2021/22 INTEGRATED HEALTH AND CARE PERFORMANCE REPORT

Relevant Board Member(s)	Caroline Morison Councillor Jane Palmer
Organisation	London Borough of Hillingdon
Report author	Gary Collier - Social Care and Health Directorate, LBH Sean Bidewell – Integration and Delivery, NWLCCG
Papers with report	None

HEADLINE INFORMATION

Summary	This report provides an update on the delivery of the transformation workstreams established to deliver the priorities within the Joint Health and Wellbeing Strategy. This report also includes an update on actions within the scope of the Better Care Fund and seeks approval for the content of the 2021/22 end of year reporting template to the Department of Health and Social care.
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 total of the BCF for 2021/22 was £106,454k made up of a Council contribution of £57,327k and a CCG contribution of £49,127k.
Ward(s) affected	All

RECOMMENDATIONS

That:

a) the content of the 2021/22 end of year template be approved;
b) delegation to the Executive Director for Adult Social Care and Health to sign-off the template submission on behalf of the Board be approved; and
c) the content of the report be noted.

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 January to March 2022 period (referred to as the '*review period'*), unless otherwise stated. The report also seeks approval for the content of the 2021/22

end of year template.

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

2021/22 End of Year Better Care Fund (BCF) Template

3. All health and wellbeing board areas in England were required to submit an end of year template summarising 2021/22 activity on 27th May 2022. Officers have submitted a draft template subject to the Board's sign-off. The template is an excel spreadsheet containing five worksheets. **Appendix 1** includes the detail of these tabs for the Board's consideration, but the key points are highlighted below.

4. **Appendix 1: National Conditions** – This asks if Hillingdon met the four national conditions for the BCF, which it did.

5. **Appendix 1A: Metrics** – This is seeking the end of year status against the targets for avoidable admissions, length of stay (LoS), discharge to usual place of residence, permanent admissions to care homes of people aged 65 and over and percentage of people still at home 91 days after discharge from hospital having received a period of reablement.

6. The key point to highlight to the Board is that Hillingdon's activity is green for three of the four targets. The data for the avoidable admissions metric (referred to as '*unplanned hospitalisation for chronic ambulatory care sensitive conditions*' in the template excerpt in **Appendix 1A**) is published by NHSE and figures for March 2022 have not been published, hence the '*data not yet available to assess progress'* response in the template. However, the Board may wish to note that the trend from April 2021 to February 2022 would suggest a positive outturn. A common approach across NWL has been taken to the update for this metric.

Ambulatory Care Sensitive Conditions Expanded

Ambulatory care sensitive conditions (ACSCs) are conditions where effective community care and case management can help prevent the need for hospital admission. They include conditions such as 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).

7. **Appendix 1B: Income and Expenditure Actuals** – Actual expenditure £739k over the agreed 2021/22 BCF value due an increase in costs for Continuing Healthcare (CHC) placements. This additional cost has been borne by the CCG. Actual Council BCF expenditure was in line with the agreed budget.

8. **Appendix 1C: Year End Feedback** – This asks for responses against three pre-set questions and the identification of two successes and two challenges.

9. **Appendix 1D: Adult Social Care Fee Rates** – This asks about actual fee rates for home

care, nursing care home and residential care homes in 2020/21 against the figures included in the 2020/21 end of your template for these service areas. Rates for 2021/22 are also required. The key points to highlight to the Board are:

- The actual fee rates for 2020/21 matched the projections, which is not surprising as the 2020/21 template was submitted in May 2021.

- 2021/22 saw an average increase of 3.5% in fees paid across the services referred to in paragraph 9. The availability of funding through the DHSC's Infection Control and Testing Fund and the Workforce Recruitment and Retention Fund were a help to providers, but allocations were often quite small and did not address the level of cost increases faced by providers.

2022/23 BCF Development

10. ***Place-based health and care budget development***: The March Board asked that work be undertaken in discussion with partners to develop a place-based health and care budget. Discussions between the Council, HHCP and the North West London Integrated Care System is in progress.

11. ***NHS Provider inclusion as party to section 75 (s75) agreement:*** The possibility of CNWL becoming a party to the 2022/23 section 75 (NHS Act, 2006) that will give legal effect to the financial and partnership arrangements within the as yet to be agreed BCF plan are currently under discussion.

