2022/23 INTEGRATED HEALTH AND CARE PERFORMANCE REPORT

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

HEADLINE INFORMATION

Summary	This report provides an update on the delivery of the transformation workstreams established to deliver the priorities within the Joint Health and Wellbeing Strategy. This report also includes an update on actions within the scope of the draft 2022/23 Better Care Fund.
Contribution to plans and strategies	The Joint Health and Wellbeing Strategy and Better Care Fund reflect statutory obligations under the Health and Social Care Act, 2012.
Financial Cost	The value for the BCF for 2022/23 is £109,080k made up of Council contribution of £58,033k and an NHS contribution of £50,947k.
Ward(s) affected	All

RECOMMENDATION

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

INFORMATION

Strategic Context

1. This report provides the Board with an update on delivery of the priorities within the Joint Health and Wellbeing Strategy for the July to September 2022 period (referred to as the '*review period'*), unless otherwise stated.

2. This report is structured as follows:
   A. Key Issues for the Board's consideration
   B. Workstream highlights and key performance indicator updates

A. Key Issues for the Board's Consideration

2022/23 Better Care Fund Plan

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

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

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

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

Winter Demand Planning

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

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

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

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

NWL Children and Adolescent Service (CAMHS) Provider Collaborative Explained

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

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

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

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

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

B. Workstream Highlights and Key Performance Indicator Updates

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

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

Workstream 1: Neighbourhood Based Proactive Care

Workstream Highlights

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

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

Health Action Plans Explained

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

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

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

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

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

About Community Champions

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

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

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

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

Key Performance Indicators

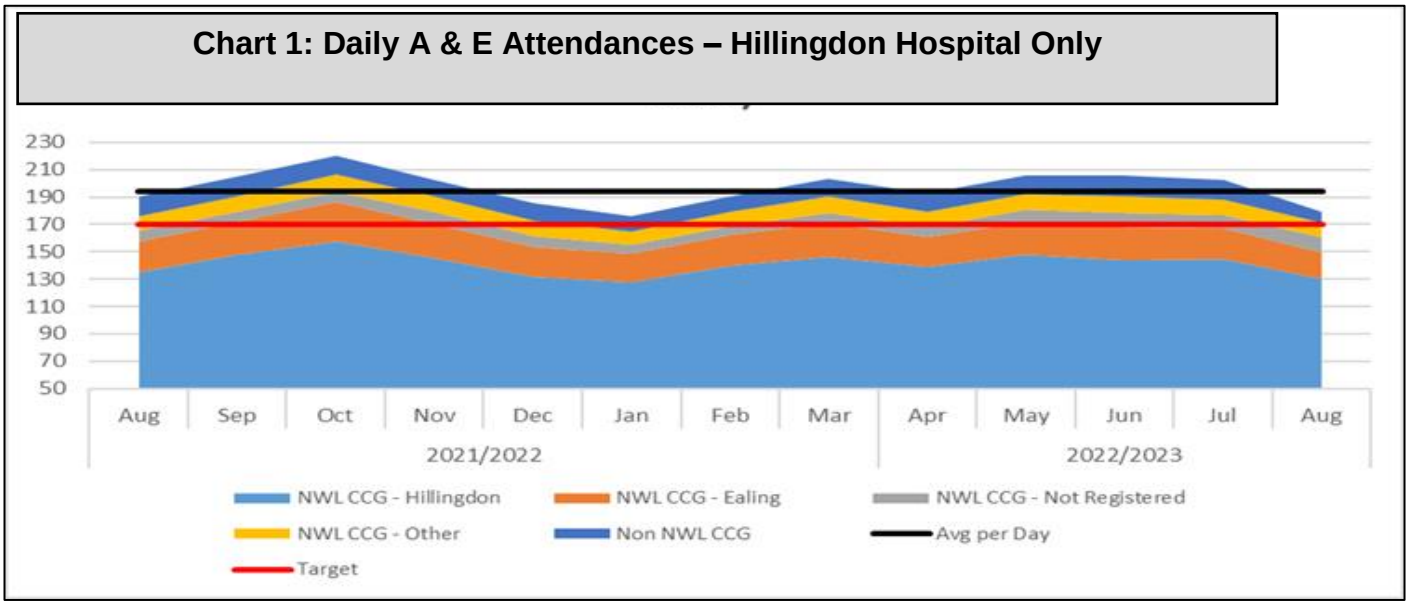
20. ***Admission avoidance:*** This BCF metric is intended to measure a reduction in adults admitted to hospital for ambulatory care sensitive conditions. The conditions within the scope of this metric include acute bronchitis, angina, heart disease, heart failure, dementia, emphysema, epilepsy, high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

