2023/24 Q3 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 – Adult Social Care and Health Directorate, LBH Sean Bidewell – Integration and Delivery, NHS NWL
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 includes progress with the delivery of the 2023/25 Better Care Fund Plan.
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 2023/24 is £96,534,618 made up of Council contribution of £66,875,873 and an ICB contribution of £29,658,745. The provisional value for 2024/25 is £98,520,040, which comprises of £67,566,876 for the Council and £30,953,164 for the ICB.
Ward(s) affected.	All

RECOMMENDATIONS

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

INFORMATION

Strategic Context

1. This report provides the Board with an update on delivery of the priorities within the Joint Health and Wellbeing Strategy for the October to December 2023 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.

3. Reference in this report to HHCP means Hillingdon Health and Care Partners, this is an alliance of local (mainly NHS) organisations that includes The Confederation of Hillingdon-

based GP practices, the Central and North West London NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust and H4All. HHCP's main objective is to improve the health and wellbeing of Hillingdon's residents and their experience of care through improved coordination and integration of services and earlier intervention to prevent crises. The Council is closely aligned with HHCP.

4. Reference to the ICB (or NHS NWL) means the North West London Integrated Care Board. NWL means a reference to the local authorities areas within the North West London sector and this includes the London Boroughs of Brent, Hammersmith & Fulham, Harrow, Hillingdon and Hounslow, the Royal Borough of Kensington & Chelsea, and Westminster City Council.

A. Key Issues for the Board's Consideration

Ofsted Inspection Outcome

5. The Council has received an overall '*Outstanding'* rating in the Ofsted inspection of Children and Young People's Services conducted in October 2023. Ofsted commended Children's Services for being an "*excellent champion for children, families, and young people*," noting that *"children in the London Borough of Hillingdon continue to receive a highly effective service"*.

6. The report specifically highlighted the increased demand for services in the borough but applauded the Council's leadership for reinforcing and enhancing practices. It recognised areas of innovation as exceptional practices that significantly improved children's experiences and progress. The strength of partnership working in Hillingdon was acknowledged as *'strong'*, with the report emphasising that services effectively enhance outcomes for children by actively incorporating feedback from partners, families, and diverse communities to drive innovative transformations. The report can be accessed via the following link London Borough of Hillingdon - Open - Find an Inspection Report - Ofsted

2023/24 BCF Plan Quarter 3 Performance Template

7. All health and wellbeing board areas in England were required to submit their Quarter 3 (Q3) 2023/24 performance template on 9 February 2024 and Hillingdon's was submitted as a draft pending formal sign-off. There are some queries relating to planned activity figures included in the original submission and work is in progress to respond to these. Once resolved sign-off will be requested under delegated arrangements approved by the Board at its November 2023 meeting, i.e., Corporate Director, Adult Social Care and Health to approve in consultation with the Co-chairs, the NHS NWL Borough Director, and Healthwatch Hillingdon Chair.

2023/24 National BCF Metrics

8. There are five national BCF metrics and the Q3 position against the 2023/24 targets is summarised below:

- Avoidable admissions – ***Data not available***. Performance against this metric is based on nationally published data which for Q3 is showing anomalies that make it unreliable. This is an issue that applies across the country.
- Discharge to usual place of residence – ***On track (Green)***.
- Emergency admissions due to falls – ***On track (Green)***.
- Residential admissions to care homes – ***Slippage (Amber)***.
- Reablement still at home 91 days after discharge – ***Data not available*****.**

BCF 2024/25 Update: National

9. The publication of a national planning template for 2024/25 is expected imminently. This is expected to require systems to include:

- Ambitions for 2024/25 for national metrics with supporting rationale.
- An updated intermediate care demand and capacity template.
- An updated expenditure and activity plan.
- Outcomes from the self-assessment against the updated High Impact Change Model for Hospital Discharge produced collaboratively by the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS), NHS England (NHSE), the Department of Health and Social Care (DHSC), the Department of Levelling-up, Housing, and Communities (DLUHC) and the *Think Local, Act Personal* partnership.

10. Officers will provide a verbal update to the Board about any national requirements should more information become available prior to its March meeting.

BCF Review: ICB

11. The next steps in the review of NWL BCF schemes has been agreed. A half day workshop will take week on the 21st March 2024 for Place representatives across NWL and key ICB leaders. The purpose of the workshop will be to deliver the agreed BCF terms of reference by:

- Establishing a clear line of sight through an analysis of available data sets on all spend, activity and impact of BCF schemes in order to assess their value in achieving whole system aims, and to develop '*go forward'* consistency across the NWL Integrated Care System.
- Developing a proposed NWL wide methodology for comparing BCF funding across Places based on an understanding of population needs and warranted variation.
- Developing and agreeing an approach for driving better value for money for BCF investment, particularly where there is unwarranted variation in value and impact across NWL including agreement on workstreams going forward.

12. Ahead of the workshop, all supporting papers (including any underpinning data analyses) will be shared in order that attendees can come fully briefed and prepared to contribute. A small Workshop Planning Team will be established to plan and deliver the workshop led by Jane Wheeler, NWL ICB and Keith Spencer, MD HHCP. Outcomes from the workshop will be shared with (and agreed by) the ICB and NWL boroughs.

