2022/23 INTEGRATED HEALTH AND CARE PERFORMANCE REPORT

Relevant Board Member(s)	Councillor Jane Palmer
Organisation	London Borough of Hillingdon
Report author	Gary Collier - Social Care and Health Directorate, LBH Sean Bidewell – Integration and Delivery, NWLCCG
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 provisional value for the BCF for 2022/23 is £108,966k made up of Council contribution of £58,025k and an NHS contribution of £50,941k.
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 April to June 2022 period (referred to as the '*review period*'), unless otherwise stated. There is a separate report on the Board's agenda concerning the 2022/23 Better Care Fund (BCF) plan.

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

Planning for Post April 2023 BCF

3. The Board will be aware from the separate report on its agenda concerning the 2022/23 BCF plan that confirmation of assured status is not expected before 30 November 2022. Publication of the planning requirements for the successor plan is unlikely to happen before January 2023 at the earliest. It is therefore suggested that a dialogue be undertaken with the Integrated Care Board (ICB) to explore receptiveness to taking forward previous Board discussions about using the BCF framework to establish a place-based health and care budget.

Mental Health Crisis House

4. Establishing a crisis house as part of the transformation of the mental health crisis pathway has been the subject of discussion at several Board meetings. Although in more detail later in this report, it is highlighted that this service is now operational.

B. Workstream Highlights and Key Performance Indicator Updates

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

6. This section also provides updates on the five enabling workstreams, where there has been progress since the report to the June 2022 Board meeting.

Workstream 1: Neighbourhood Based Proactive Care

Workstream Highlights

7. **Population health management:** This is addressed in a separate report on the Board's agenda.

8. **Community development:** H4All and the Confederation have organised six Primary Care Networks (PCNs) engagement roadshows with each roadshow designed to have a specific health focus based on a priority need with that particular PCN. To date, four roadshows have taken place over various days of the week with over 1,200 residents attending. These sessions have been very successful and are a great way for PCNs to engage with their local community and help promote health education and local support services. A full evaluation of the roadshows will take place after the completion of the final event on 31 August.

9. HHCP has committed to fund another set of roadshows in the winter. The focus of these sessions will be about vaccination uptake and key health messages delivered by partners. There will also be an emphasis on "*staying well*" with signposting opportunities to benefits, housing and other key departments to support our local population during this difficult time and HHCP and the Council will work together to ensure effective delivery.

10. **Enhanced Access Service**: From 1 October, PCNs are required under the updated 2022/23 direct enhanced service (DES) contract to provide an enhanced access service that ensures bookable appointments outside core hours within the Enhanced Access period of 6.30pm-8pm weekday evenings and 9am-5pm on Saturdays, is delivered utilising the full multi-disciplinary team. The service would be offering a range of general practice services, including 'routine' services such as screening, vaccinations and health checks, in line with patient

preference and need. All 6 PCNs within Hillingdon have opted for the Confederation to deliver this service on their behalf and currently a plan is being developed which requires submission to NHS North West London by the end of July.

11. **E-consultation:** All Confederation practices have gone live with a new e-consultation provider called Patches. Patches provides a triage service that helps to manage workloads for GPs and provides a rapid and responsive online consultation service for patients. This replaces the previous *'e-consult'* service available to Hillingdon residents.

12. **Phase 5 Covid Vaccination:** The phase 5 vaccination programme will commence on 1 September. Some analysis has been undertaken to identify that there is sufficient capacity in the system to deliver the number of vaccinations required. Currently there are 14 community pharmacy sites across the borough with 2 new sites being put forward for assurance. Hillingdon Hospital will also be providing a vaccination facility and Colne Union PCN have confirmed they would like to deliver the service as well following a site assurance process.

13. **Cloud Telephony Solution:** A preferred supplier has been chosen to offer a cloud telephony solution to all practices in Hillingdon. Having a single supplier for all Hillingdon practices will support future collaborative working and therefore have significant benefits for both residents and the practices.

