2022/23 INTEGRATED HEALTH AND CARE PERFORMANCE REPORT

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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 Joint Health and Wellbeing Strategy. This report also includes an update on actions within the scope of the 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 Better Care Fund (BCF) for 2022/23 is £111,570k, made up of Council contribution of £58,900k and an NHS contribution of £52,669k.
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 Health and Wellbeing Board with an update on delivery of the priorities within the Joint Health and Wellbeing Strategy for the October to December 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

Hillingdon Health and Care System Planning

3. Planning discussions for the post April 2023 environment have been taking place between partners. These have occurred within the context of the following key drivers:

- *An underlying system financial deficit:* NHS organisations in Hillingdon are carrying historic debt that pre-dated the pandemic but has been exacerbated by it. The projected gap between income and expected expenditure by the Council over the next three years contributes to the wider system financial outlook.
- *Hillingdon Hospitals new build business case*: The business case is predicated on the new hospital delivering a different level of capacity to what is currently in place. This is itself predicated on the implementation of new models of care that will manage demand.
- *Integrated Care Board (ICB) delegation of budgets to place*: Place-level delegation of health budgets is unlikely to be agreed without plans being in place to address the underlying causes of the system deficit.

4. A series of workshops with partners across Hillingdon's health and care system have taken place in Q4 to consider a future state operating model with the ultimate goal of preventing hospital attendances. The future state operating model has been framed around the following conceptual model of place-based health and care functions.

Place Based Functions		
Neighbourhoods	**Place**	**Integrated Care System**
Maintaining Whole Population Health and Wellbeing	**Providing Reactive Care**	**Delivering Very Specialist and/or Hospital Services**
• Streamlining same day access to care and advice for people who get ill but only use health services infrequently. • Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including those with multiple long-term conditions. • Helping people to stay well for longer as part of a more ambitious and joined up approach to population health and prevention.	Services that provide a time limited same day community based response to: • Unplanned rapid physical and/or mental health deterioration in the health of a person with complex needs or multiple long-term conditions to prevent unnecessary hospital admission or an emergency department attendance and/or premature admission to long-term care. • Promote faster recovery from acute (mental) illness to support timely discharge from hospital and maximise independent living.	• Patient safety, i.e., low demand for very specialist care skills or issues of critical mass leading services to be organisation on ICS or pan-borough level.

5. The next steps are to develop a fully costed future state operating model that is supported by a comprehensive demand, capacity, and financial modelling.

Better Care Fund Next Steps

6. The Board is advised that both the Integrated Care Board (ICB) and the Council have now signed off the BCF section 75 agreement and Hillingdon is therefore compliant with 2022/23 national requirements.

7. It is understood that the planning requirements for the next iteration of the Better Care Fund are due to be published in March 2023 and that the required plan will cover a two year period, i.e., 2023-2025. However, past experience suggests that this may be delayed.

8. What is currently known about requirements for the new plan is as follows:

- It will need to identify how health inequalities are being addressed.
- There will be a continuing emphasis on addressing hospital discharge.
- Demonstration of capacity and demand planning will form an integral part of the BCF planning and assurance process and completion of an intermediate care demand and capacity template will be required.
- A discharge fund spending plan will need to be included.
- Each area will be required to set its own delayed transfers of care target.

9. The further development of the BCF will be determined by the outcome of discussions in respect of the new operating model referred to above. Where the model requires (or would benefit from) the delegation of functions between an NHS body, e.g., the ICB and/or an NHS foundation trust, and the Council and/or the transfer of funding within a pooled budget then the *NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000* would require an agreement under section 75 of the NHS Act, 2006, to be established and the BCF framework provides a logical home.

Examples of delegation of Functions and Transfer of Funds under the 2022/23 BCF

Delegation of Functions

- *Lead commissioning*, i.e., bridging care, bed-based step-down, delirium support service, integrated therapies for children and young people.

- *Assessment and case management*, i.e., community equipment, people with learning disabilities, personal health budgets as direct payments.

Transfer of Funds

Funds are transferred in respect of the above activities but also:

- Funding or joint funding of posts such as social work support for hospital discharge, speech and language therapist in the Youth Justice Service, Designated Clinical Officer, Population Health Management support posts.