CQC Adult Social Care Assurance

13. The Board has previously considered a report on the new duty placed on the Care Quality Commission (CQC) by the Health and Care Act, 2022, in respect of local authorities with adult social services responsibilities. The new duty requires CQC to implement an assurance process for the discharge of local authority duties under the Care Act, 2014. The new CQC responsibilities came into effect on 1 April 2023. The Council received notification of a forthcoming inspection by CQC on 19 February. Work is now in progress to collate evidence

requested by CQC, which has to be submitted on 8 March. An onsite inspection can then be expected to take place in the coming month. The outcomes from the inspection are unlikely to be available until later in the year once inspections of other boroughs within NWL have concluded.

B. Workstream Highlights and Key Performance Indicator Updates

14. This section provides the Board with progress updates for the five workstreams, where there have been developments. The successful and sustainable delivery of the five workstreams is dependent on five enabling workstreams and this report provides updates where appropriate. The five enabling workstreams are:

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

Transformation Workstreams

Workstream 1: Integrated Neighbourhood Working.

Workstream Highlights

15. **Integrated Neighbourhood Teams and Neighbourhood Directors:** The performance report considered at the Board's November meeting advised that it had been agreed by partners to move from six neighbourhoods to three Integrated Neighbourhood Teams as the previous model created inefficiencies. Each INT will have a leadership team comprising of a clinical director (PCN sourced), a community manager (CNWL sourced) and a neighbourhood director, who will be a joint appointment between The Confederation and CNWL. The role of the neighbourhood director will be to:

- Achieve the population health outcome targets set for the neighbourhood by HHCP linked to the Health and Wellbeing Strategy. These would be the population health improvements sought across a range of priority conditions for instance diabetes, hypertension, etc.
- Drive the continued transformation of services in line with the new HHCP target operating model.
- Improve the processes that enable effective neighbourhood working across multiple partner agencies. For example, aligning KPIs, establishing MDTs, aligning standard operating procedures, enabling joined up governance processes.
- Improving patient experience and staff experience against a set of benchmarks.
- Relationship building and problem resolution to enable neighbourhood working.
- Delivering annualised neighbourhood efficiency targets set by HHCP.

16. **Hypertension Diagnosis Programme**: Hypertension, also known as high blood pressure, is one of the major causes of premature death and disability and Hillingdon has the second

highest prevalence rate in NWL. The diagnosis programme is now underway and standalone blood pressure monitors have been provided at the Central Library in Uxbridge and also Botwell Green and Ruislip Manor libraries. Each library has also been given a supply of 20 portal devices that can be loaned to residents. Four winter roadshows have so far been undertaken across the three neighbourhoods and this has resulted in 403 residents receiving health checks.

17. **Population Health Management Infrastructure:** NHS England Health Inequalities funding is facilitating the recruitment of additional capacity to support the implementation of PHM approaches across Hillingdon's health and care system. A programme manager and a project manager will be hosted by the Council under two-year contracts and managed by the Director of Public Health. These posts are now out to recruitment.

18. **Same Day Urgent Primary Care Hubs:** Two hubs have now opened, with one at the Pembroke Centre in the north of the borough and the second at Mead House in Hayes. The Board is reminded that the hubs are intended to create capacity in Primary Care to divert 18% and 28% of Hillingdon non-complex patients currently attending Hillingdon Hospital's Emergency Department and Urgent Treatment Centre respectively.

Same Day Urgent Primary Care Hub Explained
These are intended to provide same day urgent care for people with non-complex needs that includes community diagnostics, i.e., phlebotomy (collecting blood for testing), x-ray, electrocardiogram (ECG) to test heart rhythm and swabs. The intention of the hubs is to divert avoidable activity from A & E and the Urgent Treatment Centre .

19. **Care Home Support Service:** Care Home Matrons are undergoing training to enable them to prescribe some medications. This will expedite access to some medications for care home residents and relieve pressure on Primary Care. To free up capacity support for the Council's four extra care housing schemes is in the process of transferring to the CCTs.

Some Terms Explained	
Care Home Support Team	**Care Connection Teams (CCTs)**
This is a multi-agency team that includes six care home matrons who each have responsibility for supporting specific care homes. 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.	CCTs are community based, multi-disciplinary teams that care for Hillingdon residents aged 18 and over who have been identified by their GP as needing case management as part of their care due to their physical and/or mental health or social needs. Each CCT includes Guided Care Matrons, Care Coordinators or Nurses in addition to Wellbeing Assistants and Mental Health Nurses.

Key Performance Indicator Updates

20. Workstream 1 performance indicators include:

- **Flu vaccinations:** The 2023/24 flu vaccination programme started on 1 September 2023 and table 1 below shows performance to 12 February 2024.

