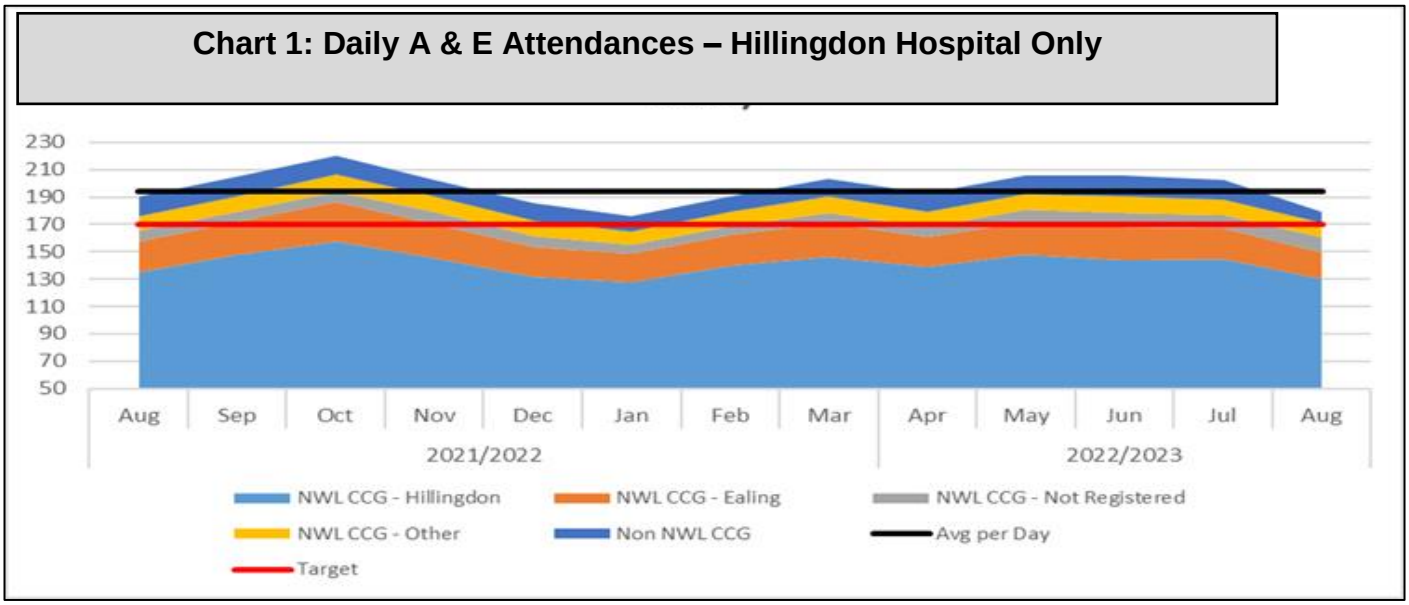
20. ***Admission avoidance:*** This BCF metric is intended to measure a reduction in adults admitted to hospital for ambulatory care sensitive conditions. The conditions within the scope of this metric include acute bronchitis, angina, heart disease, heart failure, dementia, emphysema, epilepsy, high blood pressure, diabetes, chronic obstructive pulmonary disease (COPD) and fluid on the lungs (pulmonary oedema). The ceiling for 2022/23 is 874 admissions per 100,000 18 plus population and the Q1 and Q2 ceiling was 439 admissions. Performance data against this metric is published nationally and this is not currently available.

Workstream 2: Urgent and Emergency Care

Workstream Highlights

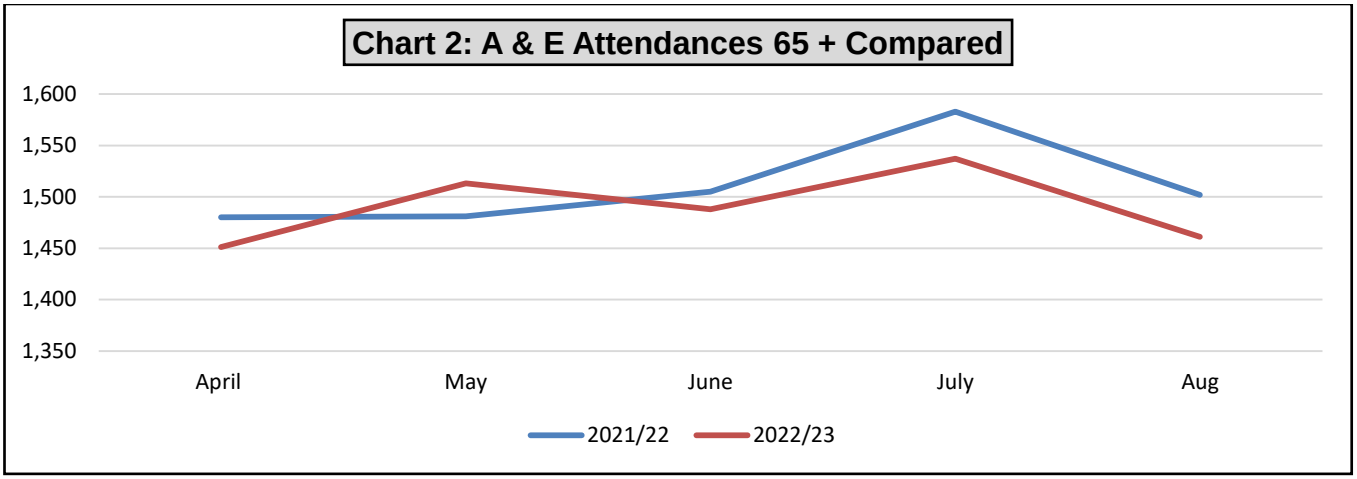
21. **A & E Attendances:** An average of 194 people per day have been attending Hillingdon Hospital in the period between April and August 2022. This is the same as the 2021/22 average. The Board may wish to note that nearly 73% of attendees were people with Hillingdon-based GPs; 12% were registered with Ealing-based GPs and the rest from a range of areas or not registered. This illustrated in chart 1 below.

Chart 1: Daily A & E Attendances – Hillingdon Hospital Only



Source: NWL BI

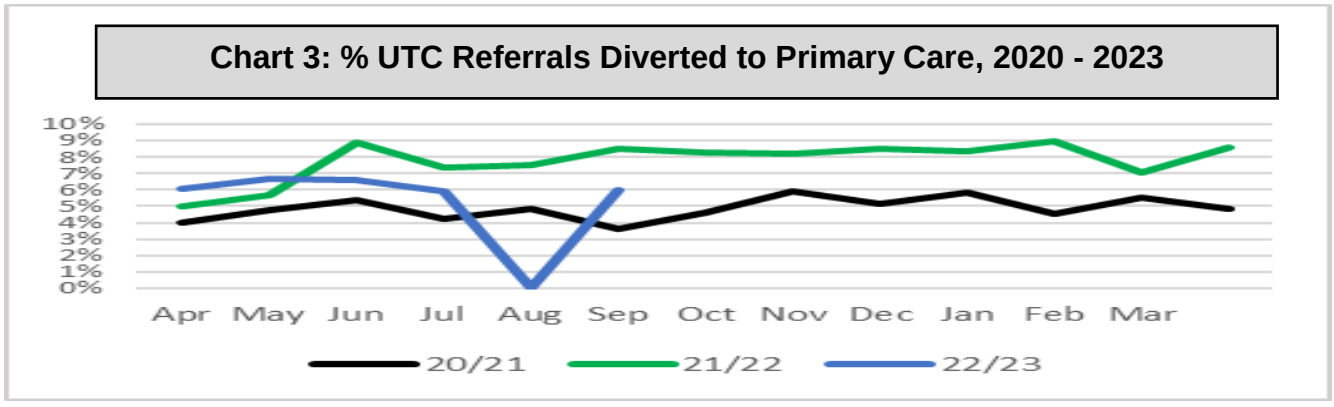
22. Chart 2 below shows a marginal reduction in the number of people aged 65 and above attending A&E between April and August 2022 compared to the same period in 2021/22.



23. **Emergency Admissions:** The total number of admissions during the April to August 2022 period, i.e., 10,946, was lower than the same period in 2021/22 by 417. The same period also saw a small reduction in the number of people aged 65 and above compared with 2021/22, i.e., 4,360 against 4,686.

24. **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 cyber-attack in Q2 means that UTC activity data is not available.

25. A key objective of the service is to redirect people to primary care who do not need treatment at the Hospital. Although there is no data for August due to a cyber-attack at the Hospital, the average redirection rate for 2022/23 is 6.6%, which compares to 8.6% in 2021/22. This suggests a higher proportion of attendances that were appropriate during the review period. Chart 3 below shows the percentage of UTC referrals diverted to primary care compared with the last two financial years.



26. For the Board's information, the ICB is currently undertaking a sector-wide procurement for UTC provision and the successful tenderer will be known in the New Year.

27. **Primary Care Surge Hub:** The Primary Care Surge Hub is managed by the GP Confederation to see same day emergency primary care patients with the intention of reducing pressure on the UTC and NHS 111. The service is based at Mead House in Hayes and

operates Monday – Friday, 10am to 8pm. The UTC is able to redirect people to the service as consultations are face to face. When it started, the service was virtual but face-to-face consultations started. Utilisation for the April to September 2022 period is 82% of capacity, which means there is scope for further referrals.

28. **Same Day Emergency Care Unit (SDEC):** The Board is reminded that this unit provides same-day assessment and treatment of people 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 of the service is to increase direct referrals from the GPs and therefore reduce unnecessary attendances at the UTC and the Hospital's Emergency Department.

29. There is work being undertaken to increase GP referrals and reduce unnecessary follow ups in the Ambulatory Emergency Care Unit (AECU) as well as to reduce number of patients attending the Surgical Assessment Unit. This work will lead to a business case being developed for consideration by the Hospital.

30. **Improving Length of Stay (LoS):** The programme of work previously reported that focuses on discharge across Hillingdon Hospital to deliver improvements to contribute to meeting targets that are shown below continues. As part of the work to develop a community step down provision based on Imperial College Hospital Trust's Specialist Neuro Rehab Outreach Service (SNROS), workshops have taken place to define the model for Hillingdon. A business case was developed for funding for a wellbeing officer post with H4All to support the patient and their family with coordinating care and support in advance of the SNROS being established.