12. ***2022/23 BCF planning requirements:*** The latest intelligence is that the planning requirements for the BCF plan will be published early in July for a submission mid-September 2022. The Board is advised that is not confirmed and therefore subject to change. If this timetable is delivered it would mean that section 75 sign-off is likely to be required by the end of December 2022 or the end of January 2023 if there is slippage in publication of the results of the plan assurance process.

13. Other indications about the requirements for the 2022/23 BCF plan include:

- ***National conditions:*** It is understood that a new national condition will be included that asks for plans to meet the national objectives of enabling people to stay well, safe and independent at home for longer and also the provision of the right care in the right place at the right time. Although subject to the content of the planning requirements, the work already in progress to delivery to the priorities within the joint health and wellbeing strategy mean that officers and partners do not believe that satisfying this national condition will be problematic.

- ***Intermediate care provision plans:*** Local systems will also be required to submit a high-level overview of expected demand for intermediate care, along with planned capacity to meet this demand alongside their BCF plans. This is also an area where there has been close working across health and care partners

Intermediate Care Services Explained

Intermediate care services are a range of short-term services provided to people free of charge to enable them to return home more quickly after a hospital stay or avoid going into hospital unnecessarily. The range of services include reablement, crisis response, home-based rehabilitation and bed-based services.

- ***Metrics:*** The only suggested change to the metrics shown in **Appendix 1A** is the removal of those concerning length of stay. Metrics concerning avoidable admissions, discharge to usual place of residence, permanent admissions to care homes and people still at home 91 days after discharge from hospital who have received a period of reablement are expected to be retained.

Adult Social Care Funding Reforms

14. On 7th September 2021 the Government announced its intention to introduce the following changes to the funding of Adult Social Care:

- ***Cost care cap*****:** From 1st October 2023 no one will have to pay more than £86,000 toward meeting the cost of addressing their assessed care needs in their lifetime.

- **Capital thresholds**: From the 1st October 2023 the maximum level of capital or savings that an adult can have and be eligible for financial assistance from the local authority with meeting their assessed social care needs will rise from £23,250 to £100,000. The minimum threshold for contributions will also increase from £14,250 to £20,000, which means that anyone with capital or savings below this figure will not have to make a financial contribution to meeting their care costs.

15. The changes in capital thresholds will increase the numbers of people eligible to receive assistance from October 2023 and the introduction of the care cap is likely to impact on demand for local authority support and related costs over time. An immediate implication of the introduction of the care cap is the need to identify a fair cost of care that should contribute to the cap.

16. The rates for care paid by local authorities are generally much lower than those paid by self-funders, which the DHSC is seeking to address. Local authorities are therefore being required to undertake a fair cost of care exercise with care home providers supporting people aged 65 and over and homecare providers supporting people aged 18 and over with the intention of identifying the true cost of care. The expectation is that rates paid by local authorities will increase as a result of this exercise and the Market Sustainability and Fair Cost of Care Fund has been introduced to cushion the financial impact of these changes. The level of this fund for 2023/24 and 2024/25 will be determined by the outcome of this exercise. The key unknowns at this stage are:

- Medium to long-term impact on care costs incurred by the Council.

- Extent to which the financial impact will be cushioned by the Market Sustainability and Fair Cost of Care Fund.

- Effect on care costs paid by the NHS.
- Overall impact on the sustainability of the Hillingdon's care market.

17. The Board will be updated as the implications of the funding changes unfold.

B. Workstream Highlights and Key Performance Indicator Updates

18. This section provides the Board with progress updates for the six workstreams, where there have been developments. The outturn for the national metrics within the 2021/22 BCF is addressed in paragraphs 5 and 6 and **Appendix 1A**.