- Population Health Management implementation initiatives.

Winter Pressures Update

10. The performance report considered by the December Board identified how partners were

seeking to ensure resilience of the health and care system through the winter months through an agreed plan that covered four themes of: prevention, demand management, flow and mental health. The winter plan has been aided by the provision of additional national funding through Hillingdon's allocation from the Government's Adult Social Care Discharge Fund, which was announced in September 2022. Allocations to local authorities and ICBs was announced on 17 November 2022 and Hillingdon has received £1,985k. The following are examples of the additional capacity that this has helped to secure:

- 6 step-down nursing care home beds.
- 3 step-down beds for people at end of life.
- 4 step-down flats in an extra care setting.
- 25 additional homecare workers.
- Additional clinical support for the discharge lounge at Hillingdon Hospitals.

11. The fund has also assisted with enabling homecare providers in contract with the Council to pay retention payments to their care workers with the intention of maintaining existing capacity within the homecare market, which is the main issue for Hillingdon. A consequence of the late publication of the grant conditions, i.e.,18 November 2022, is that the main impact of the retention payments is likely to be realised in 2023/24 rather than during the winter period of 2022/23 as intended.

12. Table 1 below provides a summary against system wide winter key performance indicators in respect of Hillingdon Hospitals activity. The Board is asked to note that Hillingdon Hospitals activity includes people who are not residents of the London Borough of Hillingdon. This is particularly relevant in respect of social care responsibility which is linked to local authority in which a person is ordinarily resident. Reference to discharge to assess (D2A) pathways in Table 1 are explained below.

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.

Table 1: Summary of Performance Against System Winter KPIs

Winter KPIs	Winter KPI	RAG Rating Key		30 day mean average (to 9/02/23)
		Amber	Red	
General & Acute Beds				
• Total adult G&A beds open	**302**			
• Of total G&A beds open, number occupied	**92%**	93%	>=94%	91%

A& E Activity & Performance				
• No. of A&E Attendances	**170**	187	>187	197
• No. of Patients treated by Urgent Treatment Centre	**210**	231	>231	148
• No. of Paediatric Attendances	**60**	66	>66	47
Admissions and Discharges				
• Number of Emergency Admissions	**46**	51	>51	55
• No. of Daily Discharges	**76**			63
○ Pathway 0	**65**	60	<60	54
○ Pathway 1	**8**	6	<6	6
○ Pathway 2	**3**	2	<2	1
○ Pathway 3	**1**		0	2
Length of Stay (LOS)				
• No. of patients with LLOS >7 days	**97**	107	>107	152
Community Beds				
• HICU bed occupancy % (22 beds)	**90%**	95%	>95%	91%
• EOL - Michael Sobell House bed occupancy (10 beds)	**90%**	95%	>95%	80%
• EOL - Hayes Cottage bed occupancy % (5 beds)	**90%**	95%	>95%	42%
Bridging Care				
• Reablement - % utilisation	**90%**	**95%**	**>95%**	72%

Key: EOL = End of Life; HICU = Hawthorn Intermediate Care Unit.

B. Workstream Highlights and Key Performance Indicator Updates

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

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

Workstream 1: Neighbourhood Based Proactive Care

Workstream Highlights

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

Key Performance Indicators

16. The following is an update on workstream 1 indicators:

- ***Admission avoidance:*** *On track*: 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 2 ceiling was 439

admissions. Performance data against this metric is published nationally and this is not currently available.

- **Health checks for people with learning disabilities and health action plans**: *On track*: As of 31 December 2022, Hillingdon has completed 61% of the health checks for the people with learning disabilities on GP registers. The national annual target is 75%. 59% of people with learning disabilities on GP registers also had an up-to-date health action plan. The national annual target is also 75%.

- There has been extensive work done by the ICB, the Council and CNWL to raise awareness and increase uptake. This includes the addition of adult health checks to the key performance indicators (KPIs) reported by social care providers. They are also reflected in annual reviews undertaken under the Care Act by social work practitioners. In addition, health checks are also a standing item at the monthly forum with adult social care providers who are registered with the Care Quality Commission. Masterclass training sessions have also been run by the ICB with GPs.