Table 1: Flu Vaccinations Performance - Hillingdon and NWL Compared			
Indicator	**Target**	**NWL Average**	**Hillingdon Performance**
% of Eligible Population Vaccinated	N/A	N/A	**38.8%**
65+ cohort	100% or equal previous year's (2022-23) uptake	67.4%	**71.5%**
At risk 6m - 64yrs cohort		41.6%	**34.1%**
Pregnant cohort		27.6%	**28.4%**
11-16 (not at risk)		34.9%	**11.5%**
4-10 (not at risk)		49.8%	**19.3%**
3 (not at risk)		37.2%	**36.2%**
2 (not at risk)		38.4%	**37.7%**
Care home (may be in other cohorts)		82.8%	**67.6%**
Carer cohort		53.1%	**27.4%**

Source: WSIC Dashboard (12/02/24)

- **Covid booster vaccinations:** The 2023/24 covid booster programme started on 11 September and Table 2 below shows that Hillingdon's performance in respect of all priority groups exceeds the NWL average in the period to 31 December.

Table 2: Covid Booster Vaccination Performance - Hillingdon and NWL Compared		
Indicator	**NWL Average**	**Hillingdon Performance**
Care Home Resident Residents who have received their AW 23 Booster (as % of Population).	65.3%	**75.1%**
80+ Residents who have received their AW 23 Booster (as % of Population).	44.8%	**53.8%**
65-79 Residents who have received their AW 23 Booster (as % of Population).	36.1%	**44.1%**
At Risk (Aged 5 plus) Residents who have received their AW 23 Booster (as % of Population).	11.5%	**12.7%**
Social Care Workers who have received their AW 23 Booster (as % of Population).	8.6%	**12.3%**
Frontline Healthcare Workers who have received their AW 23 Booster (as % of Population).	17.0%	**17.3%**
Unpaid carers (self-declared) who have received their AW 23 Booster (as % of Population).	6.9%	**7.2%**
Patients Eligible for the AW 23 Booster Campaign (65+,Care Home Residents, At Risk, Immunosuppressed Compromised with SMI or on the LD Register, Social	21.8%	**26.2%**

Care Workers, Carer, Health Care Worker etc) (as % of Population).		

Source: NHS National Data Platform Foundry (31/12/23)

- **People with severe mental illness (SMI) receiving a full physical health check:** *On track (Green)* – The 2023/24 ICB target is 60% and the Hillingdon position during the review period was 66.3%

- **People over age of 14 on a doctor's learning disability register who have had an annual health check:** *On track (Green)* - The 2023/24 ICB target is 50% and Hillingdon achieved 63% during the review period. There has been extensive work done by the ICB, the Council and CNWL to raise awareness and increase uptake, including LBH's addition of AHC to the social care providers' KPIs, and their social workers' annual review. Masterclass training sessions also continue to be held with GPs.

- **People with diabetes who have received nine care processes in the last 15 months:** *On track (Green)* – The 2023/24 ICB target is 50% and Hillingdon achieved 50.2% during the review period. All GP practices have now achieved 40% which was the minimum required by the ICB.

- **Eligible female patients who have received a Cervical Cancer Screening within the last 3.5 years for ages 25-49 (Core20Plus5 measure):** *Slippage (Amber)* **-** The 2023/24 ICB target is 80% but 64% was achieved during the review period.

- **Eligible female patients who have received a Cervical Cancer Screening within the last 5.5 years for aged 50 and over (Core20Plus5 measure):** *Slippage (Amber)* **-** The 2023/24 ICB target is 80% but 74.4% was achieved during the review period. Action to improve performance against this measure and the equivalent above for the 25 to 49 age group includes 1:1 meetings between the cervical cancer clinical lead and lower performing practices to identify issues and offer support; through proactive signposting and text message reminders to patients across our neighbourhoods; and through the clinical lead attending upcoming PCN meetings to present on performance to date and discuss further ideas for overcoming barriers to attending for cancer screening.

Workstream 2: Reactive Care

21. The Board is reminded that the priorities for this workstream are:

- Implementation of a new end of life operating model.

- Implementation of an integrated active recovery service.

- Implementation of a '*Maximising Homefirst'* programme to reduce length of stay of residents in hospital.

Workstream Highlights

22. **Palliative Integrated Care Service (PICS):** This new 24/7 service went live on 15 January 2024 with the launch of the PICS Coordination Hub. PICS brings together staff from CNWL, Harlington Hospice and THH Palliative Care staff with a single management team and provides:

- 7-Day End of Life support across all areas of the system – acute, community and care homes.

More about the PICS Coordination Hub

The Hub aims to allow more people at end of life to receive care and support at home rather than in hospital. It will do this by:

- Undertaking Holistic active case management working with PCNs/Neighbourhood for people moving into end of life.
- Providing In-reach and proactively support acute services to coordinate discharges.
- Supporting the care planning process.
- Ensuring a seamless handover from the Hillingdon Hospital Frailty Service.
- Using risk stratification tools to identify people who are not in the system but could be deteriorating.
- Addressing health & inequalities and working with the voluntary and community sector to deliver support.