Workstream 2: Urgent and Emergency Care

Workstream Highlights

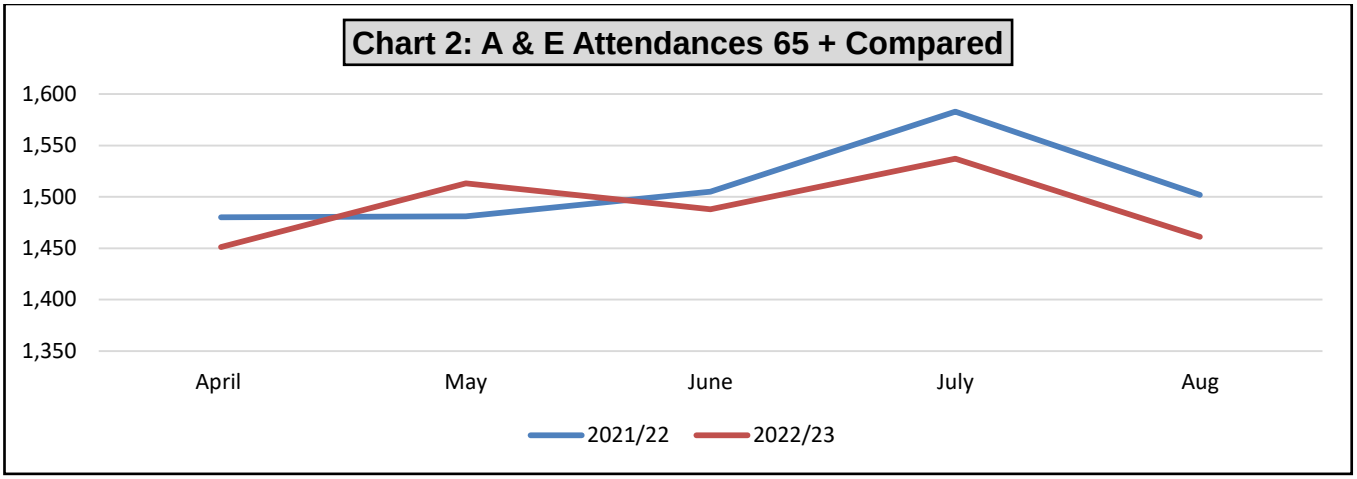
21. **A & E Attendances:** An average of 194 people per day have been attending Hillingdon Hospital in the period between April and August 2022. This is the same as the 2021/22 average. The Board may wish to note that nearly 73% of attendees were people with Hillingdon-based GPs; 12% were registered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

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



Source: NWL BI

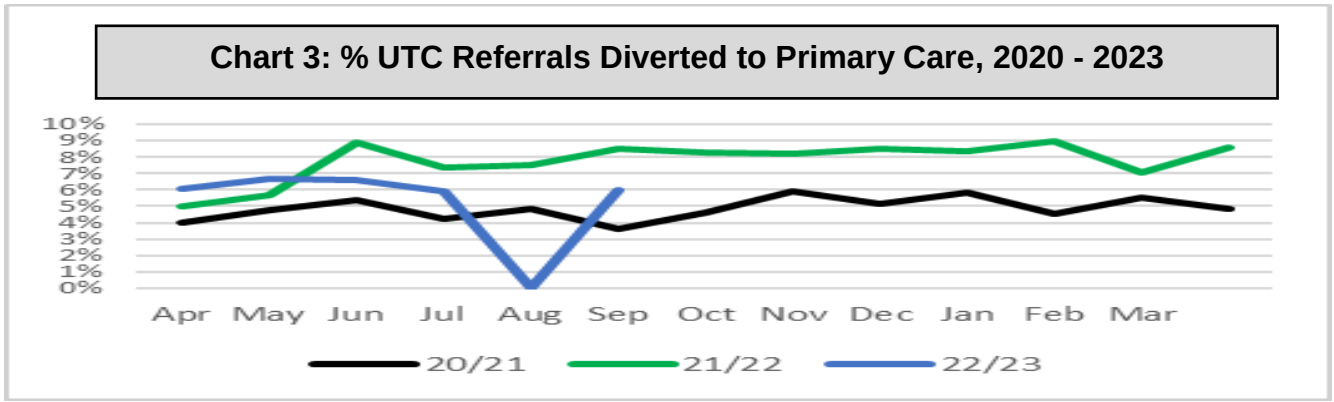
22. Chart 2 below shows a marginal reduction in the number of people aged 65 and above attending A&E between April and August 2022 compared to the same period in 2021/22.



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

24. **Urgent Treatment Centre (UTC):** This is for residents who have an urgent or severe condition or minor injury that cannot wait for a GP appointment (usually 48 hours). Hillingdon's UTC is based on the Hillingdon Hospital main site. A cyber-attack in Q2 means that UTC activity data is not available.