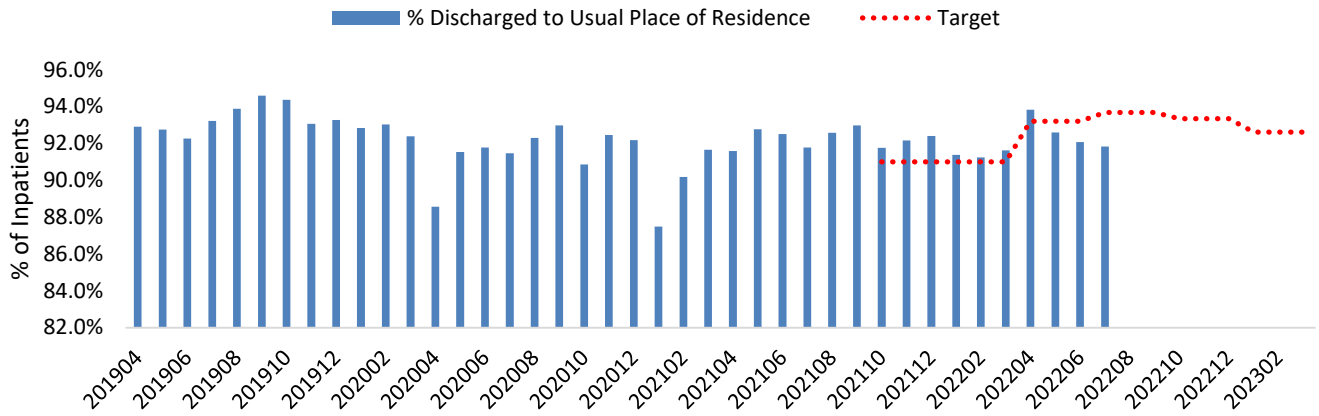
Key Performance Indicators

31. 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 85%, i.e., 47 bed capacity at the start of each day. *Slippage*: The average occupancy rate for the April to September 2022 period was 92%.

- ***Discharged to usual place of residence:*** This BCF metric is intended to measure improvements in the proportion of people discharged from hospital to their own home. The 2022/23 is average of 93.2% of people aged 18 and above admitted, i.e., estimated 19,930, discharged to their usual place of residence. *Slippage:* Chart 4 below shows that for the April to July 2022 period, which is the most recent period for which data is available, performance was slightly below the target.

Chart 4: Hillingdon Inpatients Discharged to Usual Place or Residence Apr 2019 - July 2022



- ***Length of stay:*** Table 1 below shows the length of stay targets in respect of people admitted to Hillingdon Hospital and the Q1 performance. The Board may wish to note that Hillingdon's performance for most length of stay categories, including timeliness of discharge for palliative care patients, is among the best in NWL. Hillingdon also has a successful track record of joint working between health and social care to find responsive solutions to patients' discharge needs that entails close working with families and carers.

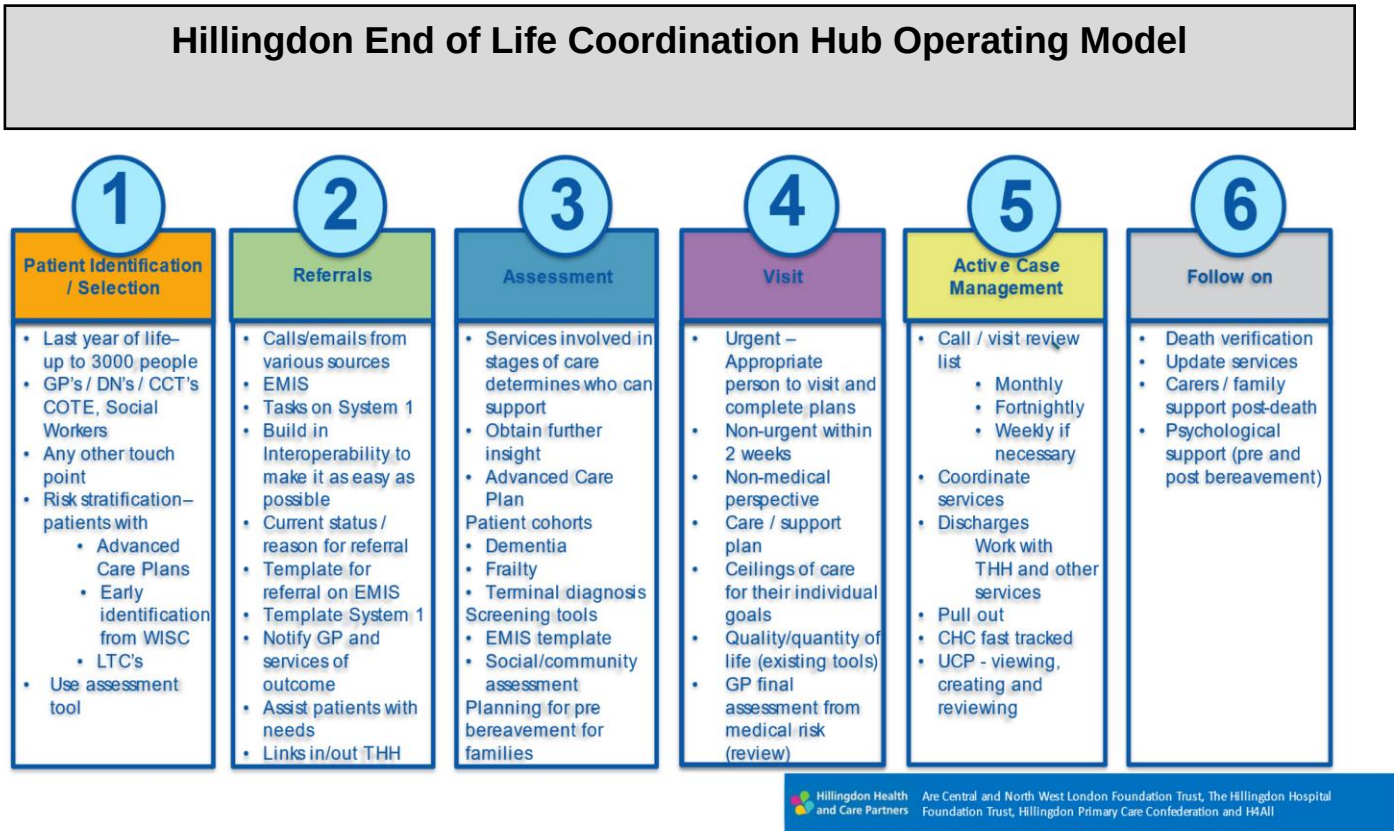
Table 1: Hillingdon Hospital Length of Stay Targets 2022/23		
Descriptor	**Target (No of People/patients)**	**Q2 Average**
• > 7 days	117	145
• 7 – 13 days	53	64
• 14 – 21 days	25	31
• 21 – 49 days	33	40
• 50 + days	10	10

- ***Effectiveness of reablement:*** This long-standing BCF metric is a measure from the Adult Social Care Outcomes Framework (ASCOF). It 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. The national sample for this metric is people entering reablement following discharge in Q3. The target is for 90.5% to still be at home at the end of March 2023. It will not be possible to report on the outturn for this metric until the end of year report to the Board in June 2023.

Workstream 3: End of Life Care

Workstream Highlights

32. **Coordination Hub:** It has been agreed by partners that Harlington Hospice will deliver the hub as a single point of coordination and link in with the Hospital's Emergency Department and Care of the Elderly Team (COTE), community services and care homes. The draft operating model for the hub is shown below and this will be implemented incrementally over the next year.

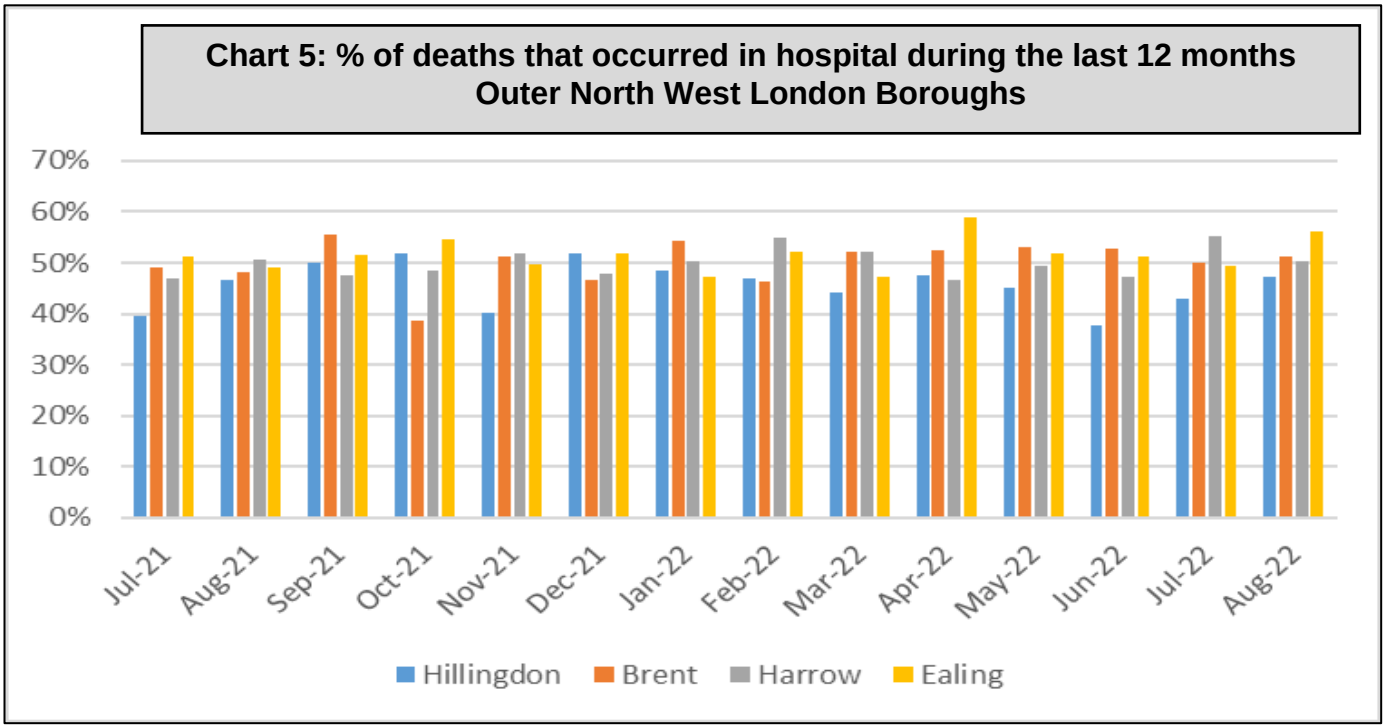


33. **Compassionate Hillingdon:** '*Compassionate Neighbours'* is a social movement that enables local people to provide support to people in their communities who are at the end of their life due to age or illness. The '*Compassionate Hillingdon'* version includes access to free care provision and 128 people are currently being supported by this service. Options for securing longer term funding for this initiative are currently being explored by HHCP.