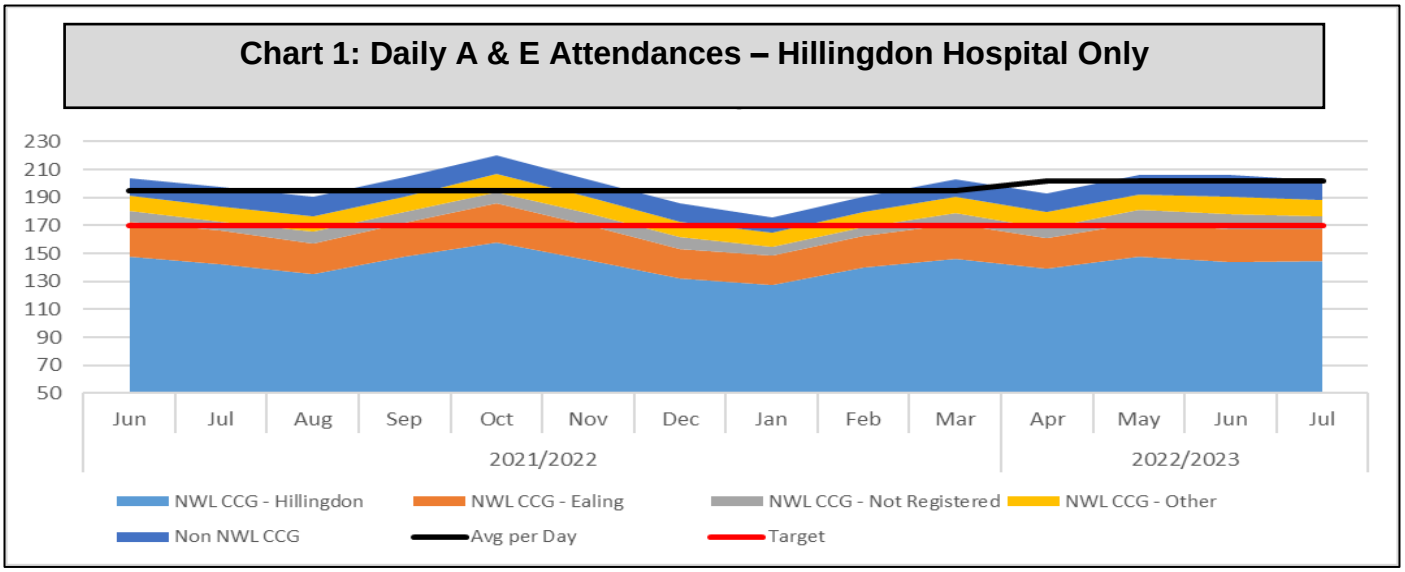
Key Performance Indicators

14. ***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). A separate report on the Board's agenda addresses the proposed 2022/23 ceiling.

Workstream 2: Urgent and Emergency Care

Workstream Highlights

15. **A & E Attendances:** An average of 202 people per day have been attending Hillingdon Hospital in the period between April and July 2022. This is a marginal increase on the average in 2021/22, which was 195. The Board may wish to note that 71% of attendees were people with Hillingdon-based GPs; 11% were registered with Ealing-based GPs and the rest from a range of areas or not registered.



Source: NWL BI

16. **Emergency Admissions:** The total number of admissions during the review period, i.e., 6,778, was identical to the same period in 2021/22. The review period saw a small reduction in the number of people aged 65 and above compared with 2021/22, i.e., 2,617 against 2,780.

17. **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. 17,771 people attended the UTC during the review period, which is slightly lower than the 18,041 who attended during the same period in 2021/22.

18. A key objective of the service is to redirect people to primary care who do not need inpatient treatment at Hillingdon 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.

19. **Same Day Emergency Care Unit (SDEC):** 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. The service saw quite wide fluctuations in activity during Q1 2022/23 with an average of 792 referrals per month.

20. Linked to the SDEC development is another project that will lead to intravenous antibiotics being delivered in the community, which will contribute to reducing demand on Hospital resources.

21. **Improving Length of Stay (LoS):** This is a programme of work that focuses on discharge across Hillingdon Hospital to deliver improvements to contribute to meeting targets that are shown below. Some projects are from HHCP and from Rapid Improvement Events run by the Trust and some are linked to the Hospital's quality priorities for the year. Work has been split by the LoS days, i.e., >7 days, 7 - 13 days, 14-21 days, 21 – 49 and 50 +. Weekly review meetings have been set up and themes identified. There is a separate programme on improving neuro rehab services with the aim of reducing LoS through developing community step down provision

based on Imperial College Hospital Trust's Specialist Neuro Rehab Outreach Service (SNROS).

22. **Step-down and discharge:** Following a competitive tender, the Council's Cabinet approved the award of contracts to two care home providers to deliver 13 beds primarily to support hospital discharge for the next four years (there is scope within the contracts to support admission avoidance, i.e., step-up). Hospital discharge is addressed in more detail in the 2022/23 BCF plan report also on the Board's agenda.

Key Performance Indicators

23. 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*: Q1 average was 93%.