- **Health checks for people with severe mental illness (SMI): *On track*:** During the period April to December 2022 59.8% of people with severe mental illness received a health check against a target for the year of 60%.

- **Population dementia diagnosis rate:** *On track*: Data for the April to September 2022 period (the most recent available) shows a rate of 65.2% against the annual target of 66.7%.

- **Diagnosis for urgent cancer referrals:** *On track*: Data for the April to December 2022 period shows an average rate of 70% against the national annual target of 75%.

Workstream 2: Urgent and Emergency Care

Workstream Highlights

17. **A & E Attendances:** During the review period, there was an average of 195 people a day attending the Emergency Department at The Hillingdon Hospitals, which is a slight increase on 2021/22 activity during the same period. Table 2 below identifies the source of attendance activity by GP registration and it can be seen from this that 74% of attendees during the review period were people registered with Hillingdon based GPs. This is consistent with previous reports to the Board.

Table 2: A & E Attendances April - Dec 2022 Patient GP Registration Summary

NWL ICB Location	2019/20 Daily Average	2020/21 Daily Average	2021/22 Daily Average	2021/22 % Daily Average	2022/23 Daily Average	2022/23 % Daily Average
Hillingdon	139	97	140	72%	144	74%
Ealing	24	15	24	12%	24	12%
NWL Other	12	8	11	6%	11	6%
Not registered	11	6	7	4%	11	5%
Non-NWL GP	14	7	13	7%	7	4%
TOTAL	**200**	**134**	**194**	**100%**	**195**	**100%**

18. Analysis during the review period of 10,353 Emergency Department attendees showed that 19% (1,923) of attendances could be deemed avoidable and, of these, 44% (855) were self-

referrals, i.e., they had not been directed to A & E by other sources such NHS 111. 49% of attendees had long-term conditions and the main conditions identified were as follows hypertension, anxiety and diabetes for adults and asthma and learning disabilities for children.

19. **Emergency Admissions:** Table 3 below shows that there has been a reduction in overall attendances in the period between April to December 2022 compared with the same period in 2021 and also for people aged 65 and above. It also shows that there has been a reduction in the rate of attendances converting to admissions.

Table 3: A & E Attendances and Emergency Admissions April to December 2021 and 2022 Compared

Population Group	Number A & E Attendances	Number Emergency Admissions	Conversion Rate Attendances to Admissions
All age groups 2021	54,338	20,102	37%
All age groups 2022	53,234	19,451	37%
65+ - 2021	13,636	8,292	61%
65+ - 2022	13,518	7,741	57%

20. **Urgent Treatment Centre (UTC):** The Board is reminded that the purpose of the UTC is to treat all minor illnesses and injuries requiring immediate care where a person does not require care in an A & E department. Attendance at the UTC has continued to climb in line with the trend established in 2021/22. The average daily attendance is 274 and, if maintained, will result in an 8% increase on 2021/22. The average redirection rate to primary care for the April to December 2022 period has reduced from 8.6% during the same period in 2021/22 to 7% in 2022/23. This suggests a more appropriate utilisation of the service.

21. **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 Mon-Fri, 10am to 8pm. The UTC is able to redirect people to the service as consultations are face to face. Utilisation during the review period was 89% of capacity, which means there was scope for further referrals.

22. **Neuro Wellbeing Support Service:** A new service to improve outcomes for patients being discharged from the Alderbourne and Daniels neuro-rehabilitation units has been introduced as part of system wide improvement plan, which identified the potential benefit of providing very early, proactive wellbeing support for patients who need neurological rehabilitation. The pilot works alongside the multi-disciplinary team to support patients while they are on the wards and help them prepare for discharge. Working in close partnership with H4All, a new neuro wellbeing support officer uses a person-centred approach to help patients regain the skills, knowledge, and confidence to manage their long-term health needs (physical and mental), lead a better quality of life, redevelop social networks, and reduce the risk of loneliness and isolation post discharge.

Key Performance Indicators

23. The following is an update on workstream 2 indicators:

- ***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 December 2022 period 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. *Slippage:* The April to December 2022 target average of people aged 18 and above admitted discharged to their usual place of residence is 93.4% but the actual performance during this period was 92.2%. The Board may wish to note that discharge into bed-based intermediate care provision such as the Hawthorn Intermediate Care Unit (HICU) or short-term care home beds does not count as '*usual place of residence'* for the purposes of the metric.

