2021/22 INTEGRATED HEALTH AND CARE PERFORMANCE REPORT

Relevant Board Member(s)	Caroline Morison Councillor Jane Palmer
Organisation	London Borough of Hillingdon
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Papers with report	None

HEADLINE INFORMATION

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

2. The Board may wish to note that formal notification of approval of Hillingdon's 2021/22 Better Care Fund (BCF) Plan by NHSE was received on the 17th January 2022. The agreement under section 75 (s75) of the National Health Service Act, 2006 that gives legal effect to the financial and partnership arrangements within the plan has been agreed by North West London Clinical Commissioning Group (CCG) and was approved by the Council's Cabinet at its February meeting.

3. Requirements for the 2022/23 BCF have not been published, although it is understood that this may take place in March 2022. A separate report on proposals for 2022/23 will be submitted to the Board for its consideration.

4. 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

NHS Recovery and Planned Care Backlogs

5. As with all NHS trusts, the pandemic has had a significant impact on the waiting lists for planned (also known as elective) procedures at Hillingdon Hospital. This is because clinical and support staff have been redeployed to assist with urgent Covid-related demands. Consequently, there are currently 1,400 people waiting 52 weeks or more for surgery.

6. National Covid recovery priorities are set out in the guidance linked to the NHSE Delivery Plan and this identifies three key tasks, and these are:

- Make progressive improvements on long waits, with a goal to eliminate waits of over one year by March 2025 and waits of over two years by July 2022.
- Reduce diagnostic waiting times, with the aim of least 95% of patients receiving tests within 6 weeks of referral by March 2025.
- Deliver the cancer faster diagnosis standard, with at least 75% of urgent cancer referrals receiving a diagnosis within 28 days by March 2024 and return the 62-day backlog to pre-pandemic levels by March 2023.

7. Planned treatment in day case, theatre and outpatient settings has steadily resumed over recent weeks. As of the 15th February 2022, waiting times for outpatient appointments from first GP referral range from 5 to 10 weeks for most routine surgery cases. However, there are longer waits for some specialties, including ear, nose and throat (ENT), ophthalmology and vascular surgery. Approximately 400 surgical operations per week have been undertaken during 2021, which is less than required to meet national delivery targets and Hospital staff are investigating ways of addressing this. However, it is important to emphasise that despite the pressures of the latest Covid wave over the winter period the Hospital was able to maintain planned care delivery.

Covid-19 Vaccination Programme

8. The Board will find more information about the delivery of Covid-vaccination programme during the review period in this report as part of the workstream 1 update (please see paragraphs 15 to 20); however, the key message to highlight is that as restrictions are lifted across the country it is becoming increasingly difficult to convince residents who have not been jabbed or who have not completed the full range of jabs to come forward.

9. Following consultation on the possible revocation of regulations requiring staff working in care settings regulated by the Care Quality Commission (CQC) to have two jabs the Secretary of State has announced this will proceed. The requirement was already in place for care home staff and was due to come into effect for NHS staff and homecare staff from the 1st April 2022.

The infection transmission implications on Hillingdon's care market will be monitored and the Board updated in future performance reports.

Workforce

10. The Board will note throughout the updates in this report that issues with recruiting staff is a recurring theme. Some issues to highlight include:

- There is a limited pool of people available, with some posts being more difficult to recruit to than others, e.g., nurses to work in care homes. This means that the availability of funding is only a part of the recruitment equation.
- Hillingdon is frequently seeking to recruit from the same pool of people as our neighbours, which necessitates ensuring that our unique selling points are promoted.
- It is recognised by the DHSC that health and care workforce recruitment challenges are national issues, and these are being considered as part of the scrutiny process for the Health and Care Bill as it proceeds through Parliament. Local workforce planning and how this can be supported by integrated care systems (ICSs) is also addressed in the health and care white paper published in February 2022.

11. Locally Hillingdon Health and Care Partners (HHCP) has a workforce planning group in place and initiatives are being implemented that include the rotation of staff across Hillingdon Hospital and community health services. A combination of rotation and flexible working helps to increase the breadth of experience as well as respond to personal circumstances that enhances job satisfaction and increases the range of people able and willing to join and remain within the NHS workforce in Hillingdon.

12. The primary care training hubs for Hillingdon and Hammersmith and Fulham have jointly won a contract for the shaping and delivery of training for primary care across North West London (NWL). This creates career development opportunities for clinicians that could assist in filling local vacancies.

13. The Council is currently planning to launch a recruitment campaign that will contribute to addressing vacancies both within in-house social care teams as well as those experienced by independent sector providers. Overseas recruitment will be included as part of the campaign. The recruitment campaign will be funded through the Workforce Recruitment and Retention Fund allocated to the Council by the DHSC.

B. Workstream Highlights and Key Performance Indicator Updates

14. This section provides the Board with progress updates for the six workstreams, where there have been developments. It also provides updates on the five enabling workstreams.

Workstream 1: Neighbourhood Based Proactive Care

15. **Covid-19 Vaccination Programme:** The delivery of an accelerated vaccination programme in Q3 was prioritised following national direction with the aim of reducing admission to hospital and the Council and Primary Care Teams have worked together closely to maximise uptake. Table 3 below provides a summary breakdown of vaccinations by priority group that have been delivered to the 4th February.

16. The approach has comprised of a combination of:

- Fixed and flexible “pop up” hubs, e.g., Mead House in Hayes and Winston Churchill Theatre in Ruislip as well as nine pharmacies across the borough; and use of the Council’s youth service Transporter bus at local sites in West Drayton, Hayes, Uxbridge and Harefield so far plus temporary vaccine sites such as at Sipson.
- Identification of the top ten parts of the borough with a population of approximately 1,500 or 650 households, where their demographics showed a low rate of take-up and high risk of mortality in the event of infection.

17. Working closely with community leaders and champions, targeted pop-up clinics were set up in those areas with low take-up rates with a roving NHS vaccination team initially able to deliver 132 vaccine doses per shift, but capacity has reduced to reflect that the numbers attending have reduced. There has also been targeted activity with rough sleeper, refugee and Traveller communities.

18. Large scale leaflet drops have taken place in the targeted areas and Council staff have been used to engage with people on the street/shop owners and local businesses about

19. The Board may wish to note that it is currently intended to continue the pop-up clinics until the end of 2021/22.

Table 3: Covid-19 Vaccinations by Priority Group

Priority Group	Plan	First Dose % Completed	Second Dose % Completed	Booster % Completed
Age 80+	11,501	92.3%	90.1%	79.8%
Age 75 - 79	7,704	93.4%	92.0%	84.2%
Age 70 - 74	8,678	91.3%	89.5%	83.9%
Age 65 - 69	10,505	89.4%	87.7%	80.5%
Age 60 - 64	8,339	86.1%	84.8%	8.2%
Clinically Extremely Vulnerable	7,910	93.3%	91.4%	68.9%
Vulnerable 16 - 65	25,553	85.3%	81.4%	63.7%
Age 16-17	6,092	61.0%	42.3%	N/A
Age 12 - 15	13,751	49.1%	N/A	N/A
TOTAL	**100,033**			

Source: Foundry data 4/02/22

20. Vaccination rates in care homes and amongst homecare staff are shown in table 4 below.

Table 4: Covid-19 Vaccination Rates by Care Settings

Vaccine Recipient	Hillingdon		North West London Average		London Average	
	Dose 2	Booster	Dose 2	Booster	Dose 2	Booster
Care Home Residents	94%	87%	93%	87%	90%	83%
Care Home Staff		52%		46%		43%
Homecare Staff	87%	30%	79%	22%	76%	25%

Source: Capacity Tracker 10/02/22

21. **Flu Vaccination Programme:** The Primary Care Networks (PCNs) have been implementing an integrated flu plan and table 5 below shows performance against targets for priority groups.