- ***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. A separate report on the Board's agenda addresses the proposed 2022/23 target.

- ***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 (People/patients)**	**Q1 Average**
• > 7 days	97	149
• 7 – 13 days	45	66
• 14 – 21 days	27	31
• 21 – 49 days	23	42
• 50 + days	2	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 proposed target for this metric is addressed in more detail in a separate report on the Board's agenda.

Workstream 3: End of Life Care

Workstream Highlights

24. **End of life (EoL) integrated care strategy:** A new strategy for the period 2022 – 2025 has been developed. The six ambitions and supporting measures are illustrated below:

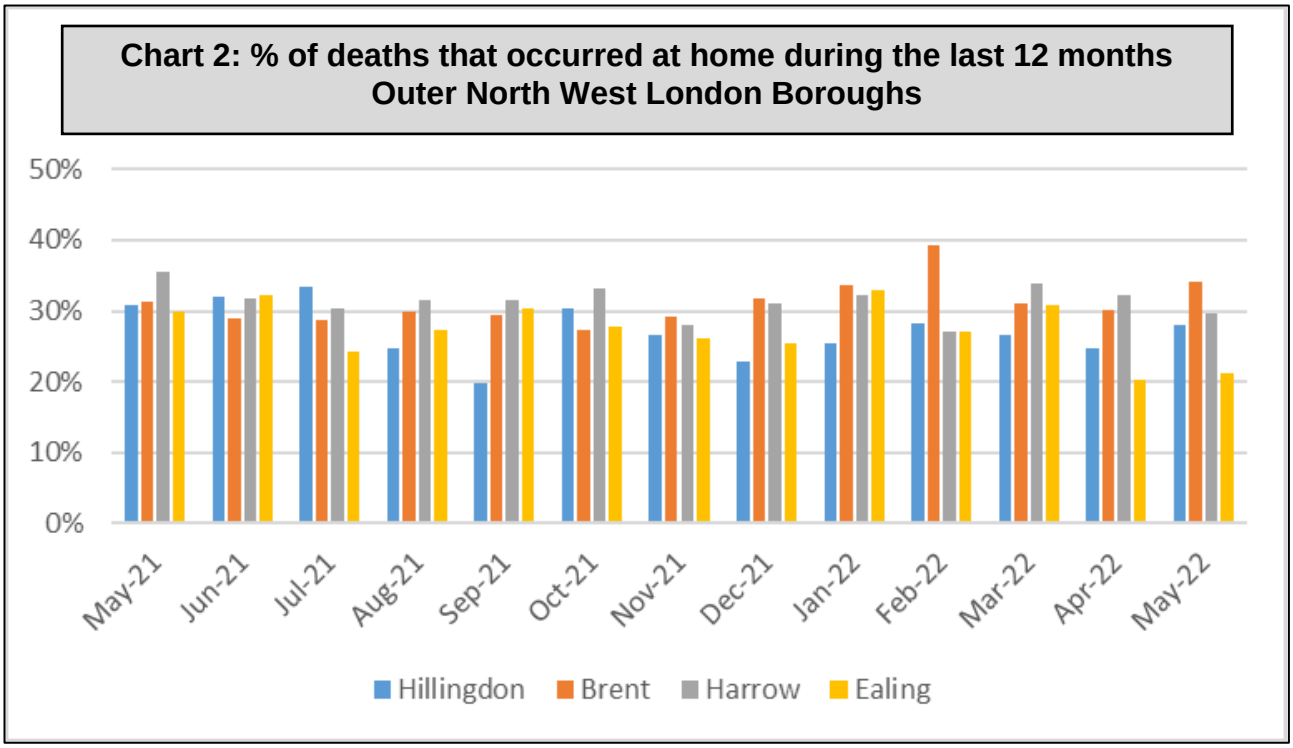
Ambition	Measure
1. Individual: Each person is seen as an individual	• % of people dying in their place of choosing. • % of people dying with an end of life care plan.
2. Fair access: Each person gets fair access to care.	• % of EoL population engaged with the health and care system. • Avoidable transfers of care to hospital from home and/or care home setting.
3. Comfort and wellbeing: Comfort and wellbeing are maximised.	• User feedback – experience. • Carer feedback – experience and outcome.
4. Coordination: Care is coordinated.	• Delays in receiving care. • Delays in receiving medication.
5. Staff: All staff are prepared to care.	• Workforce integration and training • Staff feedback – experience
6. Community: Each community is prepared to help.	• % of EoL population engaged with the health and care system.