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



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

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

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

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

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

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

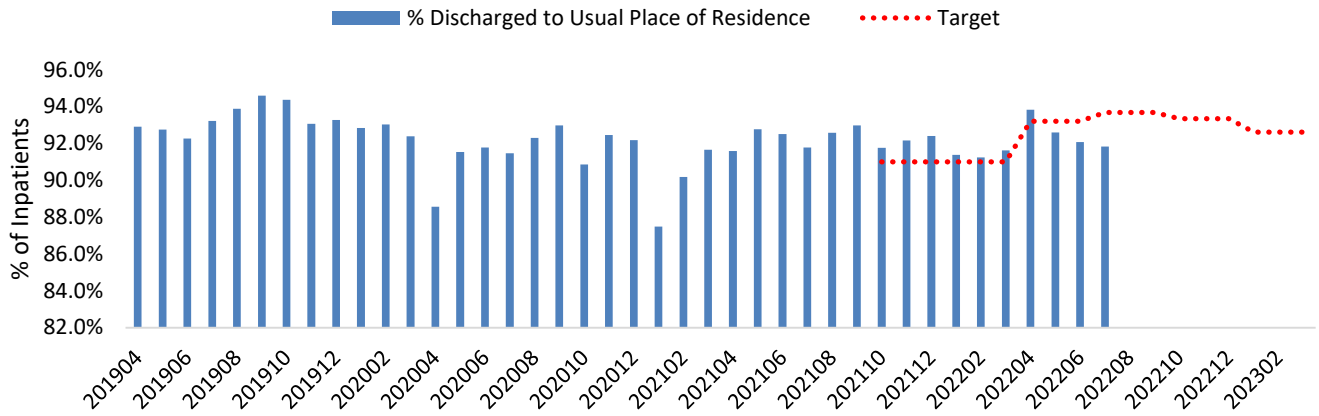
Key Performance Indicators

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

- ***Daily bed occupancy rate at Hillingdon Hospital:*** The current bed occupancy target should be at no more than 85%, i.e., 47 bed capacity at the start of each day. *Slippage*: The average occupancy rate for the April to September 2022 period was 92%.

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

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



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

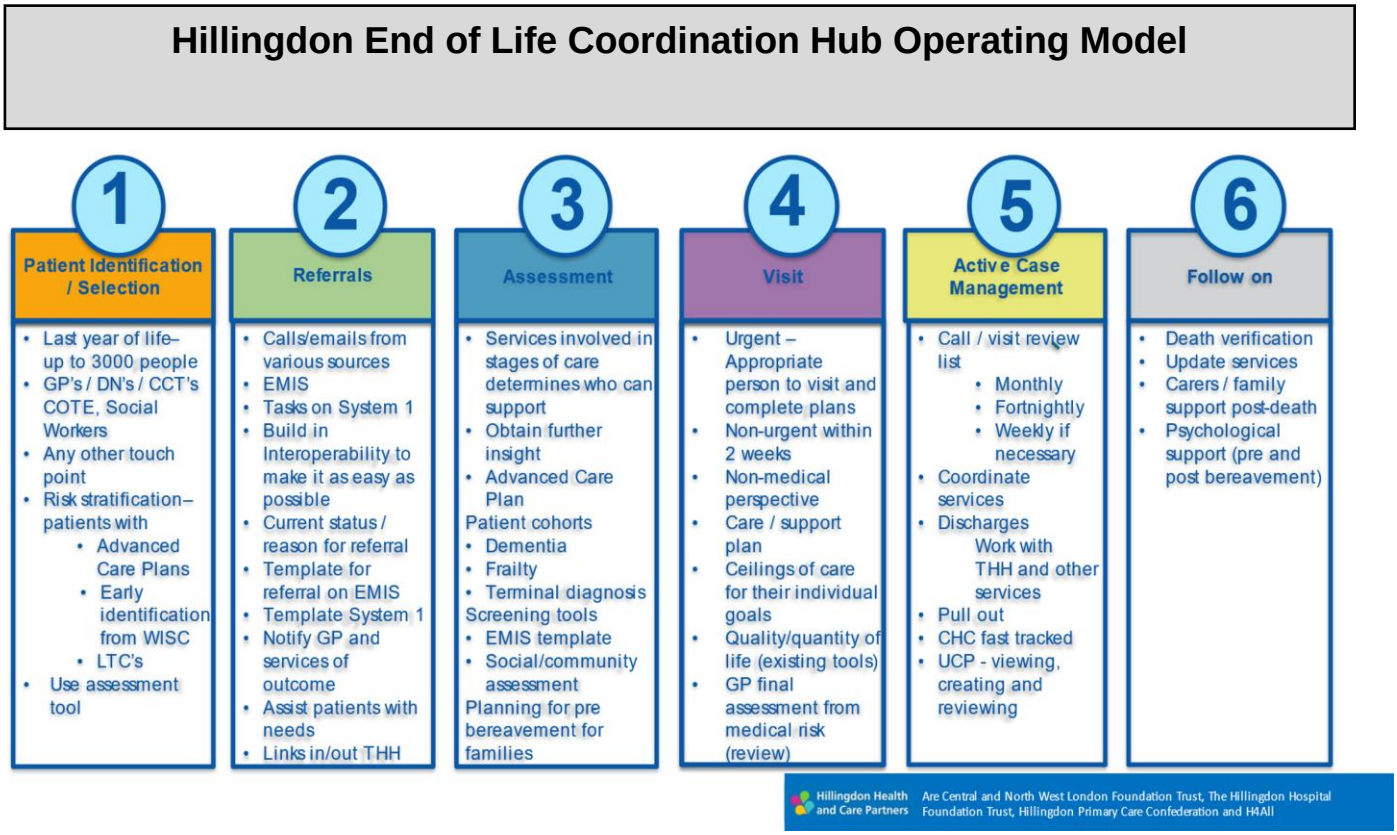
Table 1: Hillingdon Hospital Length of Stay Targets 2022/23		
Descriptor	**Target (No of People/patients)**	**Q2 Average**
• > 7 days	117	145
• 7 – 13 days	53	64
• 14 – 21 days	25	31
• 21 – 49 days	33	40
• 50 + days	10	10

- ***Effectiveness of reablement:*** This long-standing BCF metric is a measure from the Adult Social Care Outcomes Framework (ASCOF). It measures the percentage of the 65 and over population discharged into reablement from hospital who are still at home 91 days after discharge. The aim is for the percentage to be as high as possible and it has also been a BCF metric since its inception. The national sample for this metric is people entering reablement following discharge in Q3. The target is for 90.5% to still be at home at the end of March 2023. It will not be possible to report on the outturn for this metric until the end of year report to the Board in June 2023.