Table 5: Flu Vaccine Programme Delivery 2021/22			
Priority Group	**Eligible Population**	**Target**	**% Vaccinated**
2 – 3 (not at risk)	7,577	70%	44.4%
4 – 15 (not at risk)	45,799	70%	14.3%
6 months – 64 (at risk)	19,093	75%	37.4%
65+	42,772	72.9%	85%
Pregnant	3,580	75%	27.5%
Care Home	1,590	85%	68.5%

Source: Whole Systems Integrated Care database 09/02/22

22. **Community Development:** H4All has received funding to expand the Community Champions programme (see below) to increase vaccination rates in hesitant communities as well as seeking to address other health priorities. The number of champions will increase from 31 to 71 by June 2022 and recruitment will focus on people from the following groups:

- Pakistani heritage
- Bangladeshi heritage
- Eastern European heritage, particularly men
- Black Caribbean heritage
- Black African heritage
- Secondary school pupils

Community Champions Programme Explained

£23million was allocated to 60 councils and voluntary groups in England in 2021 by the Department for Levelling-up, Housing and Communities to support those most at risk from Covid-19 infection and boost vaccine take-up. Champions 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.

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

- *Physical health checks for people with severe mental illness*: The target is to achieve 60% of the people on GP registers identified as living with severe mental illness. *Exceeded:* In a rolling twelve-month period to February 2022 checks have been completed for 61% of

eligible people at a Primary Care Network (PCN) level, which compares to 49% in the previous twelve-month period.

- *Diabetes:* 66% of eligible people with diabetes have received checks up to 28th February 2022 on a rolling 12-month basis.
- *People with learning disabilities:* The NHS Long Term Plan (NHSE 2019) sets an ambition that by 2023/24, at least 75% of people aged 14 or over with a learning disability will have regular annual health checks. *Slippage:* The 2021/22 position to 31st December 2021 was 45% against the milestone for the quarter of 56%.

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

25. **Additional Roles Reimbursement Scheme (ARRS):** The Board is reminded that this scheme is designed to expand the primary care work force and enable more proactive, personalised and integrated health and social care. In Hillingdon the scheme is being used to develop an additional 91 posts across the PCNs that include clinical pharmacists, dieticians, mental health practitioners and physiotherapists. The project to establish these roles in Hillingdon is being jointly managed between The Confederation and CNWL. The goal of having posts filled by the end of 2021/22 will not be realised due to difficulties in recruiting to some posts, e.g., first contact physiotherapist, dietician and paramedic posts. The Board may wish to note that six additional mental health practitioners have been recruited through this initiative to support GP practices by providing specialist advice regarding support for people with more complex needs and four of the postholders will have started by the end of March 2022.