25. **Integrated model of care:** Integrated care for people at end of life has been identified as a key Public Health priority area for 2022/23. The aim is to have an agreed model of care for people within their last year of life for implementation in Q3. On-going resident engagement is planned, including a patient survey and a patient reference group being established.

26. **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 116 people are currently being supported by this service. Options for securing longer term funding for this initiative are currently being explored by HHCP.

Performance Update

27. Chart 2 below shows that Hillingdon is ranked third in terms of the percentage of deaths occurring at home over the twelve month period to May 2022 out of the four Outer North West London boroughs.



28. Tables 3 and 4 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 3: % of people with 3+ emergency admissions in last year of life

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

Source: NWL BI EoL Dashboard

Table 4: Average number of bed days 90 days prior to death (Emergency admissions)

Borough	2019/20	2020/21	2021/22	2022/23 (April)
Brent	19.12	14.49	15.76	17
Ealing	18.94	14.41	14.44	17
Hounslow	18.09	14.71	15.85	16
Hammersmith & Fulham	18.20	16.34	19.43	17
Harrow	17.54	15.39	16.46	17

Hillingdon	18.12	14.27	15.06	19
West London	17.83	15.67	14.59	24
Central London	17.81	14.18	17.76	23
NWL Average	**18.30**	**14.79**	**15.80**	**18**

Source: NWL BI EoL Dashboard

Workstream 4: Planned Care

Workstream Highlights

29. **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. Some key developments in 2022/23 to date include:

- *Gynaecology*: Phase 2 of the 2022/23 work programme in this specialty includes the development of a business case for a gynae psychology service, a gynae pelvic health service and a menopause service.

- *Gastroenterology*: The scope for providing a specialist dietician for inflammatory bowel disease (IBD), irritable bowel syndrome (IBS), hepatology, i.e., diseases that affect the liver and pancreas, and celiac disease, is being considered and a business case taken through HHCP governance channels.

- *Ophthalmology*: Service provision for Hillingdon residents will be reflected within a sector wide procurement exercise being undertaken by NWL and local input has been provided into the specification for the service that will be tendered in due course.

30. **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 April to June 2022 saw an average of 3,612. Data suggests that the service is being effective in reducing unnecessary referrals to the Hospital and that the service has resulted in 11,632 referrals not requiring a hospital consultant appointment being avoided within the twelve month period to June 2022.

Workstream 5: Children and Young People (CYP)