23. **Frailty Assessment Unit (FAU):** This is a dedicated consultant led 6-bedded unit delivering comprehensive geriatric assessments to avoid unnecessary hospital admissions running 12 hours a day, 7 days a week, i.e., an admission to the FAU does not count as an emergency admission. The FAU also supports calls from GPs and care homes and has established a '*Call before convey'* pilot with the London Ambulance Service (LAS) to avoid a conveyance or enable the direct conveyance of patients to the FAU rather than A & E where the latter is avoidable and unnecessary. This would follow a clinical conversation between the service and paramedics. The FAU started in October 2023 when 136 people were supported and activity levels increased to 201 in December. 84% of people supported by the service returned to their usual place of residence.

24. **Length of stay (LoS):** The ongoing migration to the Cerner Electronic Record system at THH means that there have been difficulties with accessing data relating to discharge pathway (see below) delays and average length of stay to report against key targets and key performance indicators. The expectation is that this will be resolved by the end of February. In the meantime, partners have been taking steps to minimise length of stay and these include:

- Ensuring that P1 capacity, i.e., Bridging Care and Homefirst Rehab Service is fully utilised, including daily monitoring. It is under-utilisation of capacity on this pathway that presents an issue rather than lack of capacity.
- A review to establish if there was over prescribing of P3 beds, which demonstrated that all referrals were appropriate. However, 40% of demand on this pathway is from a combination of people on the CHC pathway, self-funders and people who are not Hillingdon residents, which therefore necessitates input from other organisations that adds complexity and therefore the scope for delay.

- Trialling in a small number of wards earlier communications to care homes for returning residents. A small group comprising of the Head of Integrated Discharge, the Care of the Elderly Team (COTE) consultant and a care home matron are taking this work forward.

- Referring patients for an assessment at the point when this can reasonably be undertaken rather than when they is medically optimised. A recent audit has demonstrated that the current approach is lengthening discharge delays by 3-5 days.

- Reviewing the approach to weekend discharges with the intention of increasing these by 30% by 31 March.

Homefirst/Discharge to Assess Pathways Explained

- ***Pathway 0 (P0): 91.4% of discharges -*** Simple discharge, no formal input from health or social care needed once home.

- ***Pathway 1 (P1): 5.4% of discharges*** - Support to recover at home; able to return home with support from health and/or social care.

- **Pathway 2 (P2): *0.8% of discharges*** - Rehabilitation or short-term care in a 24-hour bed-based setting.

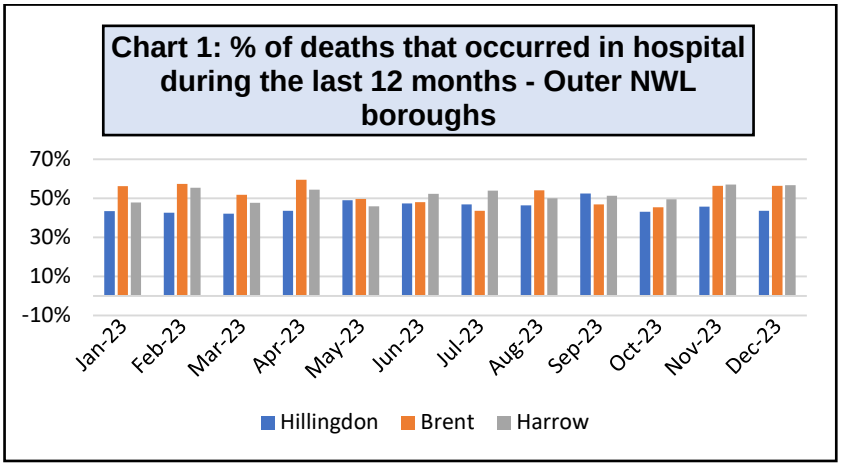
- ***Pathway 3 (P3): 2.4% of discharges*** - Require ongoing 24-hour nursing care in a bedded setting. Long-term care is likely to be required for these people.

25. An updated version of the statutory *Hospital Discharge and Community Support Guidance* issued under section 74 of the Care Act, 2014 was published on 26 January 2024. The guidance changes the pathway definitions shown above and the effect will be to significantly reduce the numbers of people discharged on P3 and increase those on P2. There is likely to be a period of adjustment as data collection is adapted to reflect the changes.