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

Workstream 1: Neighbourhood Based Proactive Care

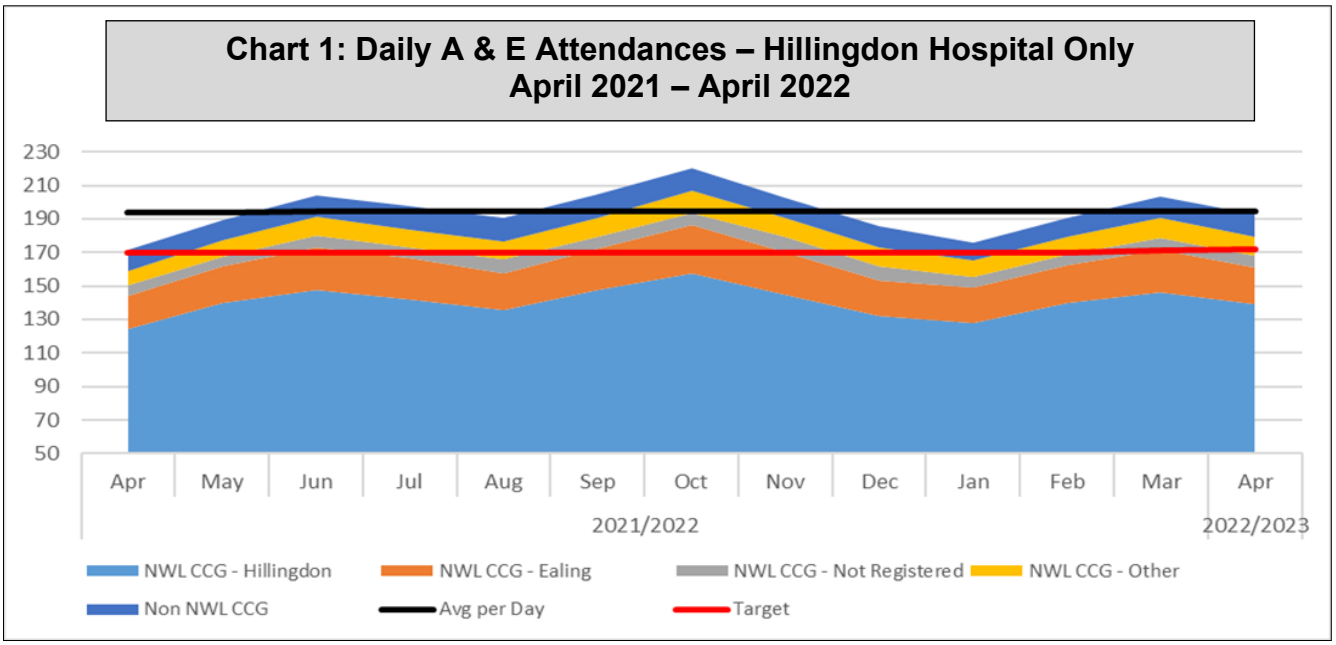
20. Developments within this workstream are addressed in a separate report entitled *Integrated Neighbourhood Care* on the Board's agenda.