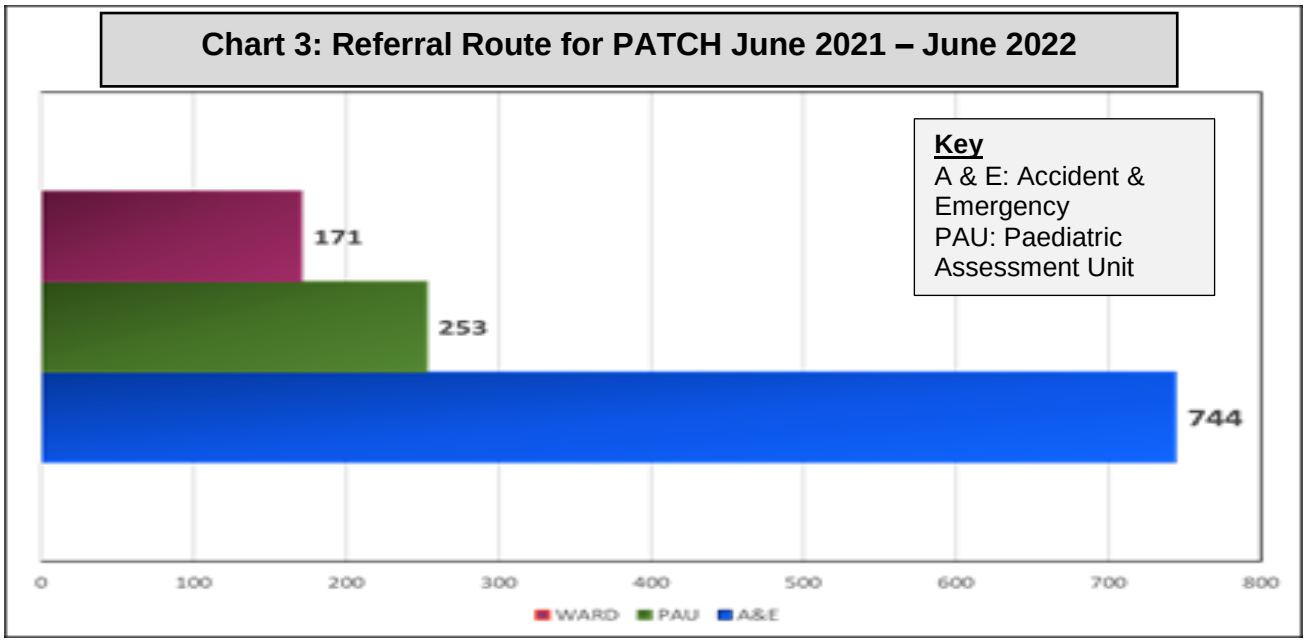
Workstream Highlights

31. **Stronger Families Hub:** Since the hub was established in August 2021 21,105 requests for assistance have been received and 9,455 of these through the portal and 1,855 families have been referred to the Stronger Families Locality Team for support.

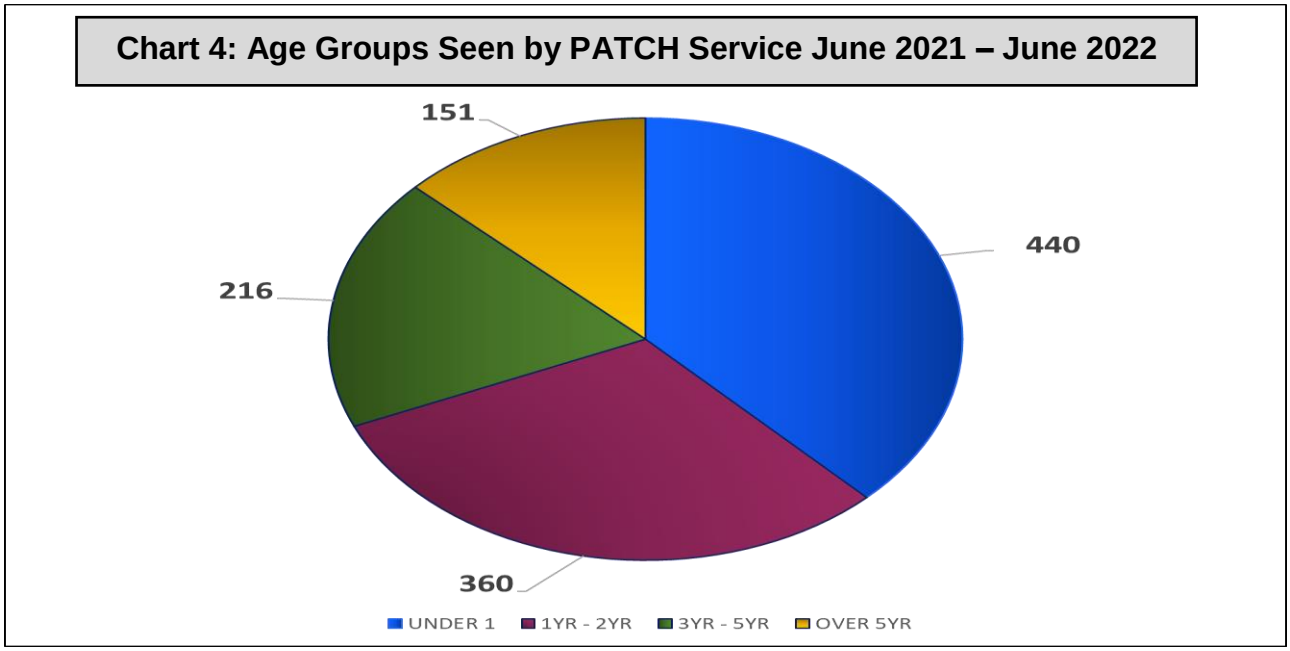
32. Two year funding has been received from the Department of Work and Pensions to establish the Parenting Apart Programme, which supports parents who are going through conflict, divorce or separation and where relationships have broken down. It also supports the emotional wellbeing of children during this time.

33. **Community step-up/step-down model:** June 2022 was the first anniversary of the