Workstream 3: End of Life Care

Workstream Highlights

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

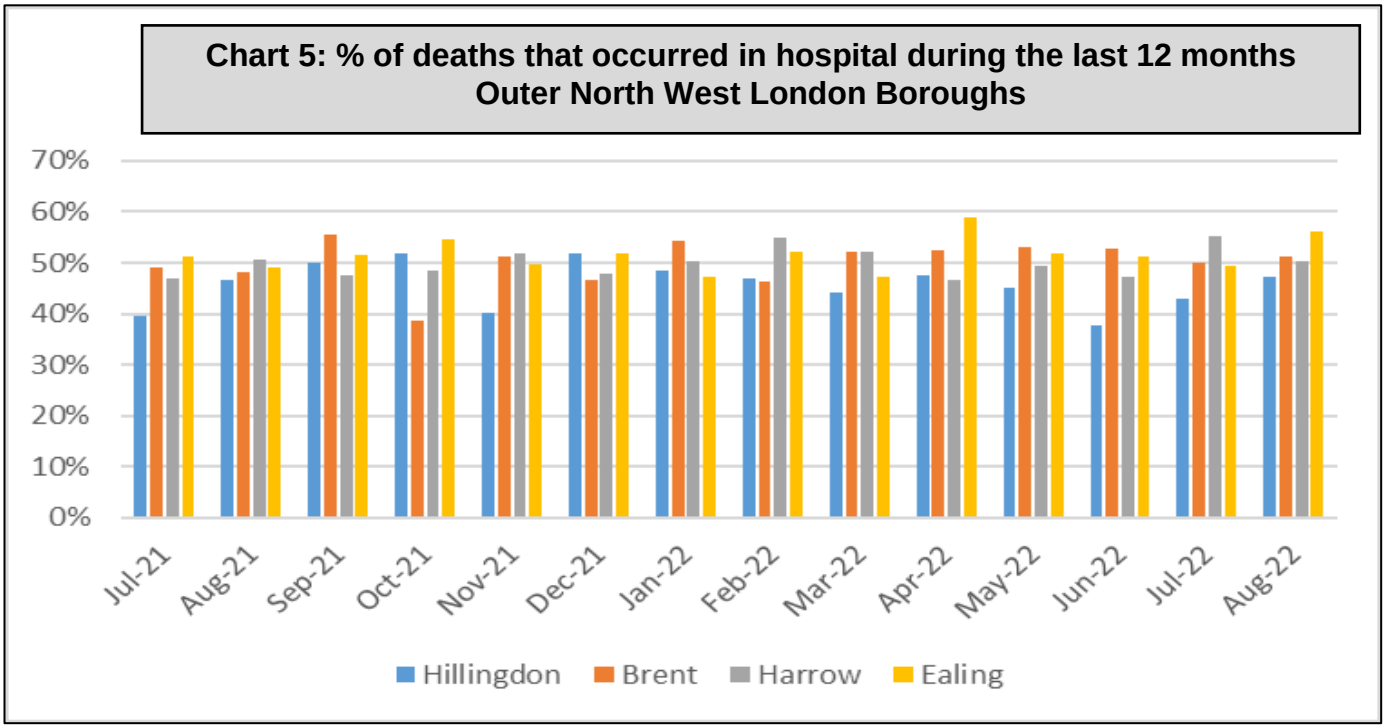


33. **Compassionate Hillingdon:** '*Compassionate Neighbours'* is a social movement that enables local people to provide support to people in their communities who are at the end of their life due to age or illness. The '*Compassionate Hillingdon'* version includes access to free care provision and 128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