34. Plans are being developed that will make Compassionate Hillingdon an anchor programme, i.e., a place-based programme that delivers projects that support people to stay independent for longer and to reduce or delay dependence on care services. The project will link closely with the End-of-life Coordination Hub. To achieve this, H4All and Carers Trust Hillingdon have allocated non-recurrent funding to create a '*Compassionate Hillingdon Carers Development Officer'* post. This will link unpaid carers of people at end of life to the support available in their communities.

Performance Update

35. Chart 5 below shows that Hillingdon had the lowest percentage of deaths occurring in hospital over the twelve month period to August 2022 out of the four Outer North West London boroughs.



36. Tables 2 and 3 below show the percentage of people with 3+ emergency admissions in last year of life and the average length of stay in hospital for people admitted as an emergency in the 90-day period prior to their deaths. The aim would be to have the necessary services in place to support people within the community, although this would be subject to their wishes.

Table 2: % of people with 3+ emergency admissions in last year of life

Borough	2019/20	2020/21	2021/22	2022/23 (Apr-Aug)
Brent	15%	9%	14%	7%
Central London	18%	10%	17%	10%
Ealing	17%	12%	22%	9%
Hammersmith & Fulham	18%	10%	16%	8%
Harrow	13%	12%	20%	10%
Hillingdon	14%	13%	15%	10%
Hounslow	15%	13%	18%	8%
West London	15%	11%	8%	8%
NWL Average	**15%**	**11%**	**17%**	**8.75%**

Source: NWL BI EoL Dashboard

Table 3: Average number of bed days 90 days prior to death (Emergency admissions)

Borough	2019/20	2020/21	2021/22	2022/23 (Apr-Aug)
Brent	19.12	14.49	15.76	16
Central London	17.81	14.18	17.76	18
Ealing	18.94	14.41	14.44	17
Hammersmith & Fulham	18.20	16.34	19.43	19
Harrow	17.54	15.39	16.46	18
Hillingdon	18.12	14.27	15.06	17

Table 3: Average number of bed days 90 days prior to death (Emergency admissions)				
Borough	**2019/20**	**2020/21**	**2021/22**	**2022/23 (Apr-Aug)**
Hounslow	18.09	14.71	15.85	18
West London	17.83	15.67	14.59	16
NWL Average	**18.30**	**14.79**	**15.80**	**17.37**

Source: NWL BI EoL Dashboard

Workstream 4: Planned Care

Workstream Highlights

37. **Pathway redesign:** Priority is being given to gynaecology, gastroenterology, musculoskeletal (MSK) and ophthalmology to determine what activity can take place in the community rather than in hospital. Key updates since the September 2022 Board meeting include:

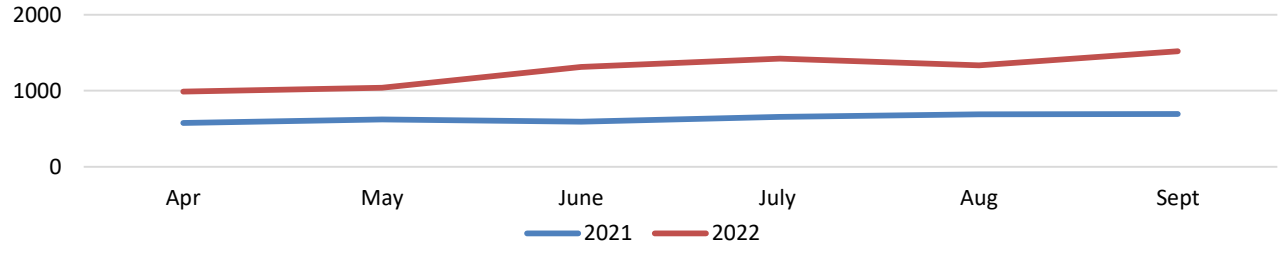
- *Gynaecology*: Five gynae clinics have been established, two of which are nurse-led pessary clinics. A new clinic structure has also been agreed resulting in three of them offering two GP-led sessions, two nurse-led sessions and one pelvic ultrasound session per month.
- *MSK*: A contract has been established with a company called Healthshare Limited to address backlogs arising from the pandemic. Both the Hospital and CNWL have transferred cases to this service.

38. **Integrated advice and guidance hub**: The Board is reminded that the Advice and Guidance (A&G) service went live across Hillingdon GP practices, THH, community and primary care providers in July 2020 with the intention of enabling consultants to triage requests from primary care to ensure that patients who required an outpatient appointment were prioritised. The average monthly A&G request since July 2020 has been 3,568 and the period from June to September 2022 saw an average of 3,612. Data suggests that the service is being effective in reducing unnecessary referrals to the hospital and that it has resulted in 11,441 referrals not requiring a hospital consultant appointment being avoided within the twelve-month period to September 2022.

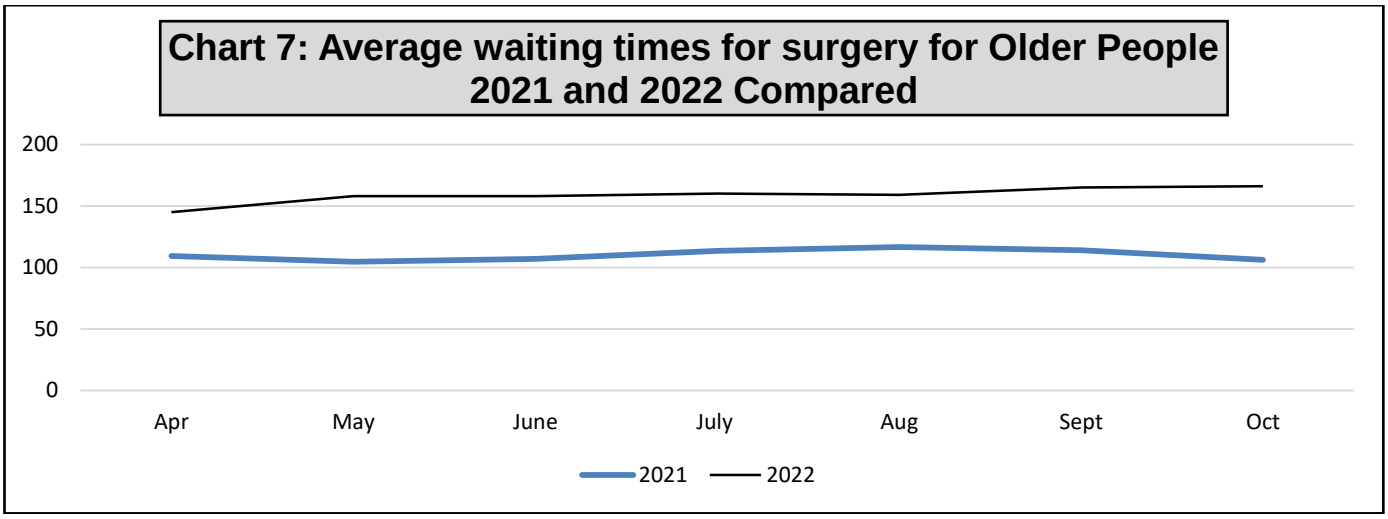
Performance Update

39. **No. of patients waiting 52 weeks or more for surgery:** Chart 6 below shows the numbers waiting 52 weeks or more for surgery have increased by approximately 500 people during the review period. Covid legacy backlogs are a significant contributor to the 2022 position compared with 2021. Actions to address this include, as referred to in paragraph 37 above, contracts with independent sector providers to secure additional capacity.

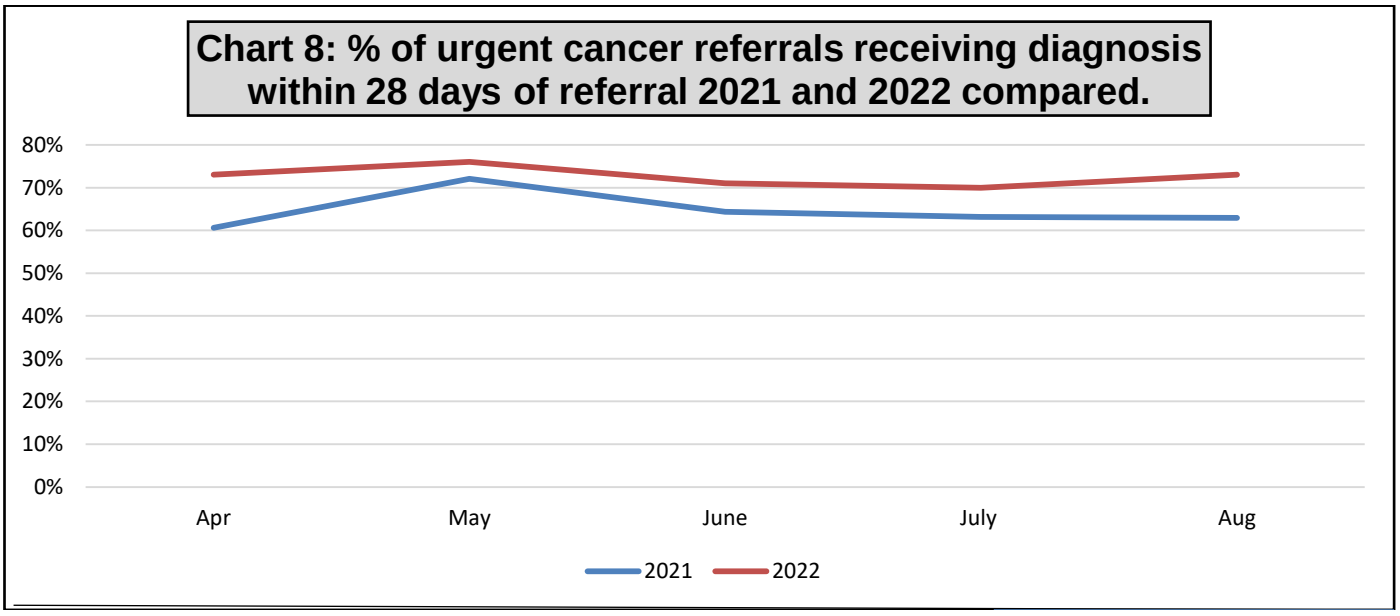
Chart 6: No of patients waiting 52 weeks or more for surgery 2021 and 2022 compared



40. **Average waiting times in weeks for surgery for Older People:** Chart 7 below shows that the average waiting for surgery for older people has increased from 145 weeks in April 2022 to 166 weeks in October. As stated in paragraph 37 above, work is in progress to address the backlogs; however, the position in Hillingdon reflects national challenges in the wake of the two-year pandemic.