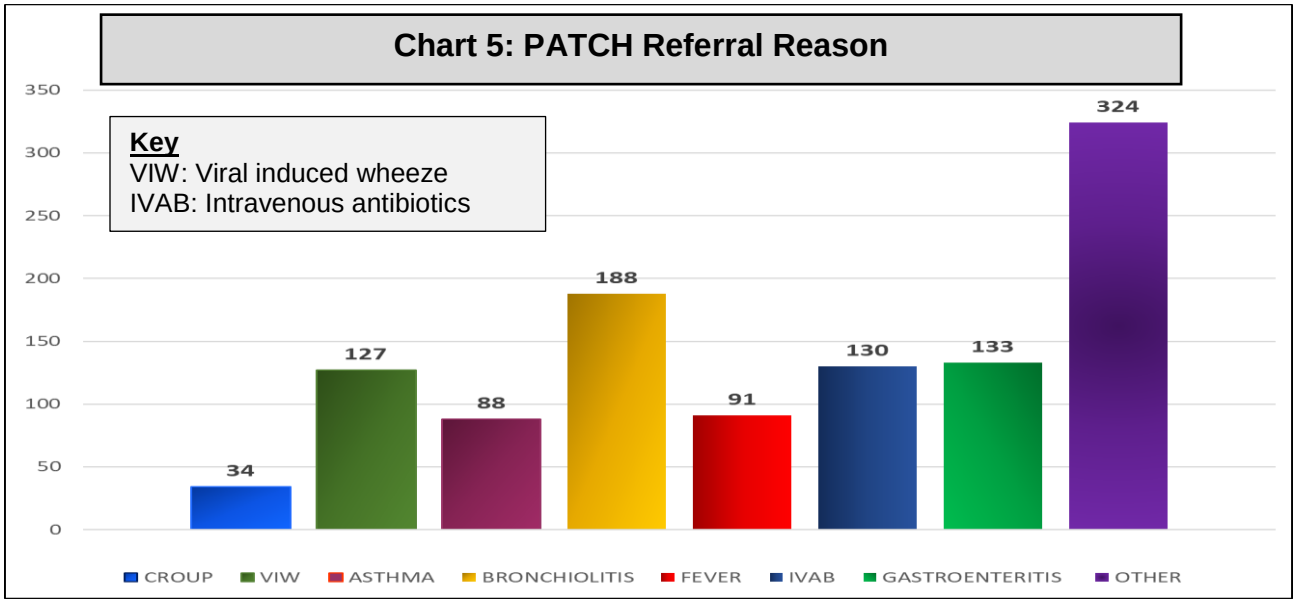
Providing Assessment & Treatment for Children at Home (PATCH) service being established. In that twelve month period 1,168 children have been seen. Chart 3 below shows the referral route into the service in the twelve month period since it became operational.



34. Chart 4 overleaf provides a breakdown of the age groups seen by the service.



35. Chart 5 below provides a breakdown of the reason for referral.



36. **Dental health:** Public Health is leading in seeking to secure recurrent funding for the supervised brushing programme and the availability of 'Brushing for Life' packs to support the oral hygiene of young children.

37. **16 – 25 young adult mental health and wellbeing partnership model:** There have been a number of developments over the review period including the new Hillingdon Young Adult Pathway lead starting on 9 May, a full time Young Adult Community Navigator being recruited by Hillingdon Mind to provide young adult focused support to develop coping and mental health self-management, navigation of services and improved engagement and the recruitment of two full-time practitioners to deliver the new At Risk Mental State Service in CNWL's Hillingdon and Harrow Early Intervention Service.

38. Other developments included grants being awarded in June to six third sector organisations to deliver a range of young adult mental health projects including creative therapies (art and drama), wellbeing courses for those with autism and attention deficit hyperactivity disorder (ADHD), and a football club with mentoring. Uxbridge College was also awarded funding to develop a new in-house counselling service, which is now in the set-up phase and Brunel University was awarded funding to deliver a young men's mental health campaign.

39. **Transition:** A trial merger of the (health focused) Transition Steering Group and the LBH Preparing for Adulthood forums took place on 5 July. The aim is to align objectives and outcomes where appropriate to ensure a more holistic approach for young people requiring both health and social care support when transferring to Adult services.

40. **Autism pathway:** The online Positive Parenting Programme (known as '*triple P*') was launched on 19 May. This programme aims to prevent – as well as treat – behavioural and emotional problems in children and teenagers. A new Supporting Autism Programme delivered in partnership with Hillingdon Autistic Care and Support (HACS) for children aged between 6 and 11 started in June and 8 parents attended.

Key Performance Indicators

41. 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 Q1 2022/23, 53% of assessments were completed within 20 weeks compared to 66% for Q4 of 2021/22 and 84% in Q1 2021/22. The drop in the recent quarter was a result of staffing absences within the team.

Workstream 6: Mental Health, Learning Disability and Autism

Workstream Highlights

42. **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. The vision is for all organisations who are involved in mental health to work in partnership to provide a menu-based approach which would allow individuals to choose what they need to help their own mental health. The project has faced difficulty in sourcing a suitable venue and the option of using a bus for this facility is currently being considered and scoped.