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

Performance Update

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



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

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

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

Source: NWL BI EoL Dashboard

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

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

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

Source: NWL BI EoL Dashboard

Workstream 4: Planned Care

Workstream Highlights

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

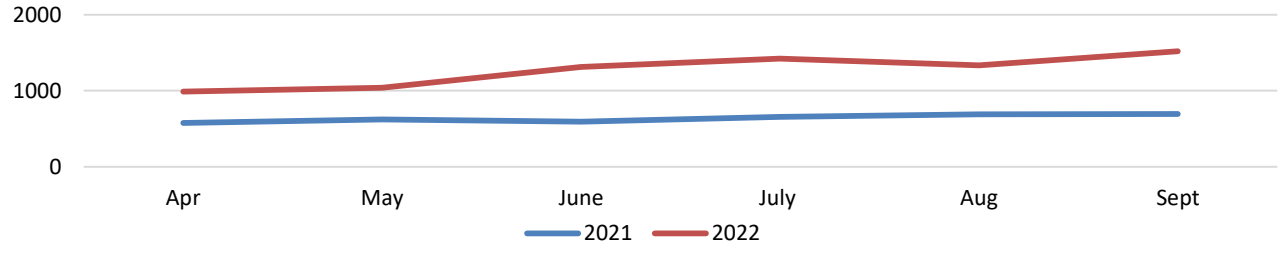
- *Gynaecology*: Five gynae clinics have been established, two of which are nurse-led pessary clinics. A new clinic structure has also been agreed resulting in three of them offering two GP-led sessions, two nurse-led sessions and one pelvic ultrasound session per month.
- *MSK*: A contract has been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

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

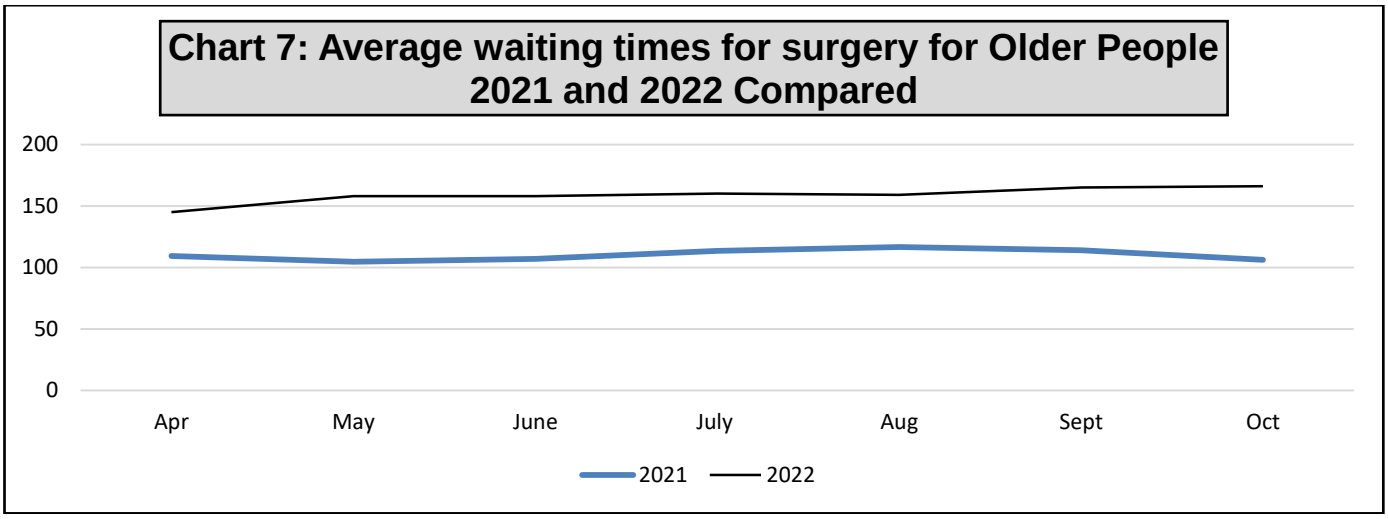
Performance Update

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

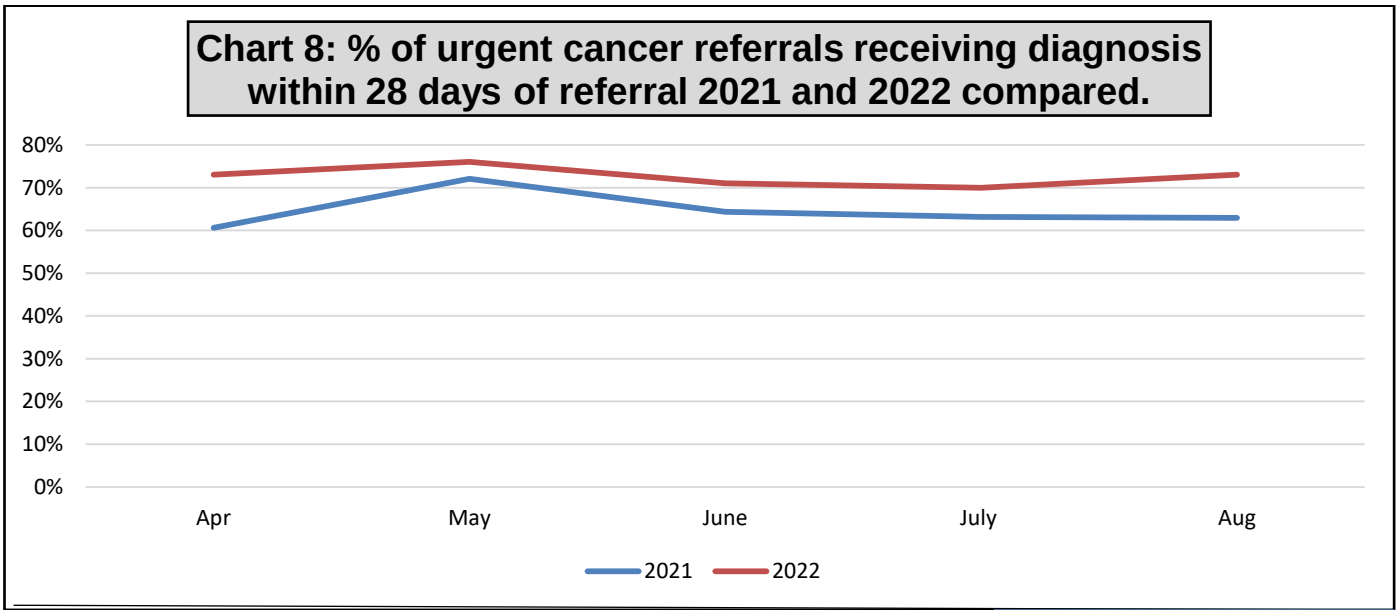
Chart 6: No of patients waiting 52 weeks or more for surgery 2021 and 2022 compared