- ***Length of stay:*** Table 4 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 4: Hillingdon Hospital Length of Stay Targets 2022/23		
Descriptor	**Target (No of People/patients)**	**Q3 Average**
• > 7 days	117	153
• 7 – 13 days	53	69
• 14 – 21 days	25	32
• 21 – 49 days	33	39
• 50 + days	10	11

Workstream 3: End of Life Care

Workstream Highlights

24. **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.

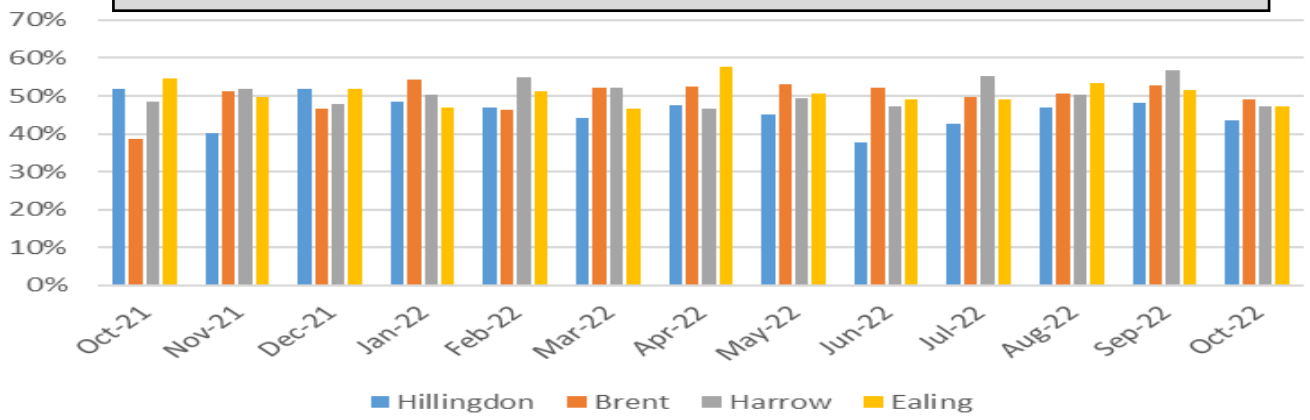
25. H4All and Carers Trust Hillingdon have allocated non-recurrent funding to create a '*Compassionate Hillingdon Carers Development Officer'* post. This will link unpaid carers of people at end of life to the support available in their communities. Additional funding has been secured via H4All to enable this role to continue into 2023/24.

Performance Update

26. The following is an update on workstream 3 indicators:

- **Deaths occurring in hospital:** Chart 1 below shows that at 43% Hillingdon had the lowest percentage of deaths occurring in hospital over the twelve month period to October 2022 (the most recent period for which data is available) out of the four Outer North West London boroughs.

Chart 1: % of Deaths Occurring in Hospital Outer-London NWL Boroughs Compared Oct 2021 – Oct 2022



- **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:** Tables 5 and 6 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 5: % of people with 3+ emergency admissions in last year of life

Borough	2019/20	2020/21	2021/22	2022/23 (Apr-Sept)
Brent	15%	9%	14%	9%
Central London	18%	10%	15%	12%
Ealing	17%	12%	19%	13%
Hammersmith & Fulham	18%	10%	13%	10%
Harrow	13%	12%	20%	11%
Hillingdon	14%	13%	13%	10%
Hounslow	15%	13%	18%	12%
West London	15%	11%	11%	10%
NWL Average	**16%**	**11%**	**15%**	**11%**

Source: NWL BI EoL Dashboard

Table 6: Average number of bed days 90 days prior to death (Emergency admissions)

Borough	2019/20	2020/21	2021/22	2022/23 (Apr-Sept)
Brent	19.12	14.49	17	16
Central London	17.81	14.18	17	18
Ealing	18.94	14.41	15	18
Hammersmith & Fulham	18.20	16.34	20	18
Harrow	17.54	15.39	17	18
Hillingdon	18.12	14.27	17	18

Hounslow	18.09	14.41	15.85	18
West London	17.83	15.67	17	17
NWL Average	**18**	**15**	**17**	**18**

Source: NWL BI EoL Dashboard

Workstream 4: Planned Care

Workstream Highlights

27. **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 December 2022 Board meeting include:

- *MSK*: CNWL has transferred 502 patients to Healthshare under a contract established to address backlogs arising from the pandemic. The treatment and management of patients is in progress and six weekly contract meetings are in place with this new provider.
- *Ophthalmology*: Procurement for a pan-NWL service is in progress with the aim of having a new contract in place for October 2023.