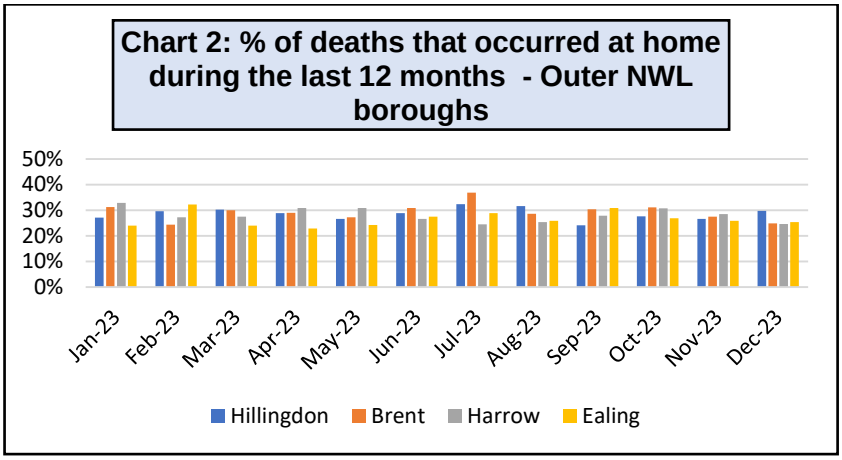
Key Performance Indicator Updates

26. The following is an update on workstream 2 indicators where data is available:

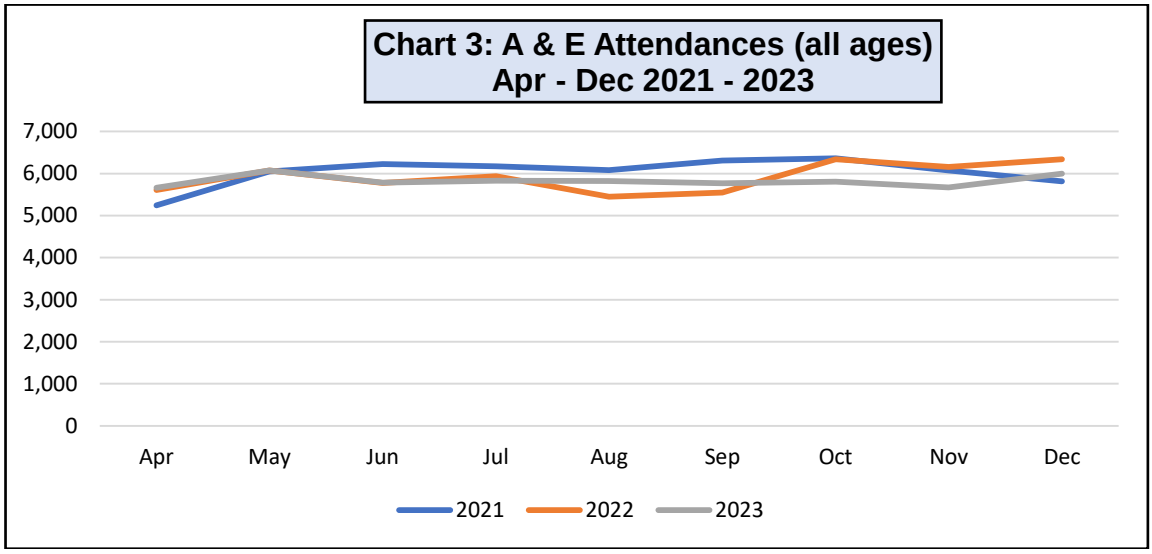
- **% of deaths of people that occurred in hospital in last twelve month period:** The objective is that the percentage of deaths that occurred in hospital should be at a minimum and reflect the last place of care choice of residents. Chart 1 below shows that for the January to December 2023 period Hillingdon's performance was better than our direct comparators within the NWL sector.



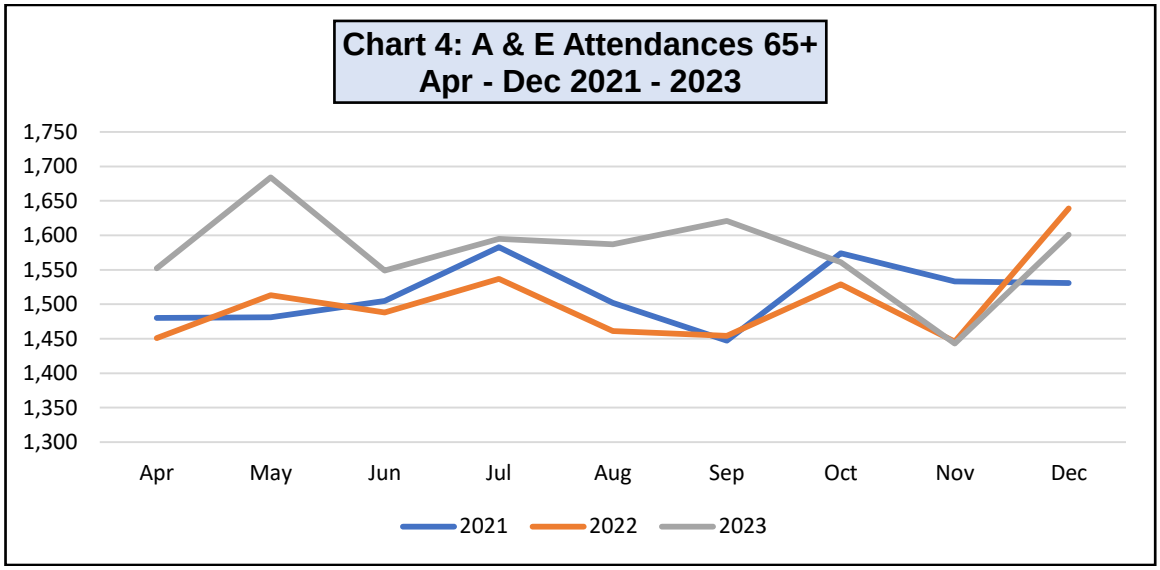
- **% of deaths of people that occurred at home in the last twelve months:** In keeping with the deaths in hospital measure above, a higher proportion of deaths of people occurring at home is desirable and the data below shows that Hillingdon was just behind Brent during the January to December 2023 period. As previously stated, an intention of the new PICS model is to support an increasing number of people on the end of life pathway dying at home if this is their preferred place of care.