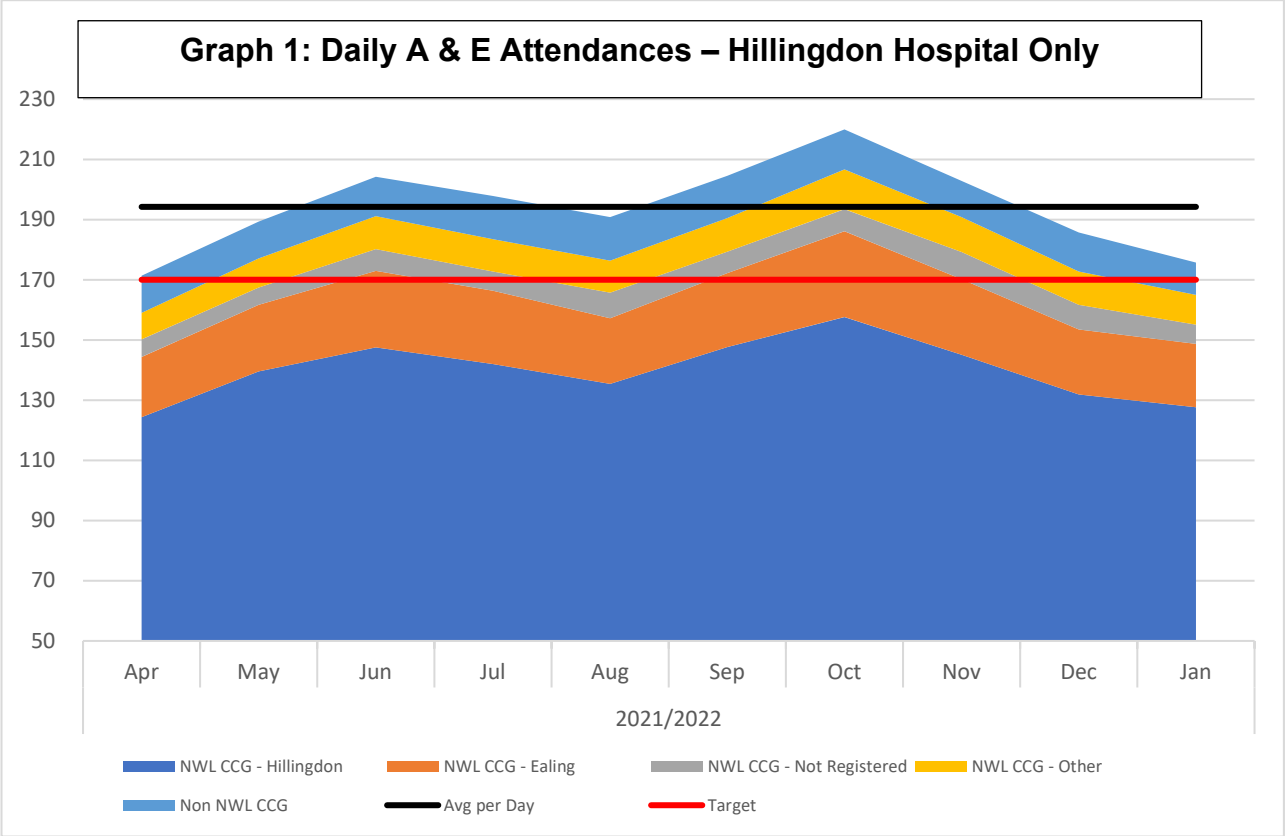
Key Performance Indicators

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

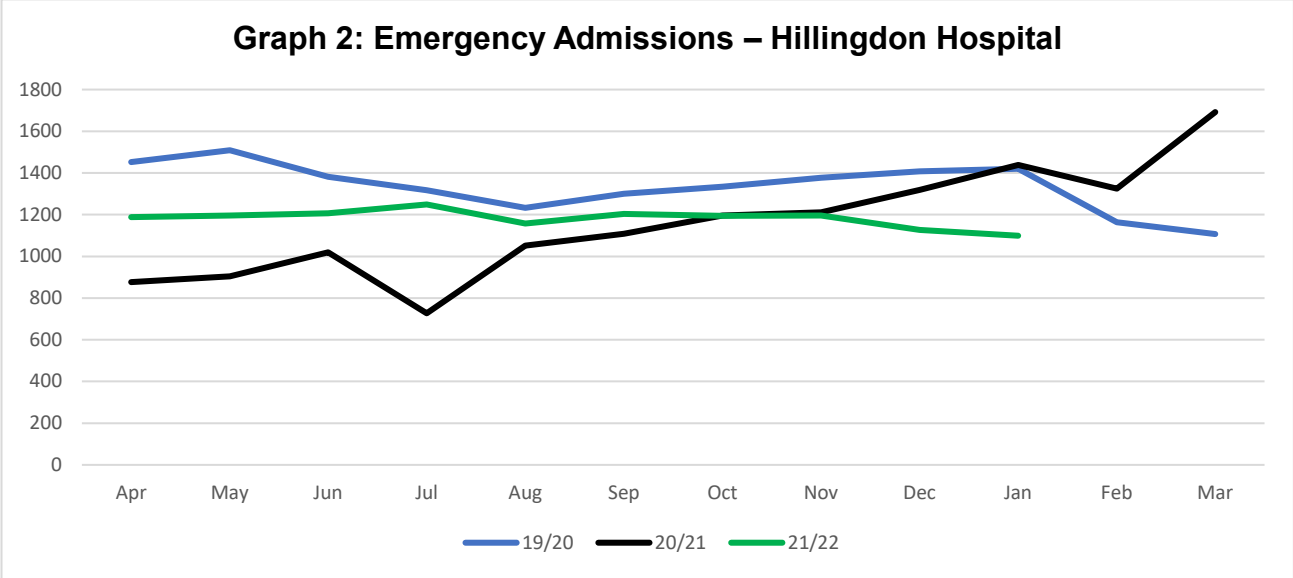
Workstream 2: Urgent and Emergency Care

Workstream Highlights

26. **A & E Attendances:** Graph 1 below shows that attendances to Hillingdon A&E continued to increase with peak daily numbers seen in October. Since October activity has reduced steadily and was at 176 per day in January 2022. The Board may wish to note that 72% of attendees are people registered with Hillingdon GPs; 12% with Ealing GPs and the rest from a range of areas or not registered.

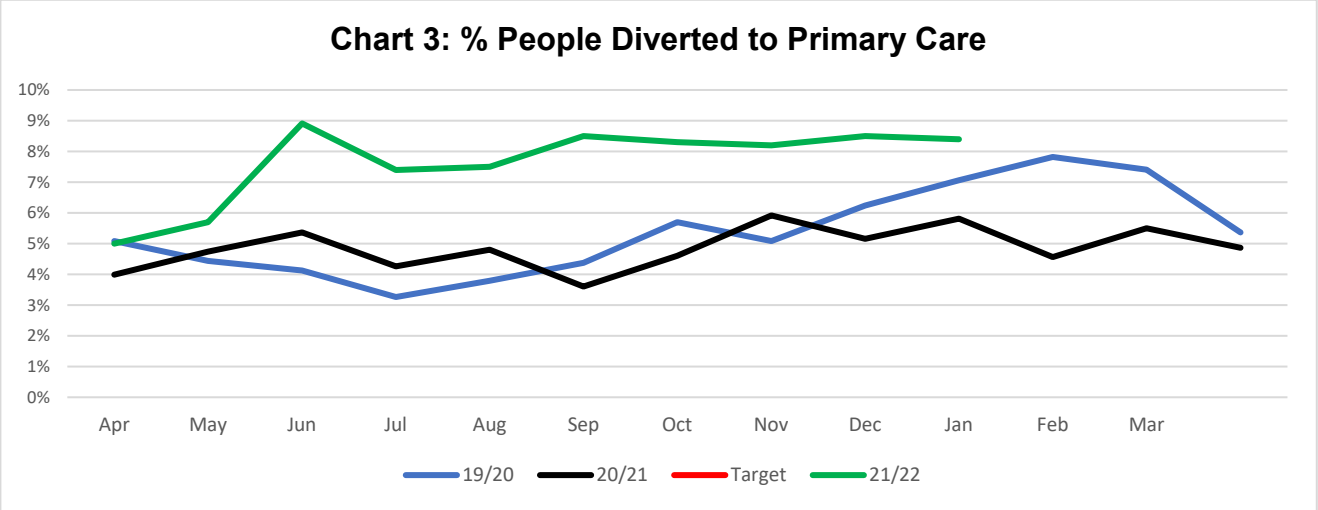


27. **Emergency Admissions:** Graph 2 below shows that there has been a levelling off in the number of emergency (also known as non-elective or NEL) admissions during Q3 and Q2 compared to Q1. Activity in December 2021 and January 2022 remains below that seen in the same months in both 2019/20 and 2020/21.



28. **Urgent Treatment Centre (UTC):** This is for residents who have an urgent or severe condition or minor injury that cannot wait for a GP appointment (usually 48 hours). Hillingdon's UTC is based on the Hillingdon Hospital main site. A key objective of the service is to redirect people to primary care who do not need inpatient treatment at Hillingdon Hospital. The redirection rate has increased from 7.4% in July to 8.5% in December 2021. Chart 3 below

illustrates progress during 2021/22 in comparison with previous years.



29. **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 is to increase direct referrals from the GPs and therefore reduce unnecessary attendances at the UTC and the Hospital's Emergency Department. Direct GP referrals have increased by 7.2% from September 2021 when it was established to 24.5% in January 2022. Additional winter pressures funding was allocated to enable the service to operate 24/7 but this has not been implemented due to recruitment difficulties.

30. **Step-down, Discharge and Winter Pressures:** During the review period partners have continued to support the discharge pathways (see below) to minimise length of stay in hospital.

Discharge to Assess Pathways Explained

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

31. The report to the November Board meeting identified a range of initiatives intended to manage demand at Hillingdon Hospital during the winter period. The implementation of some schemes has been delayed due to difficulties in recruiting staff, which has been exacerbated by the late decision about the availability of funding. Discussions are currently in progress to determine whether short-term additional capacity is required going into 2022/23 to support the reduction in length of stay at Hillingdon Hospital, i.e., D2A bridging care, Reablement, 7-day

social care support and step-down bed provision.

32. **Urgent Care Nurse Practitioner Service:** This service provides advice and can offer treatment for minor injuries or illnesses. It is led by Hillingdon Hospital and is based at Mount Vernon. The service operates 8am to 7pm seven days a week and bookings are via the UTC or GP practice staff. Appointments are initially by telephone with a face to face follow up if appropriate. The service is currently treating between 32 and 42 people a day and its effectiveness has been enhanced by increased access to the x-ray unit, which is now open until 8pm.

Key Performance Indicators

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

- ***Daily bed occupancy rate at Hillingdon Hospital:*** The current bed occupancy target should be at no more than 90%, i.e., 31 bed capacity at the start of each day. *Slippage*: Q3 average was 96%.

- ***Length of stay of seven days or more (Hillingdon Hospital):*** This metric measures the percentage of people in hospital with a length of stay of seven days or more (known as '*stranded patients'*) should be no more than 30% of the bed base, i.e., 94 people based on 313 core beds. *Slippage*: Q3 average was 45% (141 people based on 313 core beds), an improvement of 10% from Q2 with an average of 172 people with a LOS over seven days

- **Length of stay of fourteen days or more (Hillingdon residents):** This new BCF metric measures the proportion of inpatients resident in hospital for 14 days or more. The metric applies to all Hillingdon residents aged 18 and above and the ceiling for Q3 2021/22 is 10.9% and for Q4 it is 12.6%. *Exceeded*: 10.3% was achieved in Q3.

- **Length of stay of twenty-one days or more (Hillingdon residents):** This new BCF metric measures the proportion on inpatients resident in hospital for 21 days or more. As above, the metric applies to all Hillingdon residents aged 18 and above and the ceiling for Q3 2021/22 is 5.6% and for Q4 2021/22 it is 6.2%. *Exceeded:* 5.2% was achieved in Q3.