41. **% of urgent cancer referrals receiving diagnosis within 28 days:** Chart 8 below demonstrates improved performance during 2022/23 over the April to August period in 2021/22.

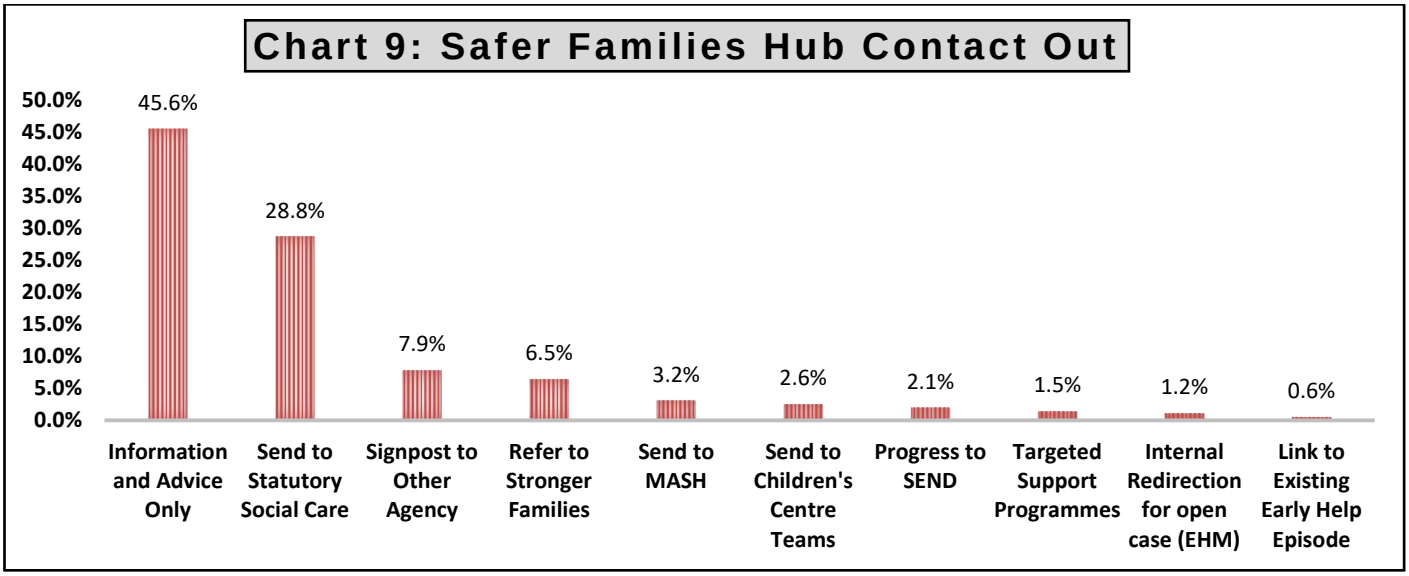


Workstream 5: Children and Young People (CYP)

Workstream Highlights

42. **Stronger Families Hub (SFH):** The hub was established in August 2021 and, in the 12 months to 31 October 2022, there were 22,723 requests for assistance, of which 9,857 (43%) came via the portal, and 1,494 families were referred to the Stronger Families Locality Team for support.

43. The SFH acts as the decision maker to ensure children access the right service at the right time and its ethos promotes targeted support and the timely provision of the most appropriate support service. The main referral routes into the hub are via email (48.2%), the Safer Families Portal (43.4%) and telephone (8.3%). Chart 9 below summarises the outcomes of the referrals in the 12-month period to 31 October 2022.



Key: *MASH* – Multi-agency Safeguarding Hub; *SEND* – Special Educational Needs and Disabilities; *EHM* – Early Help Module.

44. **Autism pathway:** Pre-diagnosis Autistic Spectrum Disorders (ASD) support pathways including navigation guides now completed and shared. Promotion push including of Triple P on-line programmes underway. TPOL info now included on Local Offer website. Referrals starting to trickle in.

45. Planning for next New Supporting Autism courses (delivered in conjunction with Hillingdon Autistic care and Support (HACS) for children aged 6-11 years underway. Aiming to run 3 courses from mid Jan to May 2023. Awaiting outcome of funding bid for Arts for Life Doodle Den.

46. **PATCH:** The Providing Assessment and Treatment of Children at Home (PATCH) service, was established in June 2021 to provide care to children and young people at home once discharged from hospital. Demand continues to increase with high numbers of infants (<1 year) with respiratory illnesses, e.g., bronchiolitis, being referred and managed at home. During the review period, 538 children were seen by the service and 39% (211) were aged <1 year. 78% of PATCH referrals were from A&E, 19% from the ward and 3% from the Paediatric Assessment Unit.

47. A fourth staff member will be starting early in November, and this will facilitate provision of a seven-day service. The Board may also wish to note that the team were awarded The Hillingdon Hospitals Board chair's special *'I am the change award'* at a ceremony in October 2022 in recognition of their achievement in implementing the new service.

48. **16-25 young adult mental health and wellbeing:** This is addressed by a separate item on the Board's agenda.

49. **Holiday Activities and Food Programme (HAF):** This is a national initiative funded by the Department for Education and managed by Hillingdon Council locally. Eligible children from

reception (aged 4/5 years) to school year 11 (aged 16), and up to age 18 years with SEND (special educational needs or disabilities), that are in receipt of benefits-related free school meals can access free holiday provision during the Summer. The purpose of HAF is for children and young people who attend provision to:

- eat more healthily over the school holidays
- be more active during the school holidays
- take part in engaging and enriching activities which support the development of resilience, character, and wellbeing along with their wider educational attainment
- be safe and not to be socially isolated
- have a greater knowledge of health and nutrition
- be more engaged with school and other local services

50. The HAF programme was delivered from 25 July to 2 September 2022. During this time, 27 providers were commissioned to deliver a total of 5,250 places on programmes, a total of 22,195 sessional places for children over the 6-week period and a total of 1,460 children benefitted.

51. **Adolescent Development Services' Emotional Health and Wellbeing Team (LINK):** During the review period additional funding provided by CNWL has enabled the team to recruit three additional counsellors under fixed-term contracts. This will enable the team to see 24 children and young people who would otherwise have faced longer waits to be seen. By 30 September, 3 additional young people had been seen and plans put in place to see a further 7.

52. Specialist autism training was also delivered during the review period to 16 members of staff to enhance their skills in supporting autistic children and young people.

Key Performance Indicators

53. The following is an update on workstream 5 indicators:

- **Education, Health and Care Plan (EHCP) Assessments**: The target for completion of assessments following referral is 20 weeks. In Q2 2022/23, 33.9% of assessments were completed within 20 weeks compared to 66% for Q4 of 2021/22 and 95.2% in Q2 2021/22. The reduction in performance is attributable to staff vacancies.

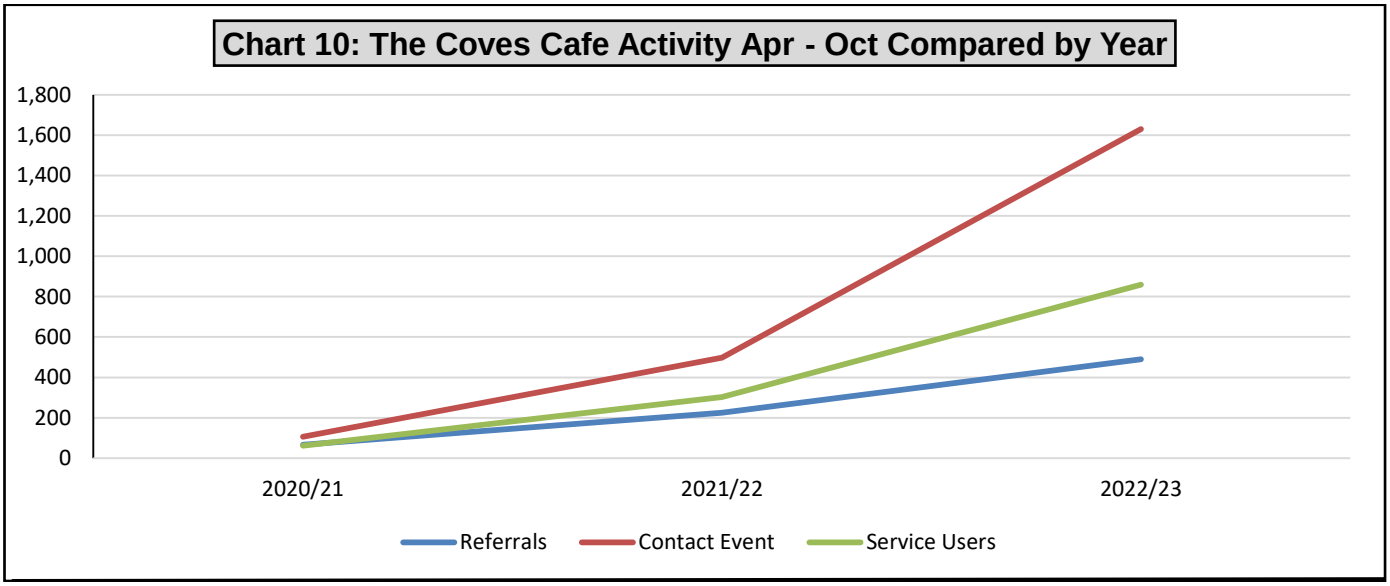
Workstream 6: Mental Health, Learning Disability and Autism

Workstream Highlights

54. **One stop shop:** The One Stop Shop (OSS) is intended to be a collaboration of partners including CNWL, the Council, GP Confederation, and third sector to provide a location-based alternative to traditional routes into mental health services. The service would operate 7 days a week, and provide walk in, appointment and virtual offers. However, progressing the project further is subject to the identification of suitable premises and discussions between partners to resolve this matter continue. The potential of a Wellbeing Bus is being scoped by partners which would potentially allow greater access to a range of services for residents across the Borough.