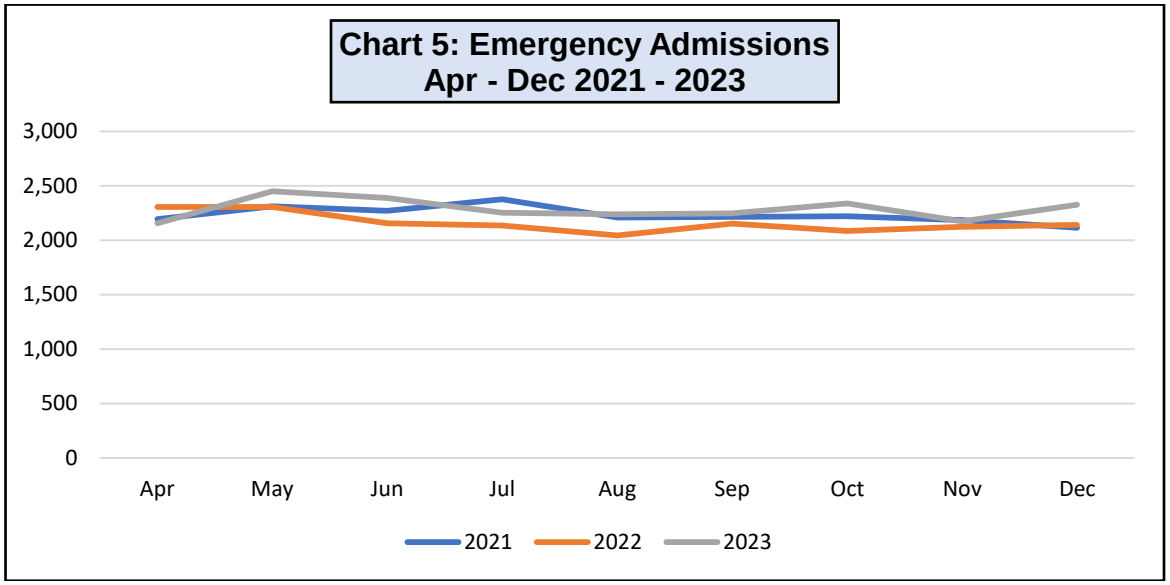
- **A & E Attendances:** Between April and December 2023 there have been 52,425 attendances, which is lower than in the two previous years. Chart 3 below shows the trend over the last three years for the April to December period.

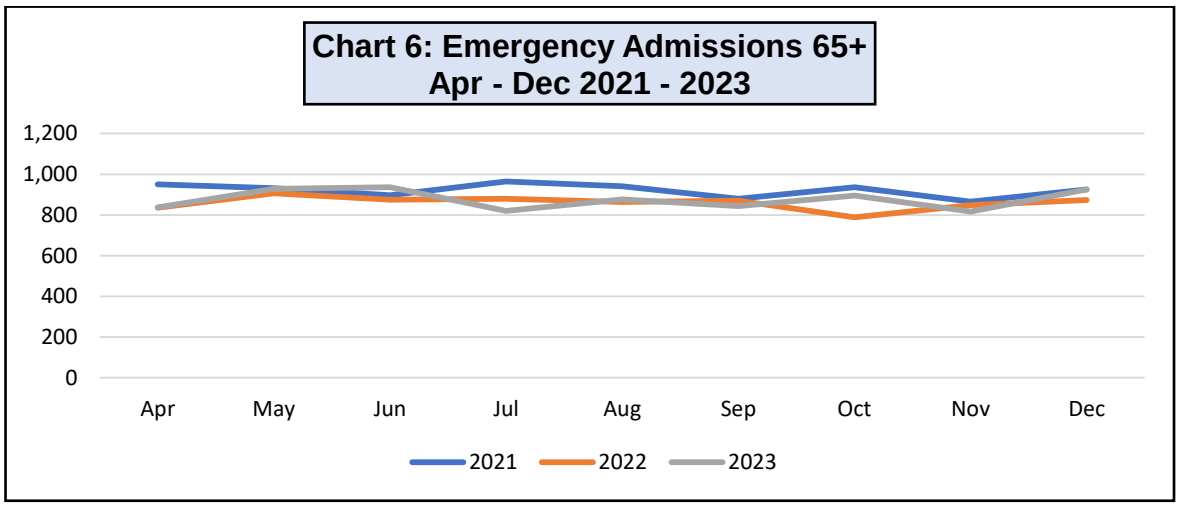


- There were 14,193 attendances of people aged 65 and over during the April to December review period, which is higher than the two previous years. Chart 4 shows the trend over the three year period.