- **Percentage of people, resident in the borough, who are discharged from acute hospital to their usual place of residence**: This is also a new BCF metric and the expectation is that most people will be discharged from hospital to their usual home, i.e., in most cases, their address at the time of admission. Once again, the metric applies to all Hillingdon residents aged 18 and above and the target for 2021/22 is 91%. The Board may wish to note that the provision of step-down provision to support pathway 2 discharges has a negative impact on this metric because step-down does not count as a '*usual place of residence*.' *Exceeded:* The Q3 position was 92.3%.

- ***Out of hospital capacity:*** Health and social care step-down capacity should be at no more than 90% utilisation. This includes bedded services such as the Hawthorn Intermediate Care Unit (HICU), Park View Court step-down flats and beds in three care homes, as well as services such as the Rapid Response D2A service and District Nursing. *On track:* The Q2 average was 76%, therefore suggesting that there was sufficient community capacity to meet demand.

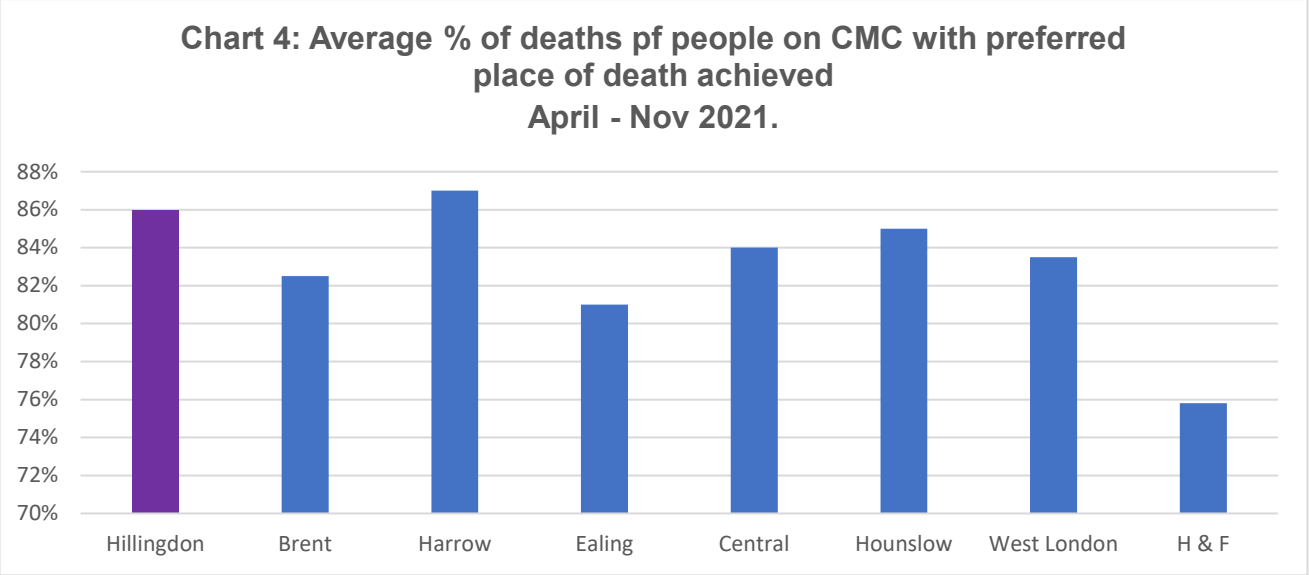
Workstream 3: End of Life Care

Workstream Highlights

34. **End of life dashboard:** The report to the November Board meeting advised that a dashboard was being produced that would show Hillingdon's comparative position in respect of the following measures:

- Average % of deaths occurring in preferred place of care.
- % of deaths occurring in hospital.
- % of deaths occurring in the community.

35. Chart 4 below shows the average % of deaths of people on the advanced care planning tool called Coordinate My Care (CMC) where the preferred place of death was achieved. This shows that Hillingdon was second in NWL in enabling people to achieve their wishes about preferred place of death.



Source: CMC. **Key**: Central – Westminster (excluding Queen's Park and Paddington); West London – Kensington & Chelsea and Queen's Park and Paddington; H & F – Hammersmith and Fulham.

36. It is intended that the report to the Board's June meeting will include Hillingdon's performance in the wider NWL context against the other measures in paragraph 34 above.

37. **Single point of coordination:** A single point of coordination model for all borough end of life services has been established and a pilot became operational on the 4th January 2022. Key to this is creating one telephone number that all services can be accessed by and which links with NHS 111. Included within the model is a 2-hour rapid day time response service that is delivered by CNWL's Rapid Response Team.

38. **Compassionate Hillingdon:** H4All has secured external funding to operate the equivalent of a '*Compassionate Neighbours'* model that has been adapted for 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. A coordinator started in post on 4th January and 20 volunteers have been identified to work on the project and are currently going

through Disclosure and Barring Service (DBS) checks.

Workstream 4: Planned Care

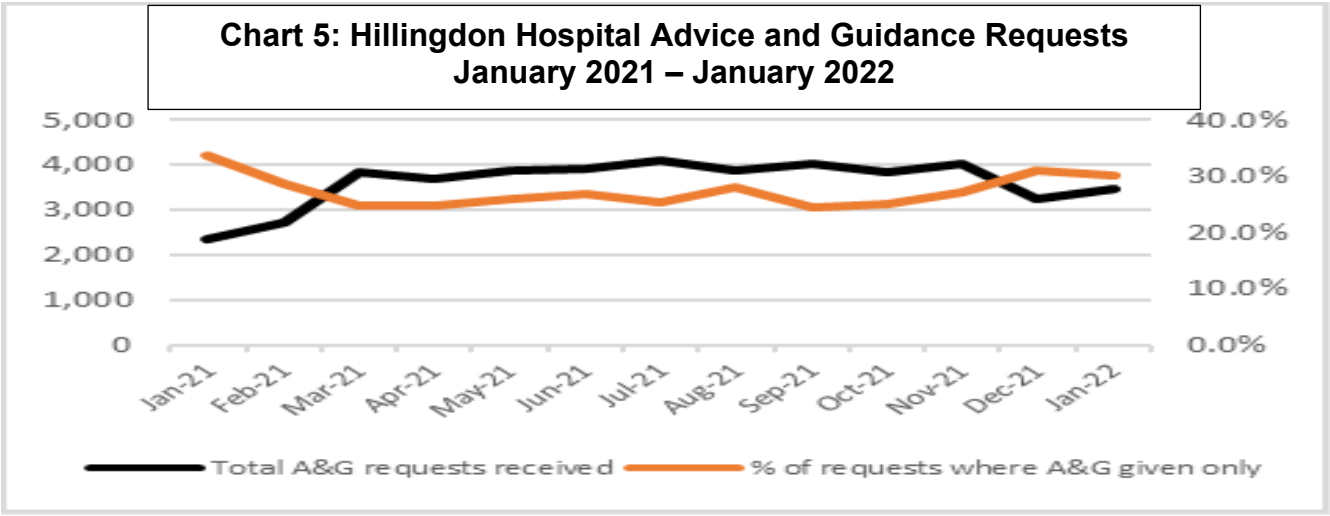
39. The update in this section is linked to the comments in Part A of this report, i.e., paragraphs 5 to 7.

Workstream Highlights

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

41. **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 3,553 and the period from November 2021 to January 2022 saw an average of 3,604. Data suggests that the service is being effective in reducing unnecessary referrals to the Hospital and that the period between January 2021 and January 2022 some 9,600 inappropriate referrals have been avoided. Chart 5 below illustrates the total A & G requests received during the twelve-month period from January 2021 and the proportion that have been A & G only.