55. **Hillingdon Cove Café:** Chart 10 below shows that referrals to the café and the numbers of people supported by it have increased significantly during the April to October period between 2020/21 and 2022/23. The number of contact events, i.e., telephone support and face to face meetings, has risen most significantly since April 2021.

56. As a result of feedback about the location of the Cove Café from services users, partners (including Hestia, the service provider) are currently exploring alternative accommodation options.



57. **Crisis recovery house:** The progress with the development of the crisis house is addressed in a separate item on the Board's agenda.

58. **Community hub model:** The Community Hubs will be aligned to Hillingdon's six Primary Care Networks (PCNs) and will provide access to a range of mental health specialists, such as GPs, nurses, therapists, social workers, pharmacists and employment support and navigators, all of which will work together to help people on their journey to recovery by providing interventions-based care. Staff consultation has launched, and data migration is in progress. The aim is that the hubs will go live in February 2023.

59. **High Intensity User Mental Health Service:** A one year pilot has been established with H4All, which builds on the success of their existing service for people with physical needs. Implementation has been delayed as it has been necessary for H4All to go back out to recruitment.

60. **Memory Service update:** The Hospital and CNWL have jointly funded a consultant physician who focuses on people who present at the Hospital with cognitive impairment in the context of complex physical health needs. This is developing better links between the Hospital's Care of the Elderly Team and the Memory Service and leading to much smoother pathways between the services when needed. It is hoped that this will contribute to reducing referral to diagnosis times and increasing diagnosis rates.

61. **Older people community framework update**: Discussions are in progress with Primary Care about the alignment of the Older People Mental Health Community Team (OPMHCT) with the six PCNs. This is not straightforward as the OPMHCT is a small team; however, partners will continue to explore this, including looking at models employed in other parts of London and elsewhere in the UK.

62. **Additional Roles Reimbursement Scheme (ARRS) Mental Health post**s: Funding was made available via the DHSC for six mental health posts in primary care to link in with Community Mental Health Teams (CMHTs) to support integrated care through involvement in

multi-disciplinary team (MDT) meeting discussions when needed. These posts have now all been filled, and people are in place. There is an issue with ensuring consistent practice about how these roles are used across the six PCNs and the GP mental health lead is working with PCN clinical directors to address this.

Additional Roles Reimbursement Scheme

ARRS was introduced in England in 2019 as a key part of the Government's manifesto commitment to improve access to general practice. The aim of the scheme was to support the recruitment of 26,000 additional staff into general practice through the provision of additional funding. In addition to mental health practitioners, the range of additional roles covered by the scheme includes:

- Care co-ordinators
- Clinical pharmacists
- social prescribing link workers
- pharmacy technicians
- dieticians
- first-contact physiotherapists
- health and wellbeing coaches
- nursing associates and trainee nursing associates
- occupational therapists
- paramedics
- physician associates
- podiatrists.

Enabling Workstreams

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

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

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

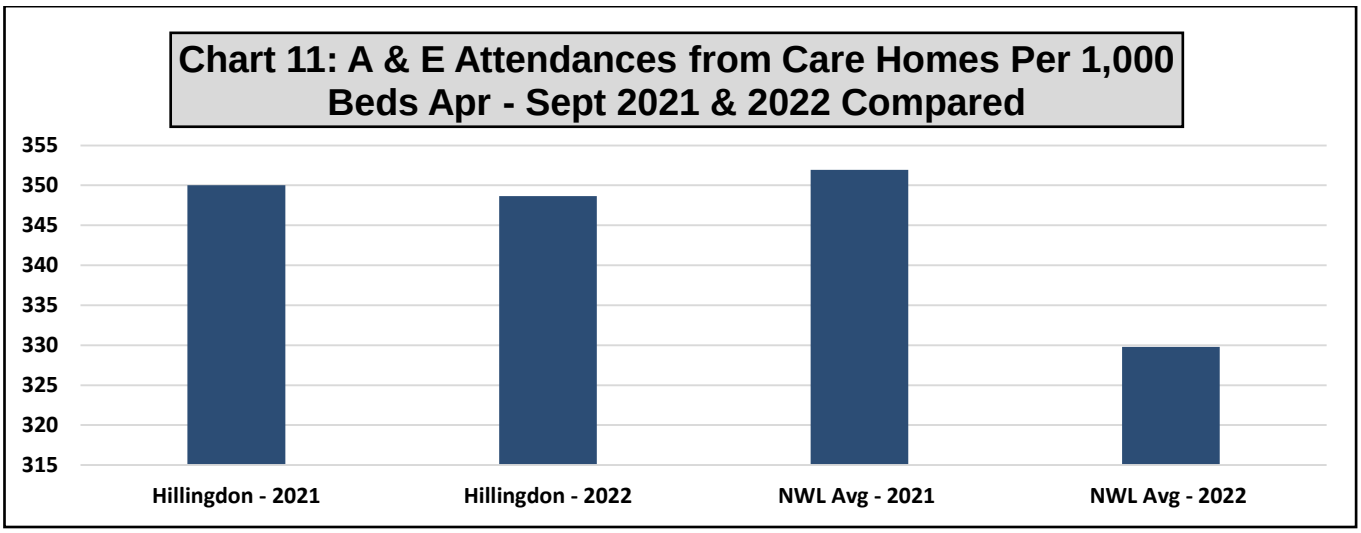
65. **Enabler 2: Care Market Management and Development:** The Council is also the lead organisation for this enabling workstream, the primary objectives of which are to support the sustainability of the market as it emerges from the pandemic and to integrate commissioning arrangements where this will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

Workstream Highlights

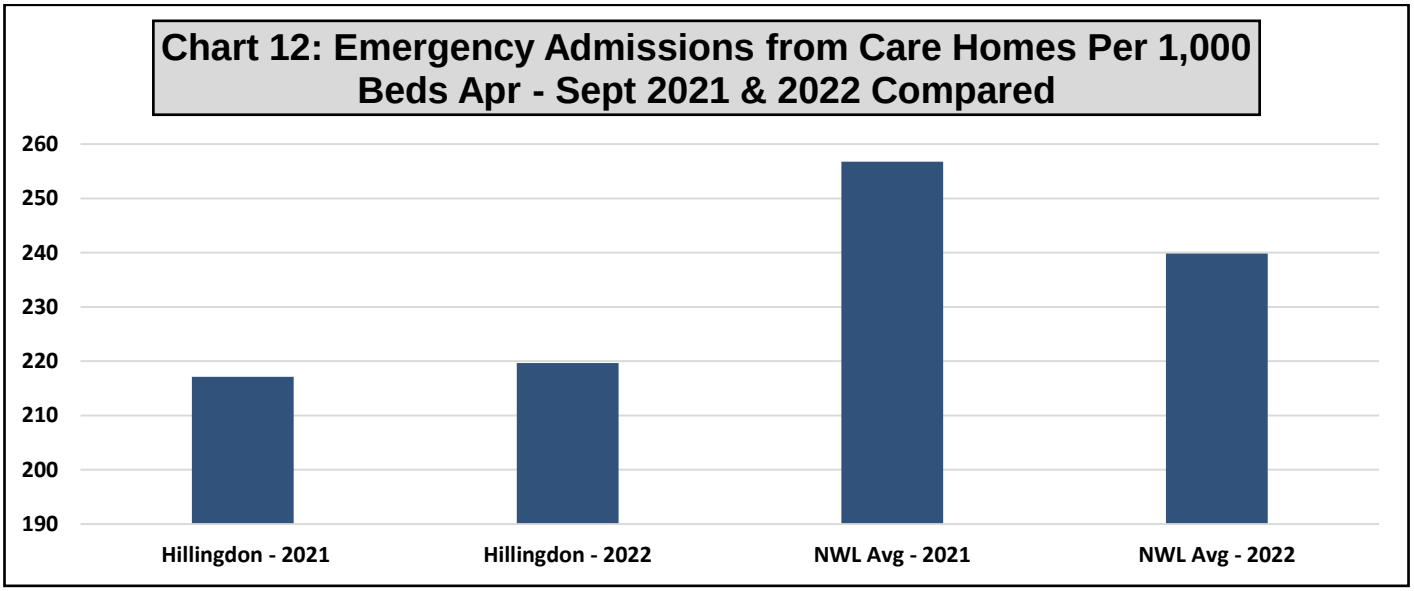
66. **Care homes:** The Board is reminded that Hillingdon has 44 care homes with a total of 1,364 beds and 89% (1,215) of these are supporting older people. This means that Hillingdon has the second highest number of care home beds in North West London after Ealing (1,560).