Performance Update

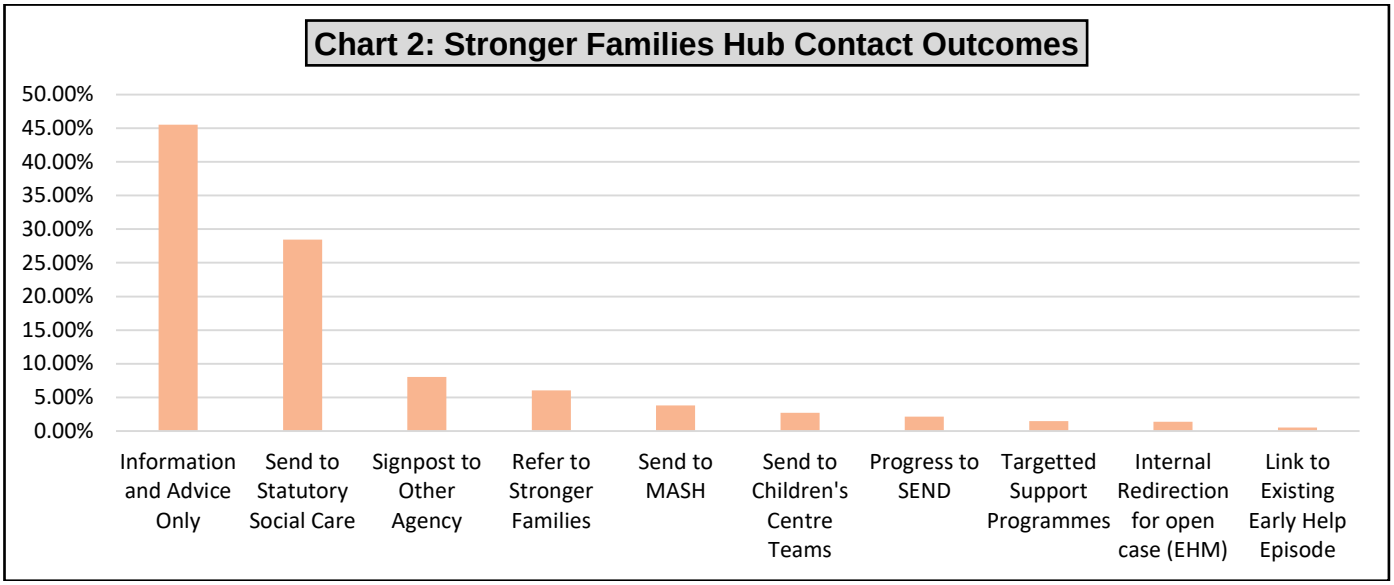
28. The following is an update on workstream 4 indicators and the Board is asked to note that the performance activity referred to in this section refers to Hillingdon Hospitals only:

- **No. of patients waiting 52 weeks or more for surgery:** In September 2022 there were 1,518 people waiting 52 weeks or more for surgery compared to 696 in September 2021. A contract has been awarded to a non-NHS provider called Healthshare to assist in reducing the waiting list.
- **Average waiting times in days for outpatients:** The average wait in September 2022 was 166 days (23.7 weeks) compared to 106 days (15 weeks) in September 2021. Healthshare has also been engaged to reduce the outpatient treatment waiting list.

Workstream 5: Children and Young People (CYP)

Workstream Highlights

29. **Stronger Families Hub (SFH):** In the twelve months to 31 December 2022 there were 22,634 requests for assistance. The Board is reminded that 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 (47%), the Safer Families Portal (44%) and telephone (9%). Chart 2 below summarises the outcomes of the referrals in the 12 month period to 31 December 2022.