- **Emergency Admissions:** There were 20,575 emergency admissions during the April to December review period, which exceeds the figures for each of the two preceding years. There were 7,880 emergency admissions of people aged 65 and over during the above review period, which is above the total for the same period in 2022 but significantly below that for 2021. Charts 5 and 6 below show emergency admission trends for the April to December period over the last three years.





- **Hillingdon Hospital bed occupancy:** *Slippage (Amber)* – The target occupancy level over the winter period is 92% but the average for the period 1st September to 31st December 2023 was 97%. Admission avoidance activities and steps to address long lengths of stay are seeking to address this.

Workstream 3: Planned Care

Key Performance Indicator Updates

27. The following is an update on workstream 3 indicators where data is available:

- **Patients waiting 52 weeks or more for surgery:** In December 2023 there were 1,113 people waiting 52 weeks or longer for surgery, which is a reduction of 687 on the same period in 2021, although significantly higher than in 2021 when there 664 people waiting.

- **% Patients receiving tests within 6 weeks of referral:** For the period April to November the average was 76%, which is an improvement on the previous two years (86% in 2022 and 73% in 2021).

- **% Urgent cancer referrals receiving diagnosis within 28 days:** For the period April to

November the average was 68%, which is a slight reduction on 2022/23 (71%) but an improvement on 2021/22 (66%).

- **Average waiting time in days for outpatients:** For the period April to November 2023 the average was 140 days, which compares to 159 days in 2022/23 but 110 days in 2021/22.

Workstream 4: Children and Young People

Workstream Highlights

28. **Holiday Activity and Food (HAF) Programme:** This programme was funded by the Department for Education and ran from 27th December 2023 to 5th January 2024. The programme included the following activities:

- *sports-based:* football, basketball, taekwondo, cricket;
- *arts-based:* dance, drama, music, arts and crafts;
- *life skills:* personal development courses/building resilience, cookery);
- *STEM (science, technology, engineering, maths) activities:* coding; and
- *multi-activity camps*.

29. Programmes were delivered across the borough from 42 venues but with a focus on venues in the south of the Borough, which data tells us is where the majority of eligible children live. 7,068 places on programme activities were offered, including 100 places for people with more complex SEND needs. 2,086 unique children, including 97 who identify as having SEND.

30. **Youth Justice Service:** In December 2023 the Hillingdon Youth Justice Service (YJS) received the Youth Justice SEND Quality Lead status with a Child First Commendation award from the Association of Youth Offending Team Managers, which is the professional association for Heads of Youth Offending Services and managers in Youth Offending Teams in England. The award recognises consistently high levels of good practice and strengths in partnership working to help children who have SEND and is given to teams who are rolling out innovative and partnership-led strategies within their services to improve outcomes for the children in community and custody. This achievement highlights the high quality of work undertaken by the YJS, local authority SEND specialist and health professionals to effectively support and meet the diversity needs of children in the youth justice system with SEND.

31. **Stronger Families Hub:** The Council's Stronger Families Hub is the single point of contact for children, young people, and families in Hillingdon to access a wide range of support services 24/7. The model combines a social work led service, adult mental health service and the Hillingdon Multi-agency Safeguarding Hub (MASH). During the review period there were 17,415 enquiries with a wide range of reasons for the contact but the majority were vulnerability of the young person (25%), domestic incident (11%) and socially unacceptable behaviour (8%).

32. The main outcomes arising from the contact were information and advice (39%), statutory social care (22%), a referral to MASH (10%) and referrals to other agencies.

33. **Local Area Special Educational Needs and Disability (SEND) and Alternative**

Provision (AP) Strategy 2023-2028: This new strategy was approved by the Council's Cabinet Member for Children, Families and Education in December 2023 and is the subject of a separate item on the Board's agenda.

Key Performance Indicator Updates

34. The following is an update on workstream 4 indicators where data is available:

- **Education, Health, and Care Plan (EHCP):** *Slippage (Amber)* – The national target for the completion of EHCPs is 20 weeks from referral. The local target is to achieve this in 80% of cases. The percentage of plans completed within 20 weeks between Apr – Dec 23 was 57%. This is a 7% increase on the same time period in 2022/23, which was 50%. This performance was impacted by staff shortages within the SEND Team. These have now been addressed and a more stable staff team will lead to improved performance against this metric.

- **Children and Adolescent Mental Health Service 18 week wait from referral to first consultation:** *On track (Green)* **–** The national target is 85% and performance for the April to December 2023 period was 95.6%.

Workstream 5: Care and support for adults with mental health challenges and/or people with learning disabilities and/or autism.

Workstream Highlights

35. **Mental health assessment lounge:** This new space supporting people with mental health concerns in A & E at Hillingdon Hospital opened on the 31st July 2023 and is called the '*Lighthouse*'. The purpose of the Lighthouse is to prevent admission. It is suitable for 4 patients and offers psychosocial support, 1:1s and signposting to the community. Since the Board's November meeting the service has moved to a 24/7 model and is now accepting people awaiting a Mental Health Act assessment. These changes have seen over four times more patients supported in January than December. The next steps are to review 24/7 medical cover as well as pharmacy and prescribing arrangements to increase flexibility in the range of people that can be supported.