67. Charts 11 and 12 below give the Board context for Hillingdon's position in respect of A&E attendances and admissions from care homes in comparison with other NWL boroughs. Chart 10 shows that A&E attendances was marginally below that of 2021 during the April to September period but above the average for NWL. The explanation for this requires further

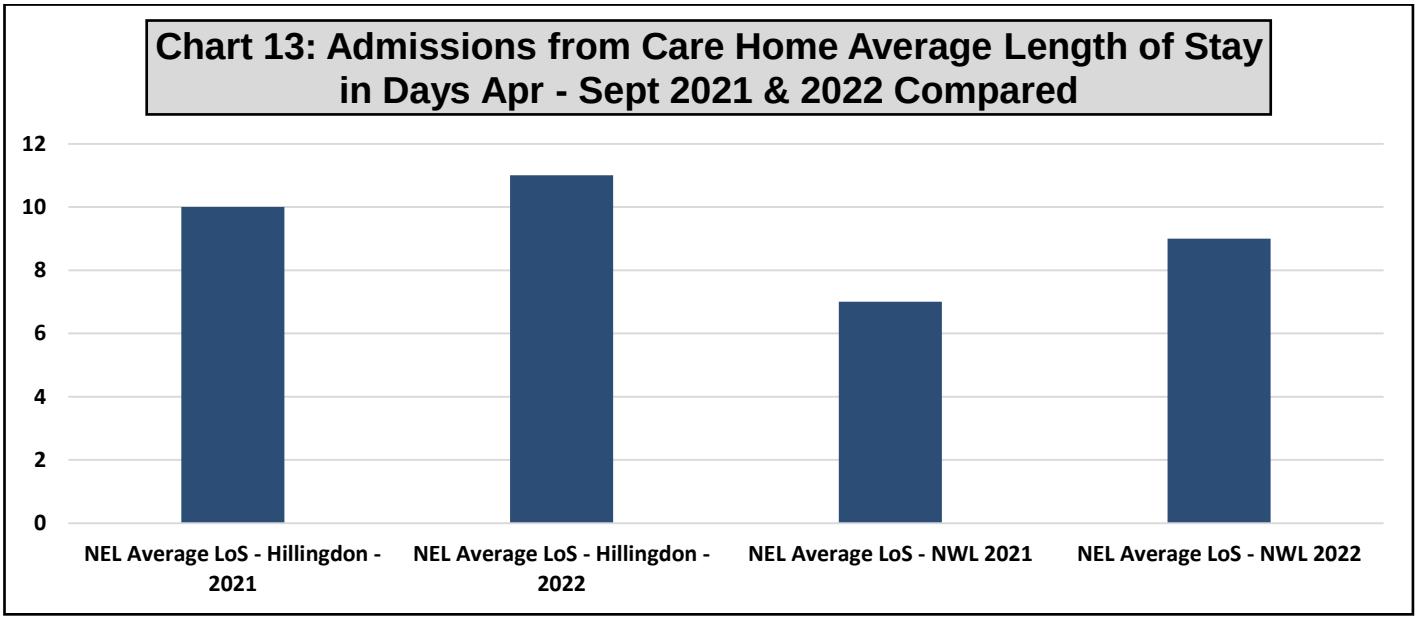
analysis.



68. Chart 12 shows that emergency admissions from care homes for the April to September period was slightly above the same period in 2021 but below the NWL average. Chart 13 shows that the average length of stay in hospital of residents from Hillingdon's care homes during the April to September period was 11 days, which compares to a NWL average of 9 days. This suggests that admissions were appropriate. A shorter length of stay would indicate that individual needs could have been addressed within a care home setting.



69. As previously reported to the Board, one of the main causes of London Ambulance Service (LAS) attendances at care homes and subsequent conveyances and admissions to hospital continues to be falls related injuries. Hillingdon Health and Care Partners continue to provide support to care homes in the prevention of falls and management of people susceptible to them.



70. The Board may be interested to note that demand from Hillingdon's care homes on the NHS 111*6 service during the April to September 2022 period was the second highest out of all NWL boroughs. The NHS 111*6 service was established by NHS England to enable care homes to obtain clinical advice and support with the intention of preventing avoidable attendances at A&E and unnecessary demand on the LAS. Utilisation shows that communication to care homes about the availability of the service has been successful.

Finance

71. There are no direct financial implications from this report.

BACKGROUND PAPERS

Joint Health and Wellbeing Strategy, 2022 – 2025
Hillingdon Winter Plan, 2022/23

MENTAL HEALTH CRISIS RECOVERY HOUSE UPDATE

Relevant Board Member(s)	Vanessa Odlin – Managing Director, Goodall Division
Organisation	Central and North West London NHS Foundation Trust
Report author	Jane Hainstock – North West London Integrated Care Board Pamela De La Fosse - Central and North West London NHS Foundation Trust
Papers with report	**Appendix 1** – Inclusion and exclusion criteria **Appendix 2** – Case Studies **Appendix 3** – Demographics: Enquiries and Guests **Appendix 4** – Guest Satisfaction

HEADLINE INFORMATION

Summary	This report is intended to provide the Board with an update on the delivery of the mental health crisis house during its first quarter of being operational.
Contribution to plans and strategies	The report contributes to the delivery of priority 5 of the 2022 – 2025 Joint Health and Wellbeing Strategy. Priority 5 is a commitment to '*Improving mental health services through prevention and self-management'.*
Financial Cost	The funding for the crisis house pilot was provided by CNWL.
Ward(s) affected	All

RECOMMENDATION

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

INFORMATION

Background

At the Board's meeting in September 2022, regular updates on the delivery of the mental health crisis house and outcomes was requested. This report provides the Board with activity and outcome information for the period between the opening of the crisis house in August to 30 September 2022. This is referred to in the report as the '*review period'*. Subject to the Board's approval, it is proposed that future updates will be included within the integrated performance report. However, it is also proposed that a separate evaluation report on the conclusions from the pilot will be brought to the Board in the autumn of 2023/24.

The mental health crisis recovery house is a key component of transformation of the adult mental health crisis pathway in Hillingdon and has been the subject of many discussions at the Board since 2018. Delivering the crisis house represents a collaboration between the Central and North West London NHS Foundation Trust (CNWL), the Council and North West London Integrated Care Board (NWL ICB). CNWL has provided the funding for a one year pilot and the Council has procured an independent sector provider with experience of delivering similar models in other local authorities in the South East. The provider, Comfort Care Services Limited (CCS) has sourced the premises, known as The Retreat, and is now part of the collaboration between CNWL, the Council and the NWL ICB to improve outcomes for people living with mental illness.

The intended outcomes of the pilot are to:

- Further understand service user experience in a time of crisis and the benefits of a short term stay within a non-clinical environment.
- Reduce 12-hour breaches in Emergency Departments.
- Reduce short stay admissions to inpatient services.
- Improve system understanding of the patient group who would most benefit from a stay in a crisis recovery house model.

The Retreat opened in a soft launch on 22 August 2022. The purpose of a "*soft launch*" was to calibrate the system, and to build the trust and understanding of the stakeholders, as well as potential residents of The Retreat (referred to as '*guests*'), their families, Mental Health teams and voluntary sector organisations about the model. The soft launch also enabled CCS and CNWL to develop shared care ways of working and align working practices, particularly with regards to risk management, and take input from the guests to adjust operations in response to their needs. The service was formally opened on 8 November 2022 by the Council's Cabinet Member for Health and Social Care.

A small project team led by the NWL ICB and CNWL has been responsible for the development and delivery of the crisis house pilot. In addition to NWL ICB and CNWL members, the project team includes representatives from the Council and CCS.

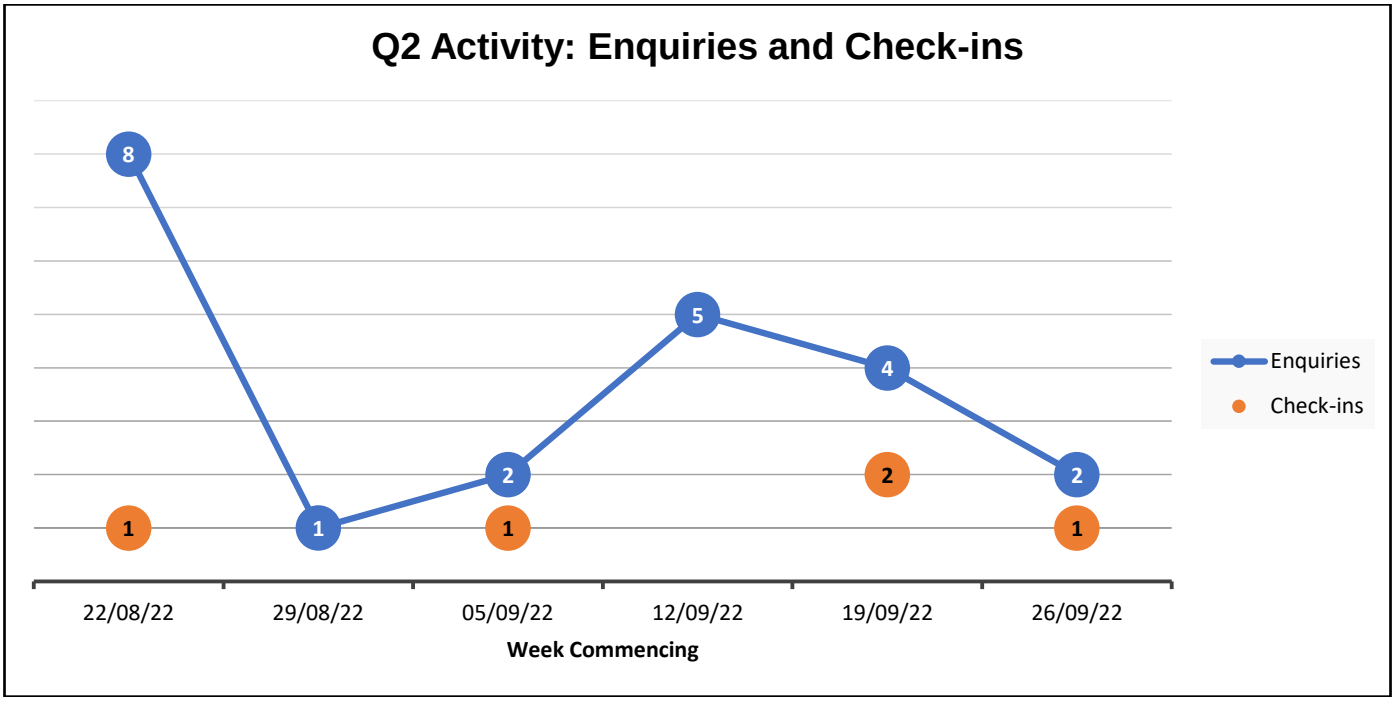
Service Activity

The Board is advised of the following definitions of terms used in this report:

- *Enquiry*: This refers to any informal discussion or identification of a service user who would potentially benefit from a referral to The Retreat.
- *Referral:* This means anyone for whom a formal referral form has been submitted to CCS for admission to The Retreat.

<u>Enquiries and Referrals</u>

There were 22 enquiries during the review period and the spread over this time is demonstrated below. The graph below also shows when guests were checked in to The Retreat.



Outcomes of Enquiries

Of the 22 enquiries:

- 6 were deemed unsuitable for referral to the Retreat based on exclusion criteria (level of risk).
- 6 service users were offered a referral but declined.
- 3 were deemed suitable for referral, however, the correct referral process was not followed (paperwork was not completed).
- 7 proceeded to referral stage.

Of the 7 referrals:

- 1 referral was declined by The Retreat due to level of risk.
- 1 referral was withdrawn due to deterioration of service user's mental state.
- 5 referrals were accepted for check-in to The Retreat.