30. **Autism pathway:** The first Supporting Autism course as part of the Triple P programme delivered in conjunction with HACs for parents of autistic children aged 6 to 11 took place on 24 January. This was the first of three courses that will take place between January and May 2023. All three courses will enable parents to join face to face or virtually. Triple P is an international company that has developed positive parenting programmes – some of the programmes have general appeal and some are more specific to children with disabilities. The ICB has commissioned 300 licences and HHCP have positioned these as an offer to parents/carers at the pre-diagnosis phase of the Autistic Spectrum Disorder (ASD) pathway as a means of offering support where the child's needs present as 'challenging' or non-standard behaviour.

31. The first Stepping Stones Triple P course (see below) took place on 20 February.

About Stepping Stones Triple P

This has been developed for parents or caregivers of children aged 0-12 with a developmental disability, such as Down's syndrome or Autistic Spectrum Disorder, as well as moderate or severe behavioural problems and is designed as a one-to-one 10-session intervention, delivered over 10 consecutive weeks. The intervention begins with a thorough assessment of parent-child interaction. Through a range of learning methods, the intervention provides parents with comprehensive support in managing their child's behaviour across settings. Parents set goals, practise strategies, complete an activity workbook and undertake homework tasks.

32. **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. The service is supported by NHS England Virtual ward funding and operates across seven days. There are high numbers of children being treated for bronchiolitis. The majority of people using the service are from Hayes, Uxbridge and Yiewsley in the south of the Borough .

33. The new intravenous antibiotic (IVAB) pathway for new born children (neonates) started in December 2022.

Virtual Wards Explained

Virtual wards provide acute clinical care at home for a short duration (up to 14 days) as an alternative to care in hospital. Patients admitted to a virtual ward have their care reviewed daily by a consultant practitioner (including a nurse or allied health professional (AHP) consultant) or suitably trained GP, via a digital platform that allows for the remote monitoring of a patient's condition and escalation to a multidisciplinary team.

34. **Primary Care Network (PCN) virtual Multi-disciplinary Teams (MDTs)**: These are taking place on a monthly basis and alternate between PCNs in the north and south of the Borough. Documentation is being developed to capture and share more widely the learning from the case studies presented to support escalating need prevention.

35. **16 – 25 young adult mental health and wellbeing:** This is addressed by a separate item on the Board's agenda.

36. **Holiday Activities and Food Programme (HAF):** The Board is reminded that 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

37. The HAF Winter programme was delivered during the period of 19 to 30 December 2022. During this time, 21 providers were commissioned to deliver over 1,400 places on 4-5 day programmes, a total of 6,495 sessional places for children were offered over the 2-week period with over 1,000 individual children engaging in the programme offer.

Key Performance Indicators

38. 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 Q3 2022/23, 65% of assessments were completed within 20 weeks compared to 62% for Q4 of 2021/22 and 83% in Q3 2021/22. Staff vacancies have presented challenges in improving performance against the national target.

Workstream 6: Mental Health, Learning Disability and Autism

Workstream Highlights

39. **One stop shop:** Due to difficulties in securing a suitable venue it has been agreed with partners to develop the Wellbeing Bus option, which would potentially allow greater access to a range of services for residents across the Borough.

40. **Hillingdon Cove Café:** The café is now open to people aged 16 and above. CAMHS staff have recently visited the café along with Young Adult Ambassadors to see how young adults can use the service. In December 2022 there were 49 referrals and 45 were from the Mental Health Single Point of Access. The remaining 4 were self-referrals.

41. **Crisis recovery house:** The Board may recall from its December 2022 meeting that 4 people moved into the service, known as The Retreat, between 22 August (when it opened) and 30 September. During the review period, there were 24 enquiries and 14 people were accepted as '*guests*'. The average length of stay following an admission was 5.6 nights. In terms of outcomes, 13 guests returned back to their usual place of residence and 1 person moved out of the area. Table 7 below summarises support arrangements for The Retreat guests on leaving the service.