Chart 5: Hillingdon Hospital Advice and Guidance Requests January 2021 – January 2022



Workstream 5: Children and Young People (CYP)

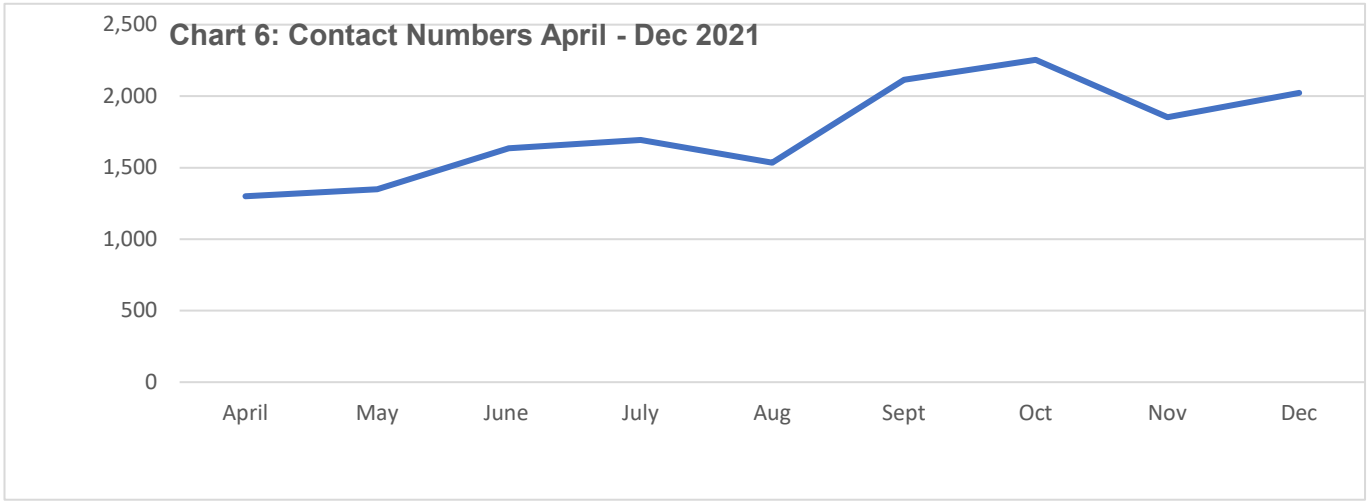
Workstream Highlights

42. **Community step-up/step-down model:** The Providing Assessment & Treatment for Children at Home (PATCH) service went live in June 2021 and 454 children were seen by the service in the period to the end of November 2022. 61% of referrals were from A & E, 30% from wards at the Hospital and 9% from the Paediatric Assessment Unit (PAU).

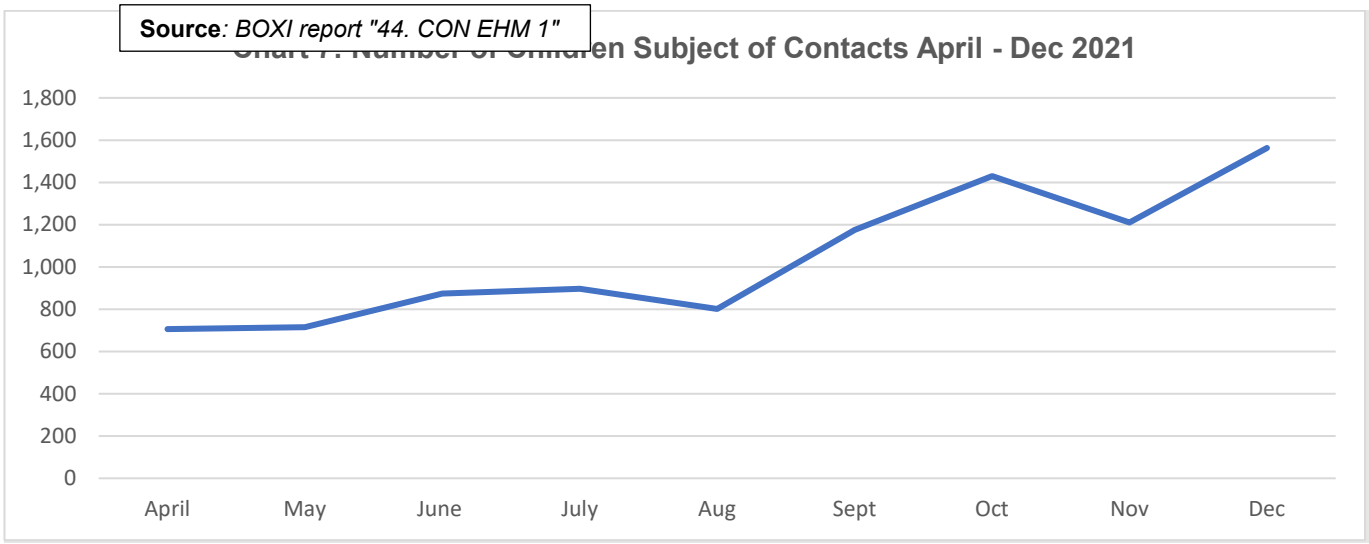
43. **Stronger Families Partnership:** The Stronger Families Hub (SFH) was launched on the 2nd August 2021. The ethos of the hub promotes targeted support and the timely provision of the

most appropriate support service and during the period between August and December 2021 there were 9,778 contacts, including 3,000 via an online portal. 6,182 children were the subject of one or more of the contacts referred to above.

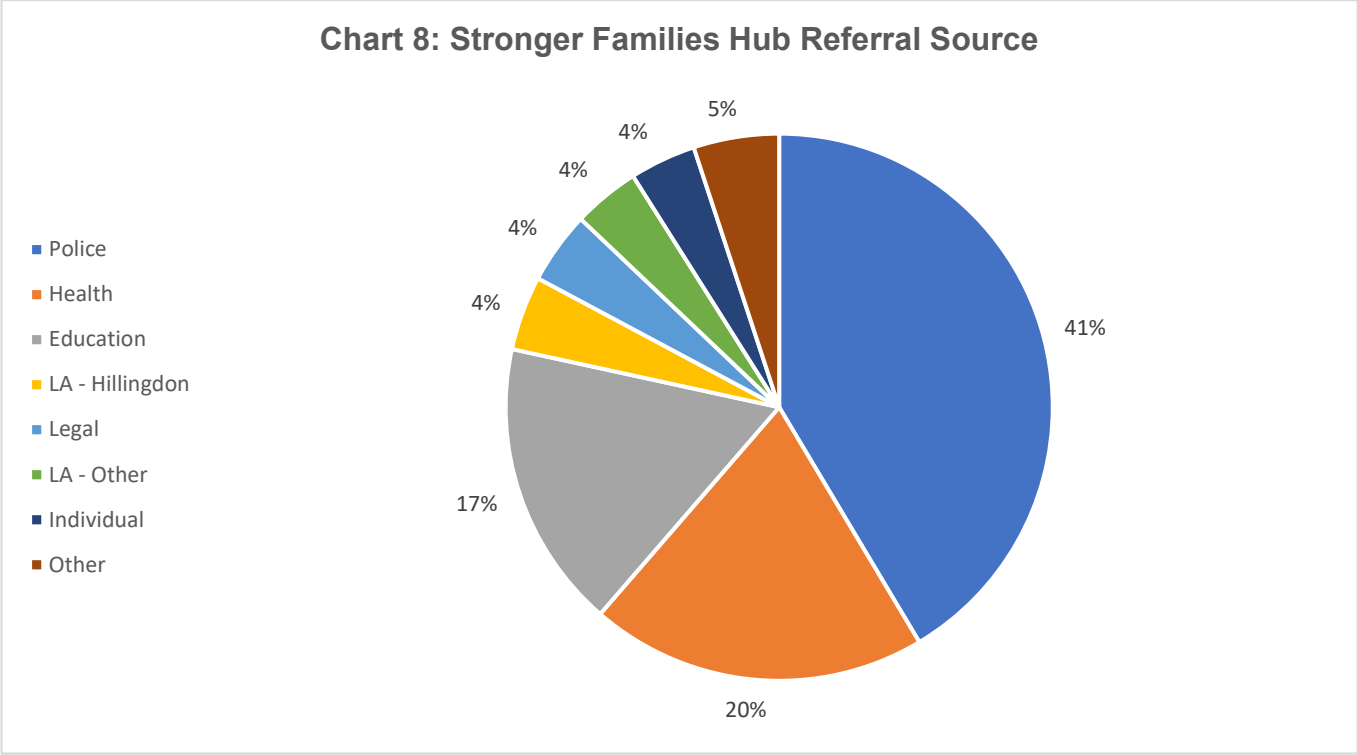
44. Charts 6 and 7 below show the significant increase in both the number of contacts following the launch of the hub in August 2021 but also the number of children who were the subject of one or more of the contacts. The impact of Covid on families, including the implications of the lifting of restrictions for children returning to school and families to work are all significant factors contributing to the increase in demand on the service. Chart 8 shows the source of referrals to the hub.