On the initial launch day, a request was made by CNWL Bed Management Team to consider all service users currently awaiting an admission to inpatient services, of which only 1 of 8 was deemed suitable for the Retreat.

As the weeks progressed, and understanding of the criteria and model grew, there was an increase in the suitability of patient enquiries, which saw a corresponding increase in the number of guest check-ins.

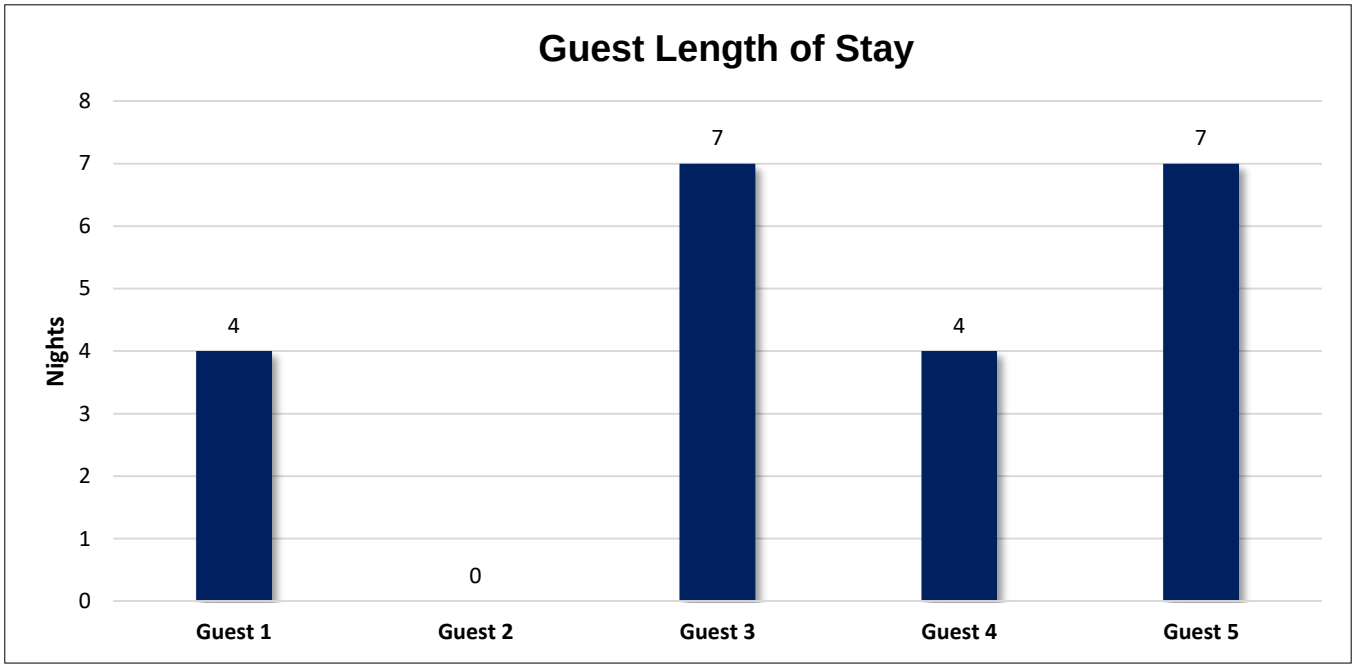
Case studies demonstrating the needs addressed by the service during the review period can be found in Appendix 2. Appendix 3 provides the demographics of the people subject to enquiries about the service and Appendix 4 reports on guest satisfaction.

Length of Stay

The average intended Length of Stay (LoS), as set out by the service specification, is 3-5 days. This can be extended to 8 days with the agreement of the Home Treatment Team (HTT) and the manager of The Retreat. A stay longer than 8 days requires the approval of the ICB

commissioner.

Of the 5 guests who checked in, 2 were within the average 3-5 LoS, and 2 were given extensions. 1 guest checked-in to The Retreat but refused to stay following a joint decision between the guest and his partner that he would prefer male only support. Subsequently, the staffing arrangements have been adjusted to have a male and female staff on shift.



Evaluation and Lessons Learned

Understanding of the Model

Prior to the soft launch on 22 August 2022, the project team held a series of engagement events and invited various stakeholders, including representatives from CNWL community mental health teams, Psychiatric Liaison Teams, LAS, Met Police, and voluntary sector services such as Hillingdon MIND and the Citizens Advice Bureau. These events were used to introduce The Retreat to different services and teams, as well as to set out the referral process and inclusion/exclusion criteria. The Project Lead and Project Support Manager also attended service specific business meetings with MIND, Adult Social Care, and service user groups.

There continue to be pressures on the acute service in terms of bed availability, and many of the patients identified for referral were awaiting informal admission to hospital and, in one instance, were a current inpatient pending discharge.

6 of 22 identified potential referrals were deemed unsuitable for The Retreat due to level of risk and presenting complaint, including risk of aggression, risk of self-harm and suicide, and risky behaviour. In order to reduce inappropriate referrals, a campaign of training has been implemented to improve referrers' understanding of The Retreat inclusion and exclusion criteria and risk management (please see Appendix 1).

In addition, a further 6 enquiries did not make it to referral stage due to the service user declining the Retreat. Patients and carers/relatives would benefit from further promotion and explanation of what the service is and has to offer prior to or at the point of referral.

A comprehensive communication package is currently in development by CCS and will be distributed to relevant stakeholders. Site visits and tours of The Retreat are available upon request to both teams and service users.

Referral Process

A number of elements of the referral process were identified as barriers to successfully referring service users to the Retreat. These included the length of the referral form and the potential to duplicate information already included within the biopsychosocial assessment and risk assessment. Additional concern was raised by The Retreat staff that the information provided in the referral forms was historic (risks, medication, incidents) rather than a current snapshot of the case, current and presenting circumstances, which made reviewing the referral and decision-making more difficult.

The referral form has subsequently been amended to require relevant and current information that will facilitate an acceptance decision weighted on current risks / crisis and less weighted on historic information, as well as shortened to make the completion process easier for referrers.

Early Intervention in Crisis

Of 22 enquiries in Q2, 17 service users were already known to or under secondary care mental health services. Consideration is being given to forward-planning and crisis-prevention, on the basis that people may benefit from an earlier referral into The Retreat rather than a referral at the height of crisis. Conversations are being held with referrers to identify individuals who may benefit from this approach.

Risk Management

It was identified that staff at The Retreat may benefit from further training on risk assessment, risk management and de-escalation to align their interpretation, understanding and practice of risk management with that practised by CNWL, thereby enabling The Retreat staff to accept and manage people with higher levels of risk. The Project Lead has reached out to the CNWL Education Team to consider which training availabilities may be suitable.

Finance

There are no direct financial implications of this report.

BACKGROUND PAPERS

Joint Health and Wellbeing Strategy, 2022-2025

Appendix 1 – inclusions and Exclusion Criteria

Inclusion Criteria

A person will be eligible for the service in the following circumstances:

- Individual is registered with a Hillingdon GP or a resident of Hillingdon
- Individual is over the age of 18.
- Individual is in distress or experiencing a mental health crisis.
- Individual is presenting as experiencing a mental health crisis and/or presenting with current risk that is deemed, on assessment, to be able to achieve resolution within 5 days.
- Has been accepted under the care of the Hillingdon Home Treatment Team (HTT).
- Can be safely supported in a Crisis Recovery House environment.
- Have identified achievable recovery goal for their time there.
- Have capacity to consent to a stay at the Crisis Recovery House, or if not, it is evident that a stay at the Crisis Recovery House would be in their best interests.
- Agree to a stay at the Crisis Recovery House and agree to work with HTT and Comfort Care Services staff to achieve the goals outlined in their Care Plan.
- Are willing to agree and adhere to the Crisis Recovery House rules.
- May pose a risk to self with regards to self-harm but agree to work with CCS and HTT staff to maintain their safety.

Exclusion Criteria

People will not be eligible for the service in the following circumstances:

- Young people under the age of 18 years.
- Adults with advanced dementia and cognitive impairment.
- Those who need to be detained under the Mental Health Act.
- Those under a Community Treatment Order service unless they are suitable to stay at the Crisis Recovery House on an informal basis.
- People who are of “no fixed abode” and have no address to return to. (Homelessness in itself is not an exclusion criterion but in order to preserve the operational integrity of the service admission will not be accepted if they do not have a clearly identified exit route for housing within 5 days of commencement of Crisis Recovery House stay.
- People who are not under the care of HTT.
- Those who are “*stepping down*” from inpatient wards.
- Service users who are not in agreement to working with staff to maintain their safety.
- Individuals whose physical condition is of greater urgency than mental health presenting symptoms and who are not medically optimised.
- Those with current or protracted homeless and social issues which cannot be resolved within 5 days of initiation of their Crisis Recovery House stay
- Individuals who cannot independently and safely manage their own personal care needs or who require high levels of care due to physical and mental health needs
- Those who require alcohol detoxification.
- Those who are actively using substances and are not willing to desist for the duration of a Crisis Recovery House stay.
- Individuals who have a current risk of violence or aggression, or which could not be safely contained within the homely environment of the Crisis Recovery House, this may include historical evidence of violence or aggression when unwell.
- Individuals who do not have capacity, or have wavering capacity, and it is not in their best interests to move them to the Crisis Recovery House for a short period.

Appendix 2 - Hillingdon Retreat Case Studies

Case Study 1

Guest 1 is a 28 year old male with a diagnosis of schizophrenia, under the care of the Early Intervention Service (EIS). He was referred to The Retreat after attending A&E, presenting with low mood and psychosocial stressors due to accommodation and difficult family dynamics. He lived at home with his mother and brother, the latter who was an active drug user and a detrimental influence on his mental health. He was offered a respite stay at the Retreat, initially 5 days, but was extended to 7.

During his stay at The Retreat, he engaged in therapeutic activities such as walks, engaged with staff in conversation which allowed him to share and lighten his emotional burden, and found great benefit in attending a local mosque daily. Staff aided him in arranging a meeting with an imam, and this proved to be a turning point for his mental state as he discovered great solace after this interaction. He was proactive in seeking support by The Retreat staff to complete his emergency housing application and to attend the local civic centre with assistance from his care co-ordinator. He was also supported to attend an induction for a new job and go to work. At the end of his stay, he moved into emergency accommodation out of borough, and remained under the care of EIS. He expressed great enthusiasm for the staff and his time at The Retreat.