43. **Hillingdon Cove Café:** The Coves changed to open access in January 2022 and numbers of attendances has increased, although there is capacity for more. Work is in progress with the provider, Hestia, to launch a publicity campaign across the borough to ensure that residents know about the service and how to access it. The contract for the service has been extended to 31st March 2023 to ensure alignment with the contracts for Brent and Harrow, which will allow for a coordinated tender process. Discussions are also in progress with the Council to identify premises in a more accessible location.

44. **Crisis house:** This 6-bedded unit (known as '*The Retreat*') operated by Comfort Care Services opened on 22 August 2022, and is intended to provide intensive, short-term (3-5 nights) support to enable people to manage mental health crises in a residential setting rather than in hospital. Supporting recovery in a non-clinical and least restrictive environment has been shown to de-escalate crises and avoid the need for admission to acute mental health settings. The first person arrived at The Retreat on 30 August, and the service will work up to its 6-bed capacity over the coming weeks as services embed the new model. A formal launch is planned for later in September 2022.

45. **Community hub model:** The community hub model has been implemented successfully in other NWL boroughs and the intention is to replicate this in Hillingdon. The aim is to open the Hillingdon service in Q3 2022/23.

Community Mental Health Model Explained

The hub model will remove the barriers between primary and secondary care community mental health in line with the NHS Long-Term Plan's vision for a place based community mental health model. The service will be modernised to offer whole-person, whole-population health approaches, aligned to the six primary care networks (PCNs). There will be three community mental health hubs in Hillingdon each one aligned to two primary care networks.

The creation and implementation of the new model of care will:

- Lead to closer, more joined up working with our primary care colleagues, helping to eliminate the existing primary, secondary care divide and encourage a '*one team*

feel'.

- Facilitate a way of working built on conversations and relationships rather than referrals and handoffs.
- Eliminate thresholds and create a shared ownership of resource utilisation across the system.
- Reduce need for multiple assessments freeing up time for staff to use their specialist skills for the provision of defined, shorter outcome informed episodes of care.
- Help increase the confidence of our primary care colleagues with regards to the provision of support to individuals with mental health needs through regular contact with mental health colleagues and MDT support.
- Give us the opportunity to redefine discharge, reducing the 'cliff edge' feeling reported by patients.
- Allow rapid communication to the patient and referrer following triage.
- Provide an enhanced offer incorporating improved joined up provision within PCNs.
- Multi-disciplinary teams will work together to help patients on their journey to recovery. The team will be made up of nurses, therapists, peer support workers, pharmacist, employment support, psychologists, consultant psychiatrists and will work with and support the new mental health practitioners who are based in the PCNs.

46. **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. CNWL is currently identifying the cohort of people to refer as well as the referral processes. Progress will be reviewed on a quarterly basis during the lifetime of the pilot.

47. **Autism strategy:** The Board is reminded that an all-age autism strategy is under development, and it is the intention of officers to bring the results of the strategy development process to the Board's attention in the performance report to its March 2023 meeting.

Enabling Workstreams

48. 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

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

50. **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

51. The annual update report on the implementation of the carers' strategy delivery plan and

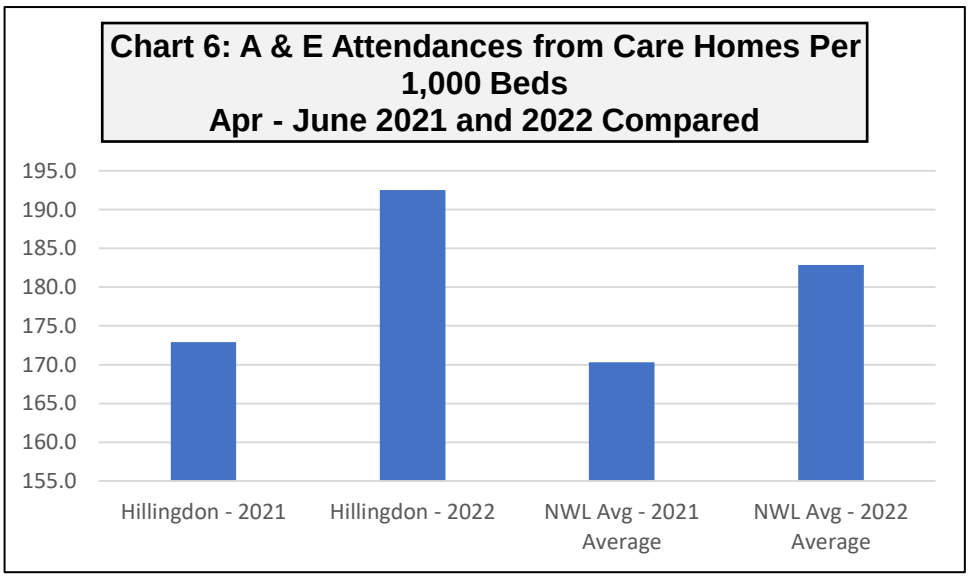
priorities for 2022/23 was considered by the Health and Social Care Select Committee at its meeting on 22 June. The report (item 9) can be accessed via the following link [London Borough of Hillingdon - Agenda for Health and Social Care Select Committee on Wednesday, 22nd June, 2022, 6.30 pm]