Source: *BOXI report "44. CON EHM 1"*



Source for charts 6 & 7: *BOXI report "44. CON EHM 1"*



Source: *BOXI report "44. CON EHM 1"*

45. **Family Assessment and Support Team (FAST):** Since June 2021 FAST has provided an effective *'very early in the process'* analysis of the needs of 257 children, young people and families who are referred to the Stronger Families Hub. The team comprises of social workers, an advanced social work practitioner or manager and a locality team representative. This is to enable swift analysis as to the right person/right service to support the family. A key focus of the team is supporting the Council's Education Service to ensure that children missing school are supported to start or resume education. Since the start of January 2022 91 children missing education have been contacted and/or visited by FAST. The funding for the team has been extended to the end of May 2022 pending a review of its scope and staff composition.

46. **Stronger Families Locality Keyworking and Partnership Update:** There are three Stronger Families Locality Keyworking Teams that cover north of the A40, Uxbridge, Yiewsley and West Drayton and Hayes, Harlington and Sipson respectively. They are staffed by 23 keyworkers and 3 team managers. The purpose of the teams is to accept appropriate referrals from the SFH and work with families on Stronger Families Plans which are family focussed, strengths based and time limited. The overall aim is to develop family strengths so that outcomes for children and young people can be achieved and problems are stopped from escalating into referrals to Children's Social Work. We know that the need to help families via the Stronger Families Plan and to '*think family'* is very pressing across health, education, and voluntary sector partners.

47. A sub-group of the Safeguarding Children Partnership Board has been established called the Stronger Families Partnership Subgroup has been established with a multi-agency membership including representatives from Social Care, Health, Education, Communities and the voluntary sector. A priority for this sub-group includes the development of locality-based multi-agency groups like the successful group that has been established in Hayes. Another priority is to ensure that all providers work with the whole family and not only with individual children and young people.

48. **Adolescent Development Service:** This service delivers targeted programmes to vulnerable children and young adults across the borough. The team offers services using an adaptive delivery model that utilises venues across the borough such as community centres, schools, children's centres, and outdoor spaces. Types of intervention offered include intensive one to one support, groupwork (both online and face to face) and residential activities. Demand for the service has significantly increased because of the impact of the pandemic on the lives of children and young people and referrals have risen from 699 in the period from April to December 2020 to 1,118 in the same period in 2021. Anxiety, emotional health issues and domestic abuse are the key reasons given for referrals and the team has devised a range of programmes to support children and young people in coping with these issues.

49. **Transition to Adulthood:** Transition to (also referred to as Preparation for) Adulthood refers to the process of moving from children to adults' services and includes the full process from initial planning, the actual transfer between services, and the provision of support throughout the journey. The transition process refers to both the move from children to adult services within Social Care but also within the NHS where paediatric and adult services are delivered in different ways. The intention is to start planning early on a multi-agency basis that includes Social Care, NHS and Education partners, including schools. Partners are working together to improve the experience of the transition process.

50. A key NHS-led development during 2021 has been the development of the Transition Support Service, which was established in October 2020 with the inclusion of a transition nurse based at Hillingdon Hospital and a clinical lead post based with CNWL. The initial focus of the service has been on young people with long-term conditions (including multiple long-term conditions), e.g., diabetes, epilepsy, cystic fibrosis, asthma, and Looked After Children (LAC). As a result of the work of the service a new neurology pathway has been established that ensures a structured clinical handover from the paediatric consultant to adult neurology services at the Hospital, the outcome of which is to improve the experience of care for the young person and their family. The approach taken is being applied to other medical specialties at the Hospital. The second phase is intended to extend the service to provide transition support for young people moving from children to adult mental health services.

51. **16 -25 Young Adult Mental Health and Wellbeing Partnership Model:** This is the subject of a separate report on the Board's agenda.

52. **CYP Dental Health:** A supervised brushing programme continues to be rolled out in partnership with 5 schools and 3 nurseries and there is engagement with other schools that could see an additional 4 as participants by the end of 2021/22.

53. **Children and Adolescent Mental Health Service (CAMHS) Early Help and Intervention Hub**: Additional funding for the CAMHS service to facilitate achievement of the national target of 35% of CYP with diagnosable conditions having access has been agreed. During the period between January and December 2021 there were 1,799 referrals to the service and nearly 58% were accepted by the service.

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

- Deliver evidence-based interventions for mild-to-moderate mental health issues;
- Support the senior mental health lead in each school or college to introduce or develop their

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

55. All recruitment to Education Mental Health Practitioner trainee posts have been successful but there have been delays in recruiting to the more senior positions. When operational the team will work initially with four schools, i.e., Pinkwell, Grange Park, Hayden High School and Uxbridge High School.

56. **Autism Pathway:** A mapping exercise of local provision has been undertaken and this is being used to develop a navigation guide.

Key Performance Indicators

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

- **Education, Health and Care Plan (EHCP) Assessments**: The target for completion of assessments following referral is 20 weeks. The April to December 2021 average for the percentage of assessments completed within 20 weeks is 86% compared to 50% for 2020/21. The Board may wish to note that it was 91% in Q3 2020/21. The improved performance continues to be attributed to strong oversight from managers and the recruitment of a permanent team. As reported in the November update, the provision of statutory advice from partners, i.e., therapists, within the mandated 6-week timeframe is also supporting delivery of the 20-week target.

- **CAMHS referral to treatment:** The Hillingdon target for CYP receiving treatment within 18 weeks of a referral is 85%. For the period April to December 2021 the average achieved was 91%. '*Treatment*' is defined as including two contacts, the first to undertake an assessment and the second to provide treatment.

Workstream 6: Mental Health, Learning Disability and Autism

Workstream Highlights

58. **Older Adults:** A new integrated care model for older people that will result in alignment of the Older People's Community Mental Health Team (CHMT) with PCNs is now in development. The scope for linking physical health services to the PCNs is also being explored to improve the service experience for residents.

59. **Crisis Pathway (Crisis House):** The November Board was advised that research on best practice showed that the development of a crisis house was a key component of a robust crisis pathway that would contribute to a reduction in acute admissions and better outcomes for people living with mental health conditions. The delivery model has now been agreed with partners and negotiations are in progress with an established local provider to secure delivery. Funds have been secured, which means that the service will become operational during 2022/23.