36. **The Retreat:** This six-bedded unit is co-located with the Hillingdon Coves Café and the Board is reminded that its purpose is to support people in crisis to prevent acute admissions. Funding options to continue the service beyond the end of the current contract in April 2024 are being explored.

37. **High Readmission Group:** The British Red Cross has been appointed to lead this group which focuses on people with mental health needs who are frequent attenders at A & E. It will be supported by the CNWL Psychiatric Liaison Service.

Key Performance Indicator Updates

38. The following is an update on workstream 5 indicators where data is available:

- **% of adult population receiving access to psychological therapies:** *Slippage (Amber)* – Hillingdon's performance for the period to December 2023 was 5.7% against an ICB target of 6.3%.

- **% of adults receiving access to psychological therapies within 6 weeks of referral:** *On track (Green)* – The national target is 75% and the average performance for the period April to December 2023 was 99.6%.

- **% of adults receiving access to psychological therapies within 18 weeks of referral:** *On track (Green)* - The national target is 95% and the average performance for the period April to December 2023 was 100%.

- **Dementia diagnosis rate for people aged 65 and over:** *On track (Green)* **–** The performance to December was 67.8% against an ICB target of 66.7%. The NWL average was 63.6%.

Enabling Workstreams

Enabler 1: Supporting Carers

39. The Council is the lead for this enabling workstream, which seeks to support unpaid carers of all ages to continue in their caring role for as long as they are willing and able to do so.

Workstream Highlights

40. **Accelerated Reform Fund:** As a result of a collaboration between NWL local authorities, the ICB and third sector organisations supporting carers (including Carers Trust Hillingdon) an expression of interest was submitted on the 12th January 2024 to develop the '*Carer Card Plus'* to deliver on two of the required priorities of the fund and these are:

- Ways to better identify unpaid carers in local areas.

- Ways to encourage people to recognise themselves as carers and promote access to carer services.

41. If the expression of interest is agreed this could lead to a grant of £130k to support the early identification of carers in Hillingdon. The Carer Plus Card would build on the existing carer card provided by Carers Trust Hillingdon to carers on the Carer Register that they have developed under the Carer Support Service contract that they hold with the Council.

42. **Carers Strategy and Performance Measures:** The draft Carers Strategy was considered by the Council's Health and Social Care Select Committee and Cabinet in November and December 2023 respectively. This is being finalised, including refinement of metrics, and will be consulted on more widely in the coming months.

43. The Select Committee and Cabinet noted that there is a high proportion of carers who decline a carer's assessment, .e.g., 76% in 2022/23 and 81% in first half of 2023/24, and asked officers to look into this further and report progress to the Board. The Council has anecdotal information as to why assessments are declined and this includes satisfaction with the care package provided to the cared for person or satisfaction with the support offer under the Carer Support Services contract, but there is no hard data. Work is therefore being undertaken to develop an IT solution to enable this data to be collected systematically, which would be through a drop-down menu in the Council's adult social care case management database called

Protocol. The Board is advised that this will not be a quick solution to implement as work will need to be done with carers to test the reasons to be included in the drop-down menu.

Enabler 5: Estates

Workstream Highlights

44. Joint work between the Council, HHCP and the ICB to fast track the development of three super hubs has now confirmed the following as priorities:

- A Ruislip hub within the redevelopment of Pembroke Road.
- A Hayes hub within a revised design at the Nestlé Development.
- An Uxbridge hub with a clinical base that includes reprovision of Uxbridge Health Centre at Beaufort House and an administrative base at the Civic Centre, which would include ICB borough-based staff.

Finance

45. Tables 4 and 5 below show the split of the 2023/25 BCF allocations. It should be noted that figures for 2024/25 are provisional, for example, ICB additional contribution and discharge allocations are currently under discussion.

Table 3: Financial Contributions by Organisation 2023/24 and 204/25 Compared

Organisation	2023/24	2024/25
NHS	29,658,745	30,953,164
LBH	66,875,873	67,566,876
TOTAL	**96,534,618**	**98,520,040**

Table 4: Financial Contributions by Funding Stream 2023/24 and 2024/25 Compared

FUNDING SOURCE	FUNDING	
	2023/24	2024/25
Minimum NHS Contribution	22,869,590	24,164,009
Additional NHS Contribution	5,524,379	5,524,379
ICB Discharge Fund	1,264,776	1,264,776
NHS TOTAL	**29,658,745**	**30,953,164**
Minimum LBH Contribution	12,578,861	12,578,861
Additional LBH Contribution	53,250,038	53,250,038
LBH Discharge Fund	1,046,974	1,737,977
LBH TOTAL	**66,875,873**	**67,566,876**
TOTAL BCF VALUE	**96,534,618**	**98,520,040**

46. Underspends and overspends at Q3 balance each other and will be managed by the Council and the ICB in accordance with the risk share and over and under-performance

arrangements described in Schedule 4 of the 2023/24 BCF section 75 (NHS Act, 2006) agreement approved in November 2023.

BACKGROUND PAPERS

Joint Health and Wellbeing Strategy, 2022 – 2025