Workstream 2: Urgent and Emergency Care

Workstream Highlights

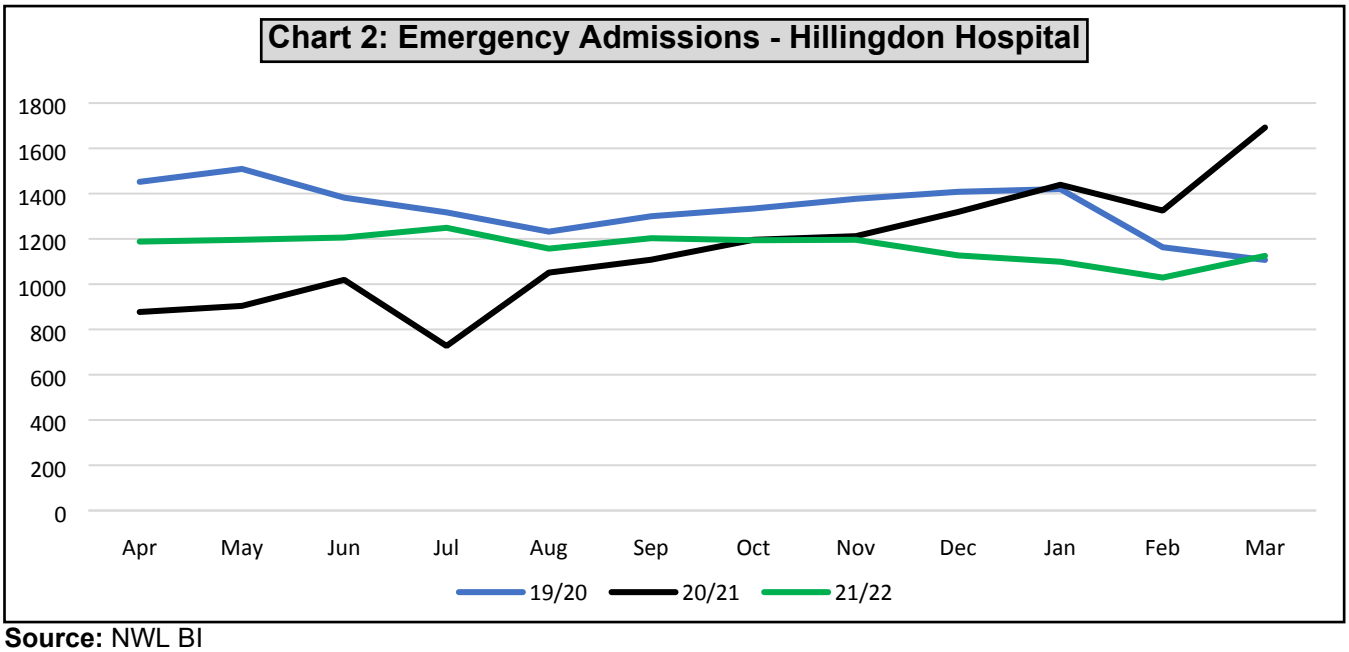
21. **A & E Attendances:** The report to the March Board showed a reduction in attendances from October 2021 to January 2022. Since January the number of attendances has increased resulting in an average of 194 per day. This has reduced to 184 a day since the beginning of April. As reported in March, 72% of attendees are people registered with Hillingdon GPs; 12% with Ealing GPs and the rest from a range of areas or not registered. Chart 1 below shows Hillingdon Hospital attendance activity from April 2021 to April 2022.

Chart 1: Daily A & E Attendances – Hillingdon Hospital Only
April 2021 – April 2022



Source: NWL BI

22. **Emergency Admissions:** Chart 2 below shows that there has been a levelling off in the number of emergency (also known as non-elective or NEL) admissions during the second half of 2021/22 until February 2022 when it started to increase to match the equivalent position in March 2019, i.e., pre-pandemic.



Source: NWL BI

23. **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 key objective of the service is to redirect people to primary care who do not need inpatient treatment at Hillingdon Hospital. In 2021/22 there was an average redirection rate of 8.6% compared to 4.9% in 2020/21.

24. **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. During 2021/22 there has been a reduction in the percentage of direct referrals coming from GPs to the Accident and Emergency Clinical Unit (AECU) from 20.9% in 2020/21 to 19.7% in 2021/22. Work is currently in progress to increase the capacity of the service.

25. **Step-down, Discharge and Winter Pressures:** Additional capacity introduced to manage winter demand has rolled forward into 2022/23 to support the reduction in length of stay at Hillingdon Hospital, i.e., D2A bridging care, 7-day social care support and step-down bed provision.

26. In order to establish a stable supply of bed-based provision to support hospital discharge and prevent unnecessary admissions a tender is in progress that will lead to four-year contracts with providers for thirteen beds including nursing and residential care home provision to support both step-down from hospital and step-up from the community to prevent unnecessary hospital admissions. The procurement is being led by the Council with specifications developed with HHCP partners.

Key Performance Indicators

27. 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*: Q4 average was 94%.

- ***Length of stay of seven days or more (Hillingdon Hospital):*** This metric measures the percentage of people in hospital with a length of stay of seven days or more (known as '*stranded patients'*) should be no more than 30% of the bed base, i.e., 94 people based on 313 core beds. *On track:* The Q4 (January and February 2022) average was 29%.

- Length of stay twenty-one days or more (Hillingdon Hospital): This metric measures the percentage of people in hospital with a length of stay of seven days or more should be no more than 6.2% of the bed base, i.e., 19 people based on 313 core beds. *Some Slippