INTEGRATED NEIGHBOURHOOD WORKING

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Papers with report	None.

HEADLINE INFORMATION

Summary	This paper updates the Board on progress and achievement in 2021/2022 against long term conditions, planned care, immunisations, access and integrated neighbourhood models.
Relevant Policy Overview & Scrutiny Committee	Health and Social Care Select Committee
Ward(s) affected	All

RECOMMENDATION

That the Board notes progress and future priorities.

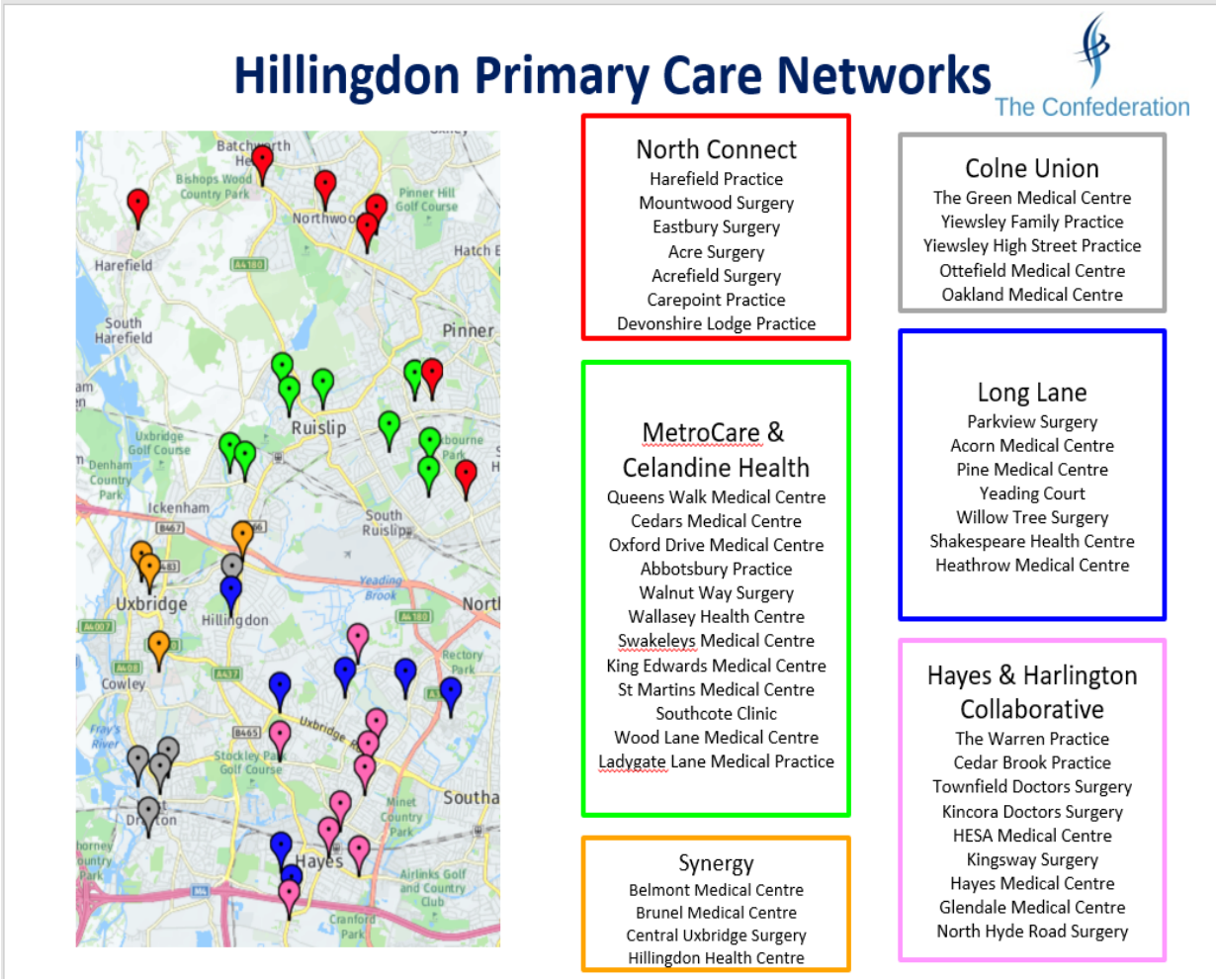
OVERVIEW

This paper is intended to provide an update on the work undertaken to date on developing integrated ways of working both across primary at scale and in partnership with other health and care teams, achievements to date and areas for future focus.

INTEGRATED NEIGHBOURHOOD MODELS

In Hillingdon neighbourhoods are established as a vehicle to deliver improvements that meet the population need through delivering care by multi-disciplinary teams arranged around groups of general practices or primary care networks (PCNs) (figure 1.). This is in line with the recommendations from the recent Fuller stocktake – *Next steps for integrating primary care*. A number of neighbourhood models of care are in place and have demonstrated value both in terms of financial savings and also through the quality of care being delivered. The impact of the care homes team is covered in the integrated performance report, the below sets out a number of our other neighbourhood and integrated models of care.

Figure 1.

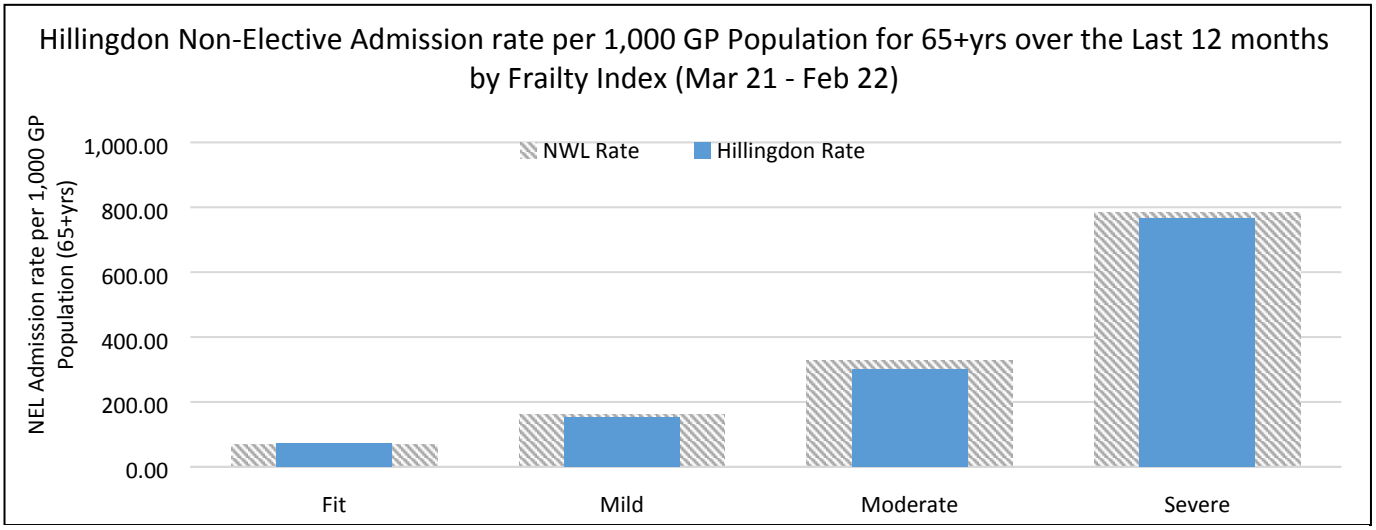


Care Connection Team (CCTs)

The Care Connection Team provides active case management and care co-ordination to the top 2% of individuals aged over 18 years at high risk of hospital admission or hospital attendance addressing their escalating care need before they cause any deterioration and therefore reducing acute activity. The teams are made up of Guided Care Matrons, Care Coordinators, Wellbeing Advisers, Mental Health Practitioner and GPs.

An analysis of the activity of those on the caseload 3 months pre and post referral showed a reduction of 440 A&E attendances and a reduction of 282 non-elective admissions which together equated to an estimated gross saving of £1,278,047 (This is based on an average PbR cost for this patient group) based on 3 months. It should also be noted that rates of non-elective admissions for the over 65 population in Hillingdon are lower than the NW London average (figure 2.).

Figure 2.



A programme of work to refresh the model post Covid has been undertaken and focuses on re-establishing links into the hospital teams to support rapid admission avoidance and proactive, timely discharge planning as well as maintaining a focus on care-coordination and joined up working across wider community teams and resources.

Integrated paediatrics

The paediatric integrated clinics provide a joined up, out of hospital model of care for families who would otherwise be attending an outpatient clinics. Clinics have been running since 2018 and rotate through different practices across the borough in order to provide access to residents and clinicians. As well as providing a community setting for specialist care and reducing the outpatient waiting lists the clinics support the development of relationships between primary care and specialist teams and an opportunity for education and training as clinics are shared by GPs and consultants. The model is currently being expanded to include MDT discussions on children with complex needs (including mental health) with the first sessions starting in October 2021 with Long Lane PCN. Representatives from local authority, CAMHS, hospital and community paediatricians, school nursing, voluntary sector as well as GPs attend. The decision to allocate year 2 funding for the mental health PCN alternative roles for children and young peoples' mental health will further support the integration of physical and mental health care planning.

Population health and preventative care

The progress and approach to population health in Hillingdon is covered elsewhere on the agenda. However, it should be noted that this is at the core of the development of neighbourhood working and will provide the focus for the operating models of our neighbourhood teams building on work that has already been established through integrated working on diabetes, learning disabilities and serious mental illness and covid and flu vaccinations.

Diabetes

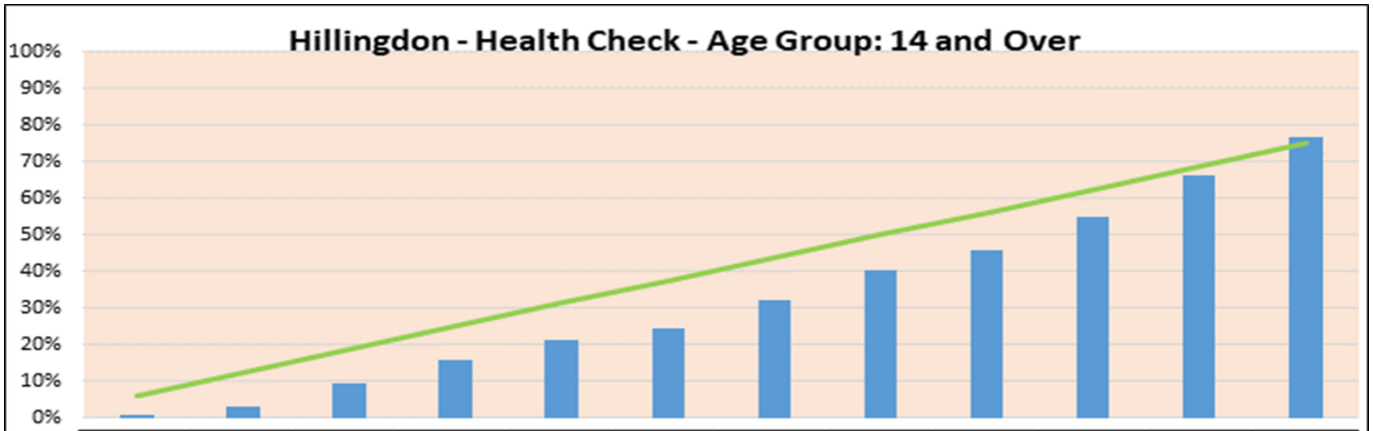
2021/22 was the first year of the NWL-wide diabetes enhanced service which builds on the service previously commissioned in the inner London boroughs. Whilst activity has been affected by covid, it is worth noting that Hillingdon ranks in the top four of the eight boroughs for HbA1c control

in people with newly diagnosed diabetes, the proportion of people attending group consultation sessions and the proportion of people starting the REWIND low calorie programme. Delivery of high quality diabetes care will continue to be a priority across the teams for 2022-23.

Learning Disability and Serious Mental Illness and Common Complex Mental Health Need

People with a Learning Disability on GP practice registers aged 14 and over are required to have a physical health check once a year. The chart below (figure 3.) shows the progress made across the year of people in 2021/22. The end of year outturn confirmed that performance was above the target.

Figure 3.



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Actual	1%	3%	10%	16%	21%	24%	32%	40%	46%	55%	66%	77%
Target	6%	13%	19%	25%	31%	38%	44%	50%	56%	63%	69%	75%

There has been a nationally mandated requirement that 60% of people with an SMI have a physical health check consisting of 6 checks since 2018. In 2021/2022 NWL introduced a new enhanced service aiming for 70% of people with a Serious Mental Illness and the top 5% of 70% of CCMI having a health check with an extended number of checks (20). During 2021/2022 partners (The GP Confederation, CCG, MIND, and the Local Authority) worked together to increase access for health checks to the wider group to support this aspiration.

Following a Masterclass session for practices held on 24 March 2021 covering the mental health transformation programme and how voluntary sector organisations can support delivery a training programme was implemented with MH First Aid training and other bespoke training sessions set up and held each quarter.

The end of year (2021/2022) position saw 53.3% of SMI and CCMI patients having all 20 enhanced checks completed. Although this level was not the 70% expected by NWL it was a notable improvement from that achieved in 2020/21 when the outturn was 16.9% for the Nationally mandated checks for SMI. Reaching the national target will continue to be a priority for 2022-23.

Covid vaccinations

As of 15 May 2022, Hillingdon is the highest achieving Borough across NWL for first dose uptake of the Covid vaccination (70%) with 98% of care home residents vaccinated (also the highest level in NWL). Figures for the majority of the younger cohorts also rank highest across NWL. Delivery of vaccinations continues to be a partnership approach including the provision of a local

authority bus to support roving 'pop up' sites, the ongoing GP Confederation sites at Winston Churchill Theatre and Mead House, joint primary and community care delivery models with CNWL teams for care home and housebound residents, pharmacy sites across the borough and the NWL vaccination bus staffed by the NWL roving team who have been attending two Hillingdon primary schools for after school clinics from 9th May onwards at Pinkwell school (Monday and Tuesday 3-7pm) and Harmondsworth (Thursday and Friday 3-7pm).

Resources using Aggie the Alien, created by one of our younger residents as part of a Hillingdon CCG initiative, have been developed to promote the vaccine from 5-11 years old, these launched the week of 23 May and Aggie has also been featured on the BBC.

In addition to joint planning for an autumn vaccination campaign there is ongoing work to support the increase in uptake for cohorts that are showing lower uptake rates through a combination of community conversations, identifying targeted locations for pop ups and proactive communications.

Flu vaccinations

For 2021/22, Hillingdon Borough was the highest performing borough across the ICS for uptake of flu vaccinations, based on data extracted from NWL Business Intelligence (BI) team; the uptake for the over 65 cohort was 75.8% compared to 70.4% in 2020/21 and for the clinically vulnerable cohort uptake was 52% compared to 42% in 2020/21.

The NHS 22/23 influenza programme for this year covers cohorts offered vaccine prior to the pandemic. Cohorts that were eligible in the 2021 to 2022 season but that are not included in the cohorts for 2022 to 2023 are:

- those aged 50 to 64 years
- secondary school children in Years 7 to 11 (between 11 and 15 years of age on 31 August 2022)

Last year's NWL performance will be used as one of the benchmarks for next season but still a requirement to work towards 75% uptake ambition. A NWL Workshop will take place the end of May with system partners looking at forward planning for the forthcoming season.

For 2022/2023, we will work with Hillingdon Health Care Partners (HHCP) to continue to build on last year's Flu approach, ensuring effective planning and delivery across the Borough. Increasing uptake in line with all national targets; most notably ensuring we reach the majority of our homeless population and improve uptake in pregnant women.

ACCESS

Winter Access Funding

The national Winter Access Fund (WAF) was offered to systems in addition to any existing or usual local winter funding arrangement. Hillingdon created a financial framework for the distribution of funds which was a total allocation of £1.094m. The schemes were a combined offer of enhanced access for identified practices, support to PCNs to address workforce demand and at scale provision of in and out of hours appointments.

A comparison of 2019/20 and 2021/22 December to April appointments shows on average there

were 106,124 more appointments offered in 2021/22 than in 2019/20 during the Winter Access Fund period:

2019/20 December to April Appointments	2021/22 December to April Appointments
377,558	483, 682

In Hillingdon this included the mobilisation of a primary care 'surge' hub to support additional primary care demand over the winter months from 111, the UTC and practices.

Enhanced Access Requirements

Currently the Hillingdon GP Confederation provide the extended access hub service spread across three geographical sites within the Borough. NHS England recently wrote to all GP Practices and Primary Care Network (PCN) Clinical Directors to set out the General practice contract arrangements in 2022/23.

The enhanced access 2022/23 DES establishes a principle of Network Standard Hours which must be provided by all PCNs for a period of 18:30-20:00 every weekday evening and 09:00-17:00 on Saturdays. PCNs are able to provide a proportion of Enhanced Access outside of these hours, for example early morning or on a Sunday, where this is in line with patient need locally and it is agreed with the commissioner. PCNs can choose to deliver this requirement in collaboration or independently.

The NWL Primary Care team, alongside local patients, have developed a range of resources within this 'NWL Enhanced Access Pack' to support PCNs in undertaking the actions required in order to submit the PCNs' proposed plans by 31 July 2022. The Hillingdon Confederation and local Healthwatch is supporting the six PCNs with overseeing the patient engagement required within their local populations and the development of the PCN's proposed offer, in line with the national specification

Across London, NWL has been at the forefront of providing additional appointments for patients outside of core hours with well-established models in each borough of 08:00-20:00 provision Monday-Sunday. This means that we have a higher starting point of provision than other parts of the country which has benefited patients and practices alike in the capacity made available.

PLANNED CARE

Work continues across primary, secondary and community care clinicians to develop new pathways to improve access to care, make best use of our teams and collective resources and alleviate demand into specialist services.

Gynaecology

The community Coil and Pessary clinic is led by the GP Confederation and delivered in the community. This clinic has seen high utilisation with plans to further develop the service through developing the workforce and identifying additional gynaecology pathways that could be incorporated. Patient satisfaction is high with 98% of patients stating they would recommend the service and rate their experience as good or better. There has only been one DNA in the 27 clinics so far.

Ophthalmology

The Covid Urgent Eye Service (CUES) finished at the end of May as this was part of the covid response to face to face services temporarily being stood down. Activity through the service had been very low (average of 2 patients per day) and pre-existing pathways are in place for patients to be referred into. A new model of care has been specified through the clinical working group and has been submitted to NWL to join the system wide procurement process. Engagement will be undertaken to inform the model prior to procurement commencing by late summer 2022.

Gastroenterology

A shared service has been developed to support the management of IBS, IBD and Coeliac disease across acute and primary care and is currently progressing through governance processes. The service will deliver senior dietician support through primary care-based and hospital-based clinics and is intended to go live during quarter 2 of 2022/23.