60. **Crisis Pathway (Hillingdon Cove Café)**: The café opened on the 29th November and in the period between its opening and the 19th January 2022 there were 79 attendances. The service is co-located at Haya House Community Centre, 90A East Avenue, Hayes, UB3 2HR and is

open access, i.e., people do not need to be referred and have an appointment made. Nearly 22% of the people supported since November have made use of the open access opportunity. The service is run by Hestia. Mental health recovery workers support attendees to build on their resilience, develop coping strategies and self-management techniques around their mental health.

61. **High Re-admission Group**: Discussions between CNWL and H4All have taken place with a view to the latter developing a model of support for people who are frequently admitted to acute mental health services. H4All already delivers an equivalent service for people who are frequent attenders at Hillingdon Hospital's Emergency Department.

62. **Rapid Engagement Support Team (REST) model**: The November Board meeting was informed that funding has been secured to trial a model that has worked effectively in Milton Keynes and entails working with stakeholders and community organisations to:

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

63. The work undertaken as part of the model includes specialist comprehensive assessment, clinical advice and psychosocial and peer support. The service went live in November 2021, although not all posts have so far been filled. A review of the outcomes from implementation of the model will be undertaken at the end of 2021/22.

Enabling Workstreams

64. 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

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

66. **Enabler 1: Supporting Carers**: The Council is the lead for this enabling workstream, which seeks to support carers of all ages to continue in their caring role for as long as they are willing and able to do so.

Workstream Highlights

67. **Carer champions in GP practices:** The pandemic has seen a reduction in the number of practices with an identified Carer Champion (see below) from 46 to 27 and some PCNs have resorted to having champions covering more than one practice. An action within the Carers' Strategy Delivery Plan for 2021/22 was to increase the number of practices with their own champions. Unfortunately, the focus within primary care on the vaccine roll out programme has necessitated this action being deferred to 2022/23.

Carer Champions in GP Practices: The Role Explained

Key tasks include:

- Proactively identifying and supporting Carers, many of whom do not see themselves as carers.
- Ensuring that a practice Carer Register is maintained and updated regularly.
- Ensuring the practice provides active signposting to the Hillingdon Carers Partnership.
- Ensuring that standardised packs of information for carers are available within the waiting room
- Feeding into the Confederation and its partners, e.g., Hillingdon Carers Partnership and the CCG, any gaps in provision or requirements to help practices to support carers further.
- Working with colleagues in the practice to provide enhanced access and flexibility of appointments for carers.
- Attending any training/information sessions that relate to the support of Carers within General Practice.

68. **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 also to integrate commissioning arrangements where this will produce better outcomes for residents and the local health and care system.

Workstream Highlights

69. **Infection Control and Testing Fund and Workforce Recruitment and Retention Fund:** Since the performance update to the November Board a further round of the Workforce Recruitment and Retention Fund has been announced for the period 10th December 2021 to 31st March 2022. A further new grant, the Omicron Support Fund, was also introduced in January 2022. The total additional funding that the Council has received to manage pressures relating to the pandemic for the period October 2021 to March 2022 is £3,655,512. The respective allocations are shown below and with the mandated provision for care homes in brackets, where applicable:

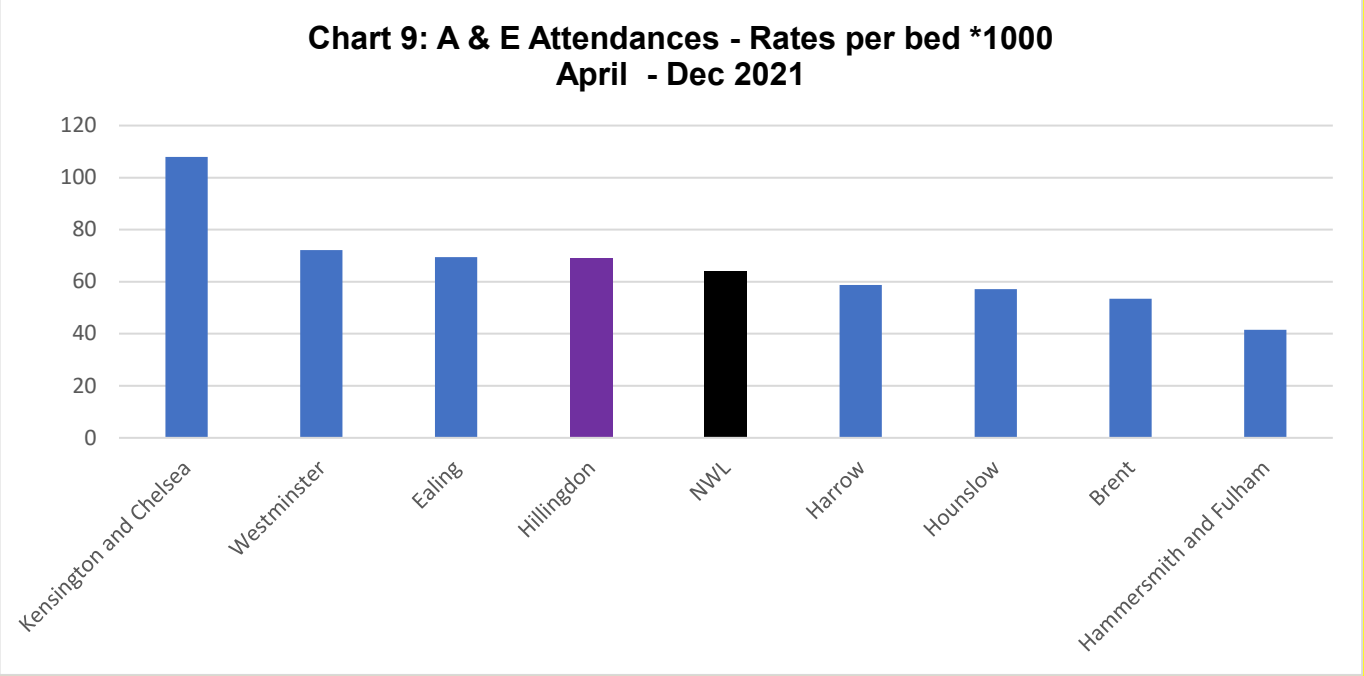
- Infection Control: £841,767 (£417,707)
- Vaccines: £93,661 (£29,375)
- Testing: £453,505 (£296,801)
- Workforce Recruitment and Retention Fund: £2,006,302
- Omicron Support Fund: £260,277

70. Unfortunately, rigid criteria for some of the grants has made it difficult for some providers to spend the funding. With the Omicron Support Fund, the criteria have been loosened and the 31st March 2022 spend deadline removed. This increased flexibility will be beneficial to providers.