Table 7: Summary of Support Arrangements On Leaving The Retreat	
Referral to Community Mental Health Team	7
Primary Care (including GP and Talking Therapies)	3
Voluntary & Community Services, including Hillingdon MIND/ARCH addiction support.	3
Out of Area	1
TOTAL	**14**

42. Since the start of the pilot, only CNWL's Home Treatment Team have been able to make referrals. A six month review meeting took place on 7 February 2023 where it was agreed to expand the referral routes into the service. The mechanics of this change are currently under discussion between partners.

43. The Board may wish to note that additional funding is being made available by CNWL to extend the pilot beyond the initial period of a year and discussions are in progress with the service provider. A detailed report on activity and outcomes of the pilot since the opening of The Retreat will be presented to the Council's Health and Social Care Select Committee at its April meeting at its request.

44. **Community hub model:** CNWL is in the process of changing their community mental health provision to a community hub model. Community hubs wrap mental health care around PCNs to bring together primary care and mental health teams ensuring that residents find it easier to access mental health services through their GPs. Patients will jointly develop care plans with the hubs which will reflect their needs and goals. These changes are due to go live on 17 April 2023.

Enabling Workstreams

45. 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.

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

47. **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

48. **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).

49. Table 8 below summarises Hillingdon Hospitals attendance and admission activity from in-Borough care homes during the April to December 2022 period. The data is consistent with what was reported to the Board at its December 2022 meeting. Members of the Board may recall from previous reports that falls related injuries are one of the main causes of London Ambulance Service (LAS) attendances at care homes and subsequent conveyances and admissions to hospital. During the review period, CNWL's Community Adult Rehabilitation (CARS) Team has targeted falls prevention and management training at those care homes with the highest falls-related calls to the LAS.

Table 8: Hillingdon Hospitals attendance and admission activity from in-borough care homes April to December 2022	
Attendances per 1,000 beds	
Hillingdon	72.1
NWL average	67.7
Admissions per 1,000 beds	
Hillingdon	43.66
NWL average	48
Average length of stay	
Hillingdon	10.41
NWL average	8.31

Source: NWL BI Team

Finance

50. The value of the BCF pooled budget for 2022/23 from **£109,080k** as previously agreed by the Board under delegated arrangements on 17 October has increased to **£111,570k.** This **£2,490k** increase results from the inclusion of the following additional funding streams:

- **Adult Social Care Discharge Fund:** The £1,985k from this fund announced by the Department of Health and Social Care (DHSC) in September 2022 is added to the pooled budget. This comprises of £868k paid directly to the Council by the DHSC and a £1,118k contribution from the ICB's allocation. It is a national requirement that this funding is included within the BCF section 75 agreement.

- **NHS Health Inequalities Funding:** The inclusion of £504.6k in the BCF from funding received by the ICB from this national fund is being utilised to develop infrastructure to

deliver Population Health Management (PHM) in Hillingdon. This is intended to enable a more proactive approach to be taken to managing demand for health and care services.

51. The final financial breakdown of the BCF for 2022/23 is summarised on Table 9 below.

Table 9: BCF FUNDING SUMMARY 2021/23			
Funding Breakdown	**2021/22 (£,000)**	**2022/23 *(£,000s)***	**% Difference**
MINIMUM NHS CONTRIBUTION	**20,485**	**21,645**	**5.8**
Required Spend			
• Protecting Social Care	7,470	7,892	5.6
• Out of Hospital	5,821	6,150	5.7
• Other minimum spend	7,194	7,603	5.9
MINIMUM LBH CONTRIBUTION	**12,359**	**12,579**	**1.8**
Required Spend			
• Disabled Facilities Grant (DFG)	5,111	5,111	0
• Improved Better Care Fund (iBCF)	7,248	7,468	3
MINIMUM BCF VALUE	**32,844**	**34,224**	**4.2**
ADULT SOCIAL CARE DISCHARGE FUND	0	**1,985**	100
• LBH Contribution	0	868	100
• NHS Contribution	0	1,118	100
ADDITIONAL VOLUNTARY	**73,610**	**75,361**	2.3
• Additional NHS Contribution	28,642	29,907	4.3
• Additional LBH Contribution	44,968	45,454	1
TOTAL BCF VALUE	**106,454**	**111,570**	**4.3**

52. There are no direct financial implications arising from this report.

BACKGROUND PAPERS

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