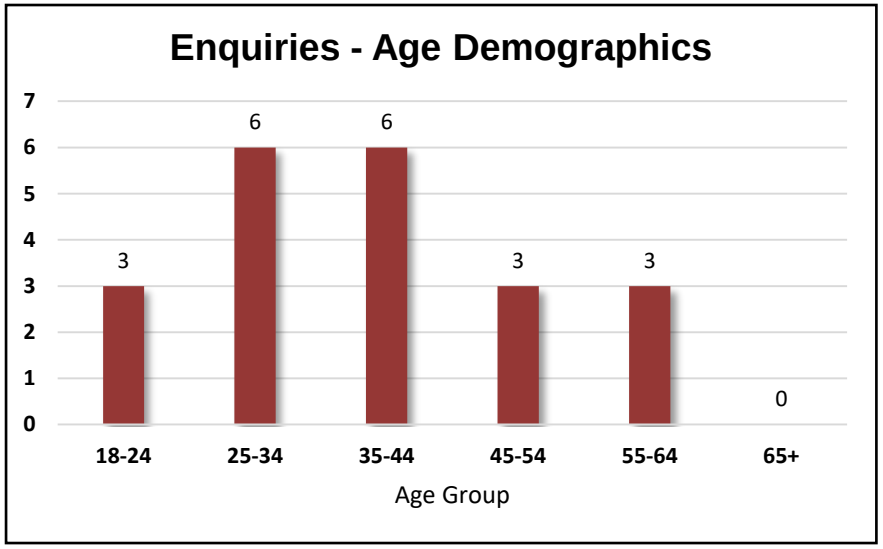
Case Study 2

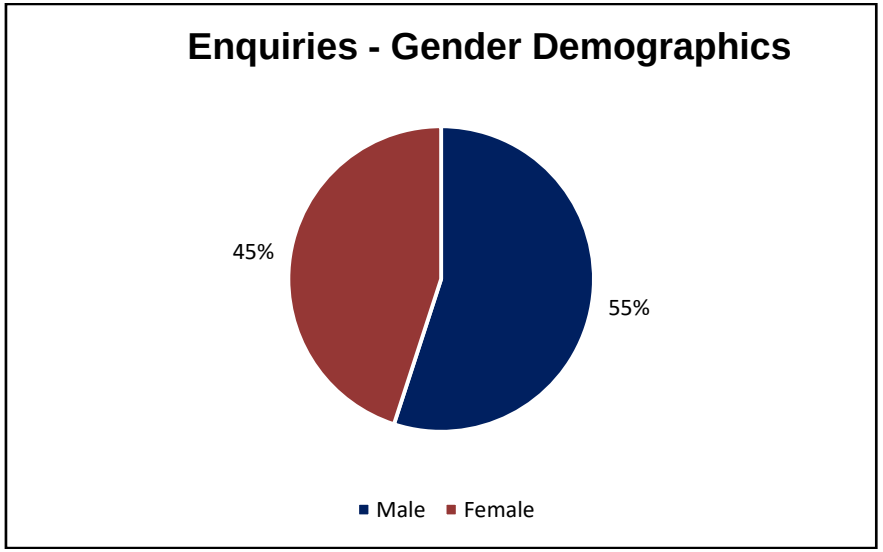
Guest 2 is a 36 year old male with a diagnosis of depression and HIV, and a history of cannabis and alcohol use. He was brought to A&E after getting into an argument at work and expressing suicidal thoughts to his manager. He reported experiencing psychosocial stressors, particularly related to workload and flatmates, the pandemic, and current cost of living crisis, and difficulty in regulating his emotions. He felt let down by health services over the past few years. He was very appreciative of staying at The Retreat and being listened to, and engaged in mindfulness activities, as well as cooking meals with the staff in the evening. Staff assisted him with booking onto hot yoga sessions which he found very uplifting, as well as arranging a continued discount for sessions after his stay. He checked out of The Retreat after 4 days, and reported feeling more optimistic and hopeful, and indicated that he would think about moving accommodation. He returned to work and reported HR to be supportive of his needs. HTT conducted a medical review and increased his medication, and he was discharged back to his GP with a recommendation for a referral for an Attention Deficit Hyperactivity Disorder (ADHD) assessment, as well as a self-referral to the Talking Therapies Service.

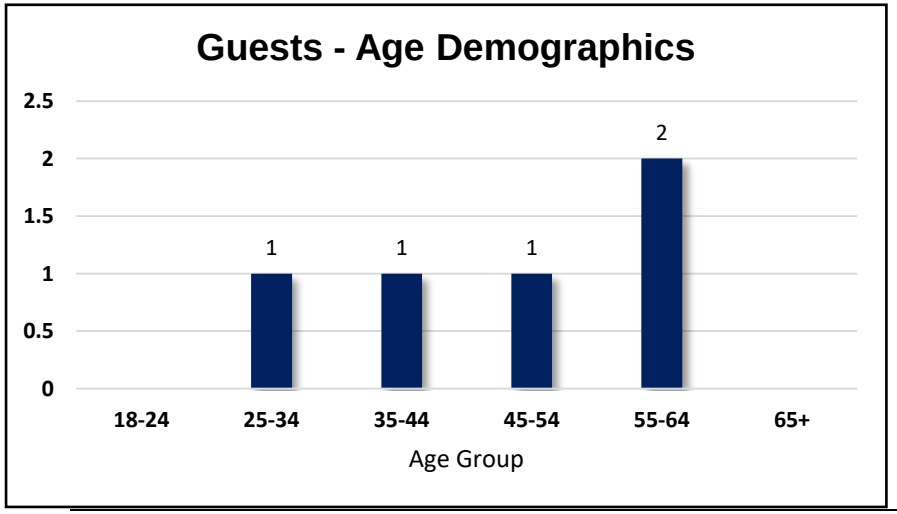
Case Study 3

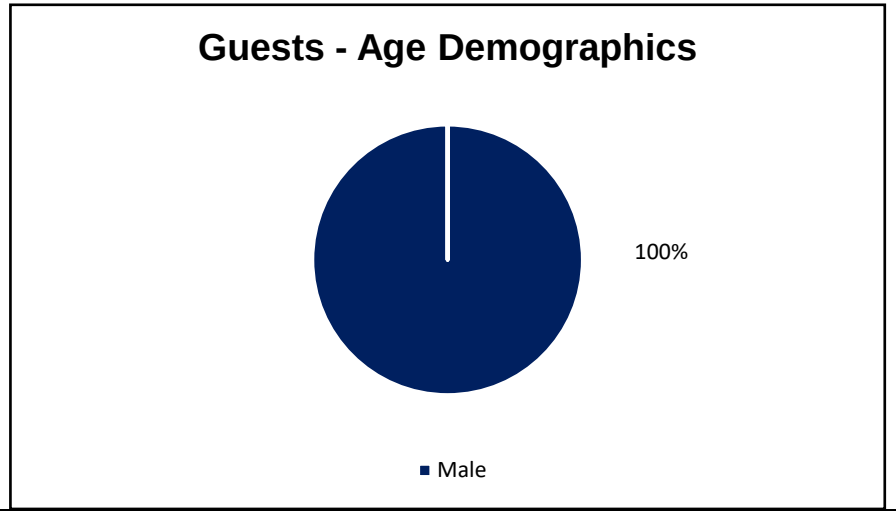
Guest 5 is a 61 year old male with a diagnosis of bipolar disorder/schizoaffective disorder under secondary care mental health services. He attended A&E following an overdose of prescribed medication due to feeling overwhelmed by family affairs, in particular his tenants not paying rent. His family were struggling to cope at home, and his wife reported feeling burnt out. He regretted his overdose and was grateful to stay at The Retreat to have some respite for himself and his family. Staff offered a chance to reflect and taught him some breathing techniques and exercises to help him relax. He attended the gym most days as he reported it helped him stay motivated. He stayed at The Retreat for 7 days and reported that it benefited him.

Appendix 3 - Demographics: Enquiries and Guests









Appendix 4 - Guest Satisfaction Experience

Guest satisfaction is recorded via a Feedback Questionnaire which is provided on check-out.

Questions	Responses
Q1: How satisfied are you with the general standard of support you received from staff in general?	Excellent – 75% Very Good – 25%
Q2: How satisfied are you with the standard of support you received from your keyworker?	Excellent – 100%
Q3: How satisfied are you with the support you received to meet your mental health needs?	Excellent – 75% Very Good – 25%
Q4: How satisfied are you with the support you received to meet your physical health needs?	Excellent – 75% Very Good – 25%
Q6: How satisfied are you with the support you may have received to manage your budgeting and finance?	Excellent – 50% Very Good – 25% Not applicable – 25%
Q7: How satisfied are you with the standard of your accommodation?	Excellent – 100%
Q8: How satisfied are you with the atmosphere within the Retreat?	Excellent – 100%
Q9: Did you feel that staff listened and responded to your requests?	Excellent – 100%
Q10: Did you feel that staff respected you, your dignity, and acted in your best interest?	Excellent – 100%

It's been a nice experience staying here, staff have been very kind and caring. When I came in I felt really like I was at the end, but a few days chatting in a nice environment has changed my outlook to a healthier one where I feel like I can deal with life's ups and downs in a balanced way. Everyone has been fantastic, it's good to know people care. 5 Stars.

My stay at the Retreat was very good. The staff were excellent and very supporting. They tried everything to help me get better.

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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, Democratic Services
Papers with report	Appendix 1 - Board Planner 2022/2023

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 2022/2023 Board Planner, attached at Appendix 1.

3. INFORMATION

Supporting Information

Reporting to the Board

The draft Board Planner for 2022/2023, 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 2022/2023 were considered and ratified by Council at its meeting on 24 February 2022 as part of the authority's Programme of Meetings for the new municipal year. The proposed dates and report deadlines for the 2022/2023 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 2022/2023

7 Mar 2023 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Thursday 23 February 2023 **Agenda Published:** 27 February 2023
	2022/2023 Integrated Health and Care Performance Report and BCF Progress	LBH/HHCP	
	Health Check Project Update	LBH	
	Board Planner & Future Agenda Items	LBH	
	PART II - Update on current and emerging issues and any other business the Co-Chairman considers to be urgent	All	

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