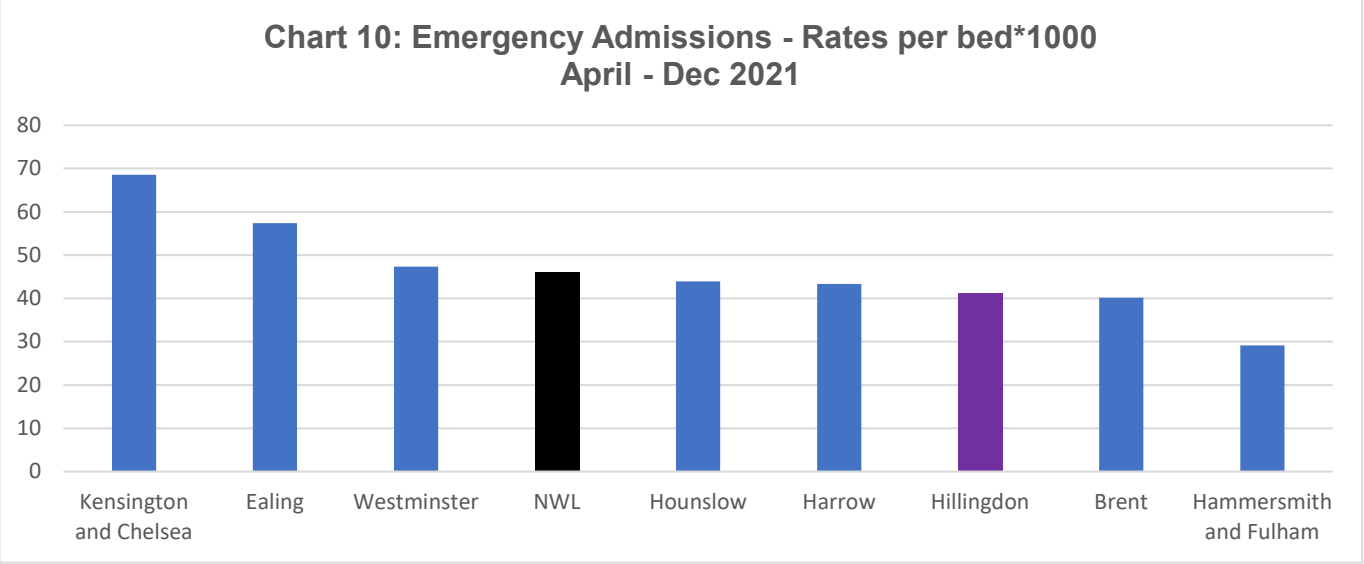
71. **Care home dashboard:** The systemised production of a dashboard containing information about care home-related hospital attendances and admissions as well as cause of this activity is now being produced by the NWL Business Intelligence Unit (NWL BIU). Activity information

from the London Ambulance Service (LAS) about call-out incidents, the reasons behind them and numbers conveyed to hospital is informing the dashboard and this is supporting targeted activity by the Care Home Support Team and Quality Assurance Team to address particular issues faced by care homes. For example, the largest single cause of LAS call outs between April and December 2021 was calls.

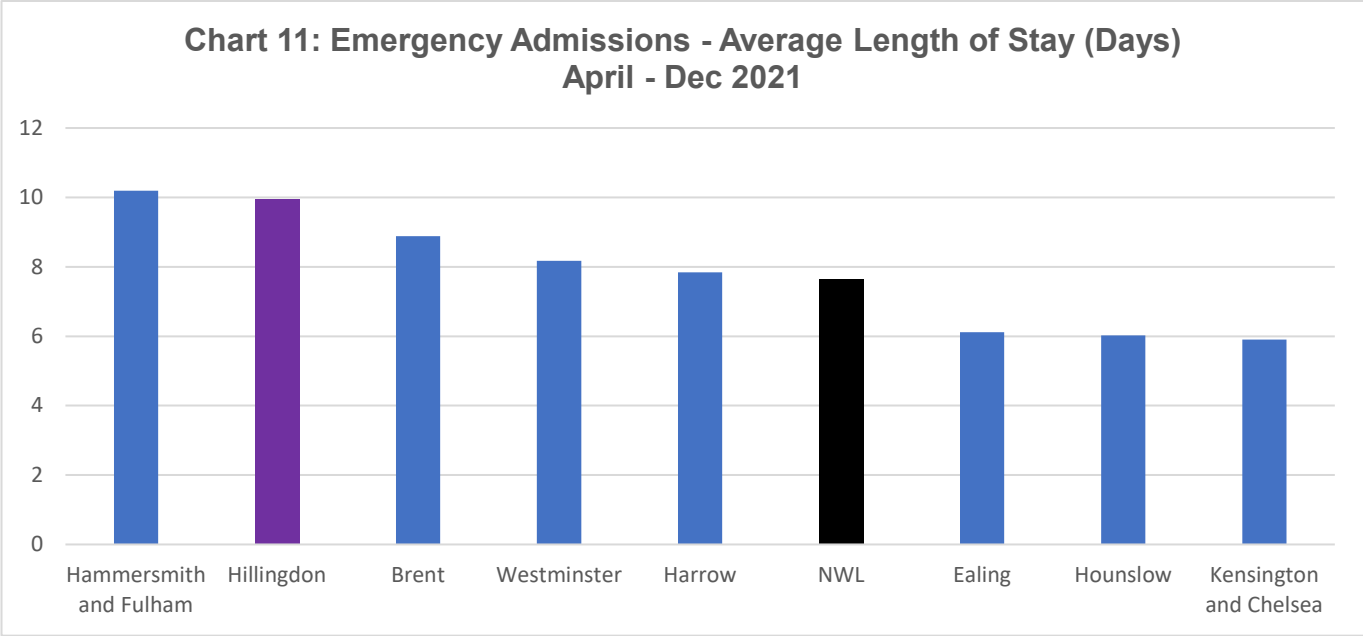
72. Charts 9 to 11 below compares the hospital related activity of care homes in Hillingdon with the other local authority areas within NWL. The Board may wish to note that Hillingdon has the second highest number of care home beds in NWL (Ealing has the highest at 1,560 compared to Hillingdon's 1,427). Chart 8 shows that during the review period Hillingdon had the fourth highest number of attendances at A & E, but chart 9 shows that we had the third lowest number of emergency admissions. Chart 10 shows that Hillingdon had the second highest length of stay for care home admissions.



Source: NWL Care Home Dashboard 21/02/22



Source: NWL Care Home Dashboard 21/02/22



Source: NWL Care Home Dashboard 21/02/22

73. **Enabler 5: Estates:** This workstream concerns maximisation of available property assets to meet current and future needs of the health and care system.

Workstream Highlights

74. **North of Hillingdon Health Hub:** Planning permission has been granted for the development of the new hub on the site of the former Northwood and Pinner Community Hospital and Northwood Health Centre.

75. **Hillingdon Hospital rebuild:** The Council's planning officers are in discussion with Trust representatives on a pre-application basis and offering feedback on proposals.

Finance

76. Table 6 below provides a summary of the financial contributions to the 2021/22 BCF plan.

Table 6: BCF FUNDING SUMMARY 2020/22			
Funding Breakdown	**2020/21 (£,000)**	**2021/22 (£,000)**	**% Difference**
MINIMUM CCG CONTRIBUTION	**19,401**	**20,485**	5.6
Required Spend			
• Protecting Social Care	7,075	7,470	5.6
• Out of Hospital	5,513	5,821	5.6
• Other minimum spend	6,813	7,194	5.6
MINIMUM LBH CONTRIBUTION	**12,359**	**12,359**	**0**
Required Spend			
• Disabled Facilities Grant (DFG)	5,111	5,111	0
• Improved Better Care Fund (iBCF)	7,248	7,248	0
MINIMUM BCF VALUE	**31,760**	**32,844**	**3.4**

• Additional CCG Contribution	28,608	28,642	<1
• Additional LBH Contribution	43,089	44,968	4.4
TOTAL BCF VALUE	**103,457**	**106,454**	**2.9**

77. Table 7 below summarises the contributions by the Council and HCCG in 2021/22 compared with 2020/21.

Table 7: Financial Contributions by Organisation 2020/21 and 2021/22 Compared		
Organisation	**2020/21** ***(£,000s)***	**2021/22** ***(£,000s)***
CCG	48,009	49,127
LBH	55,448	57,327
TOTAL	**103,457**	**106,454**

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

CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance Comments

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

Hillingdon Council Legal Comments

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

BACKGROUND PAPERS

Joint Health and Wellbeing Strategy, 2022 – 2025
Joining up care for people, places and populations: The government's proposals for health and care integration (DHSC Feb 2022)