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



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

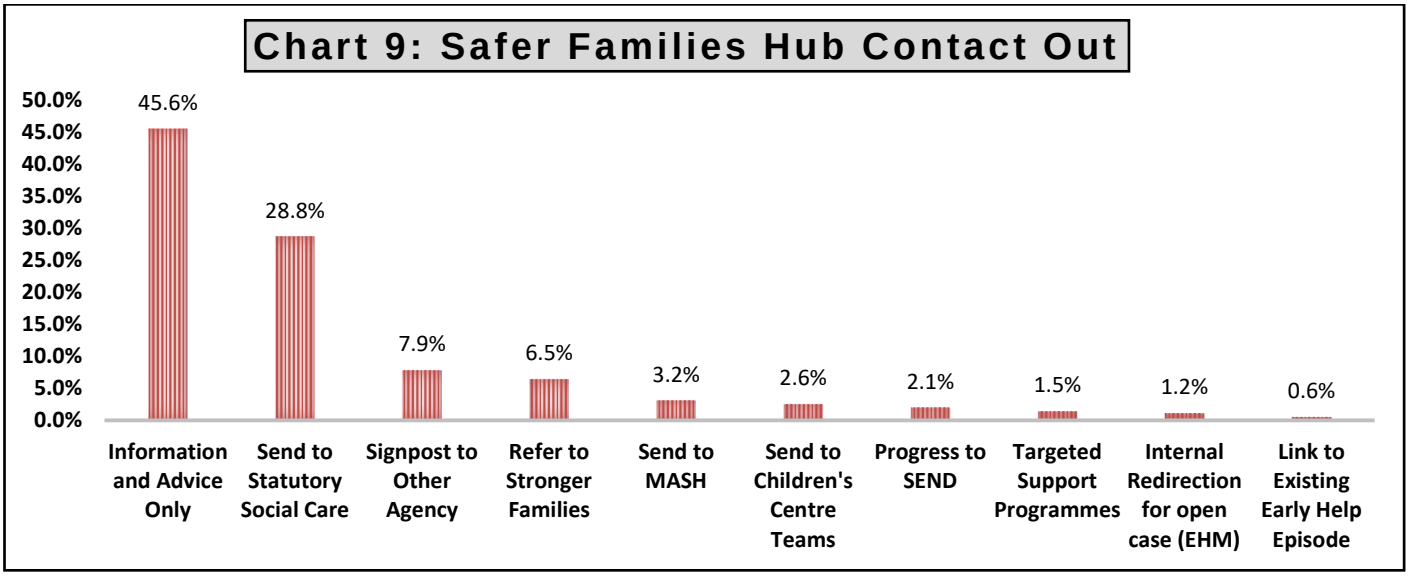


Workstream 5: Children and Young People (CYP)

Workstream Highlights

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

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



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

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

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

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

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

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

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

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

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

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

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

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

Key Performance Indicators

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

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

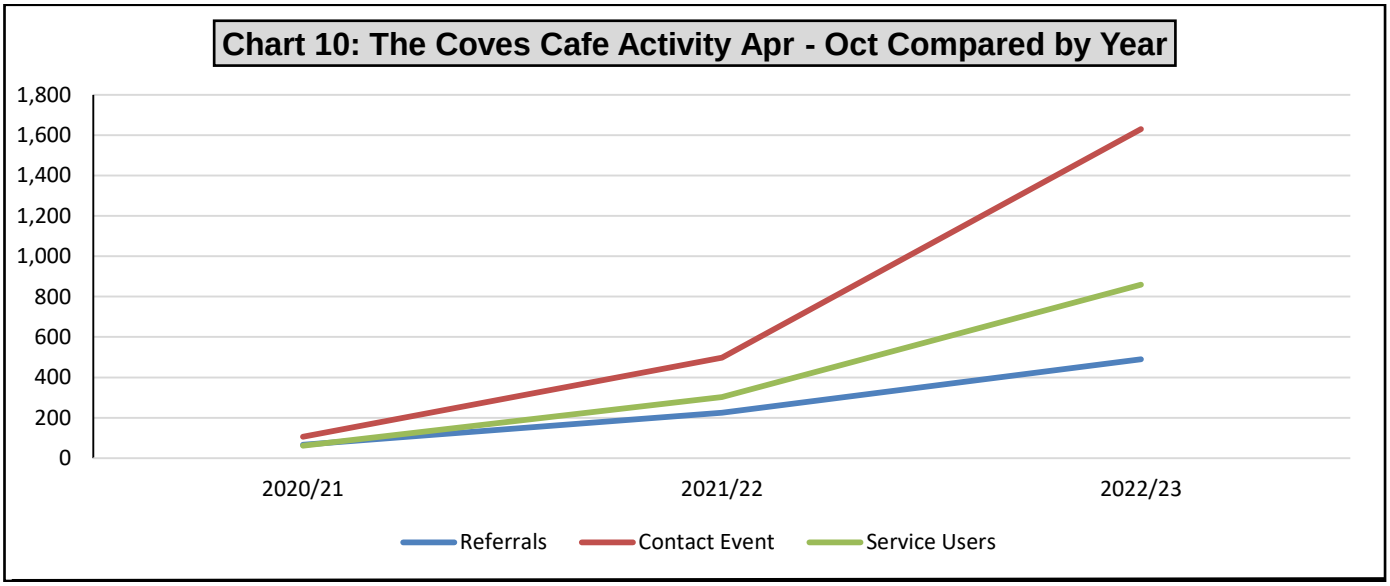
Workstream 6: Mental Health, Learning Disability and Autism

Workstream Highlights

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

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

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



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

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

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

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

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

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

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

Additional Roles Reimbursement Scheme

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

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

Enabling Workstreams

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

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

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

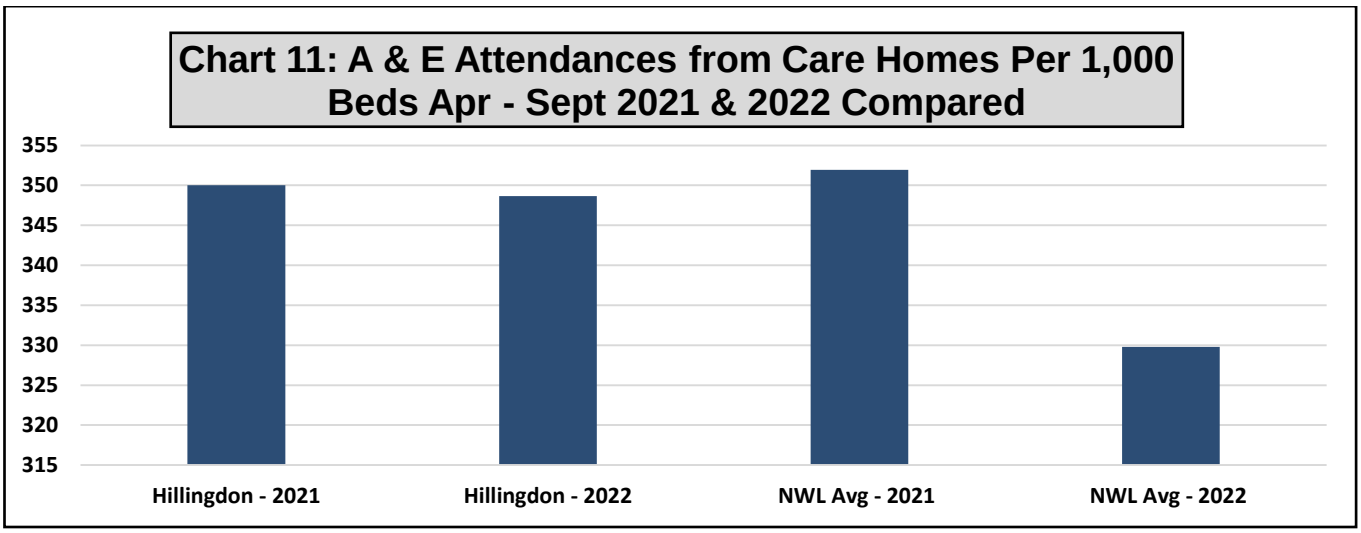
65. **Enabler 2: Care Market Management and Development:** The Council is also the lead organisation for this enabling workstream, the primary objectives of which are to support the sustainability of the market as it emerges from the pandemic and to integrate commissioning arrangements where this will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

Workstream Highlights

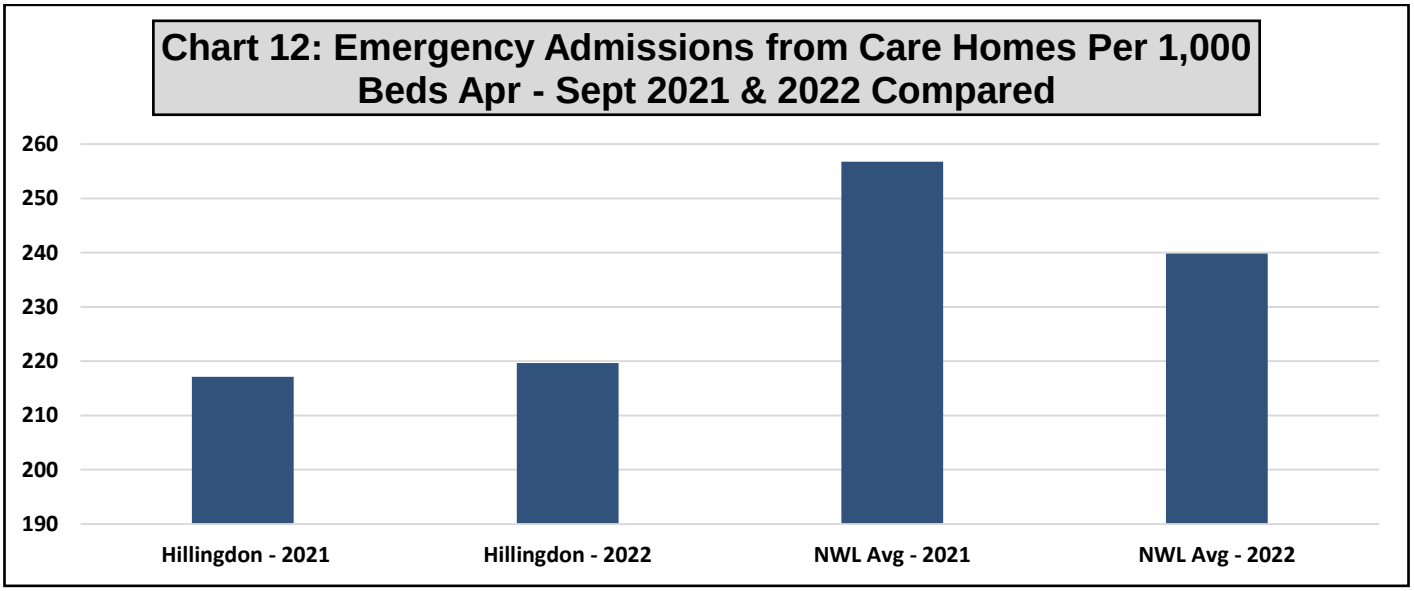
66. **Care homes:** The Board is reminded that Hillingdon has 44 care homes with a total of 1,364 beds and 89% (1,215) of these are supporting older people. This means that Hillingdon has the second highest number of care home beds in North West London after Ealing (1,560).

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

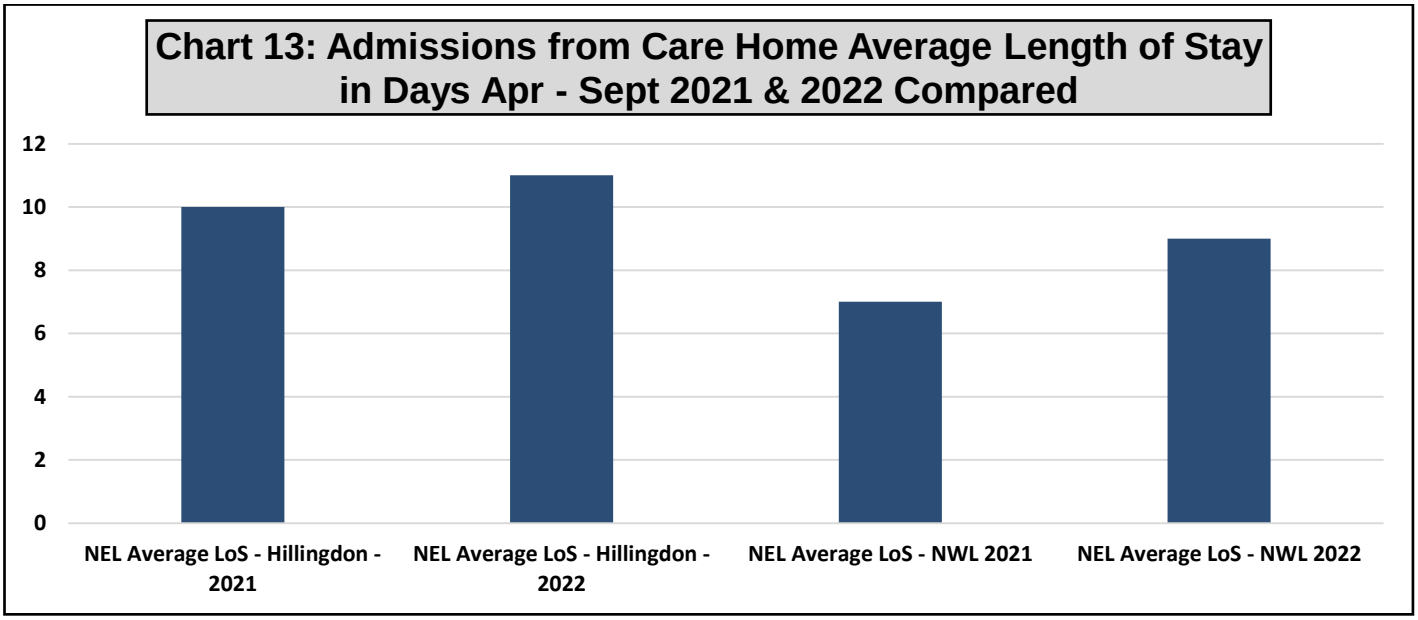
analysis.



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



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



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

Finance

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

BACKGROUND PAPERS

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