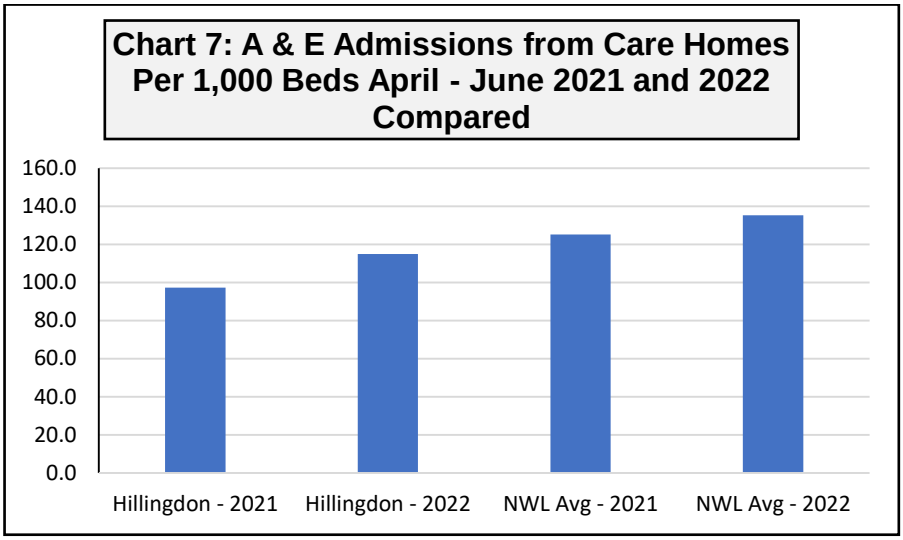
52. The Board is reminded that an updated joint carers' strategy is in development that will seek to address the support needs of carers in the period to 2028. It is also the intention of officers to bring the results of the strategy development process to the Board's attention in the performance report to its June 2023 meeting.

53. **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

54. **Care homes:** 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). Charts 6 and 7 below help to 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. In 2021/22 Hillingdon managed to achieve a rate of admissions that was below the NWL average and this has continued during the review period. The average length of stay in hospital of residents from Hillingdon's care homes during the review period was 12.5 days, which compares to a NWL average of 9.5 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.





55. It was reported to the June Board meeting that the main cause of London Ambulance Service (LAS) attendances at care homes during 2021/22 and subsequent conveyances and admissions to hospital was falls related injuries and this continues to apply in 2022/23. The Board may also wish to note that the multi-agency Falls and Frailty Steering Group has developed a '*Falls Prevention and Management in Care Homes'* resource pack that is currently being socialised in care homes by the Care Home Support Team.

Care Home Support Team Expanded

This is a multi-agency team established in 2017 that includes six care home matrons who each have responsibility for supporting specific care homes and extra care schemes. For older people's care homes this means daily contact and for other homes it means a minimum of weekly contact. The team is also supported by GPs, a dietician, a speech and language therapist (SALT), a mental health nurse and tissue viability specialist. Specialist medical advice and support is also provided by a care of the elderly consultant at Hillingdon Hospital.

56. The Board may be interested to note that intensive support from the Care Home Support Team to one of the borough's larger care homes has contributed to it moving from the 5th highest user of the London Ambulance Service in NWL in January 2022 to the 60th at the end of July.

Key Performance Indicators

57. The following is an enabler 2 workstream indicator:

- **Permanent admissions to care homes:** This BCF metric is intended to measure the number of people per 100,000 aged 65 and over who have been permanently admitted to care homes. This is addressed in more detail in a separate report on the Board's agenda.

CORPORATE IMPLICATIONS

Hillingdon Council Legal Comments

58. There are no legal implications arising from the recommendation set out within the report.

BACKGROUND PAPERS

Joint Health and Wellbeing Strategy, 2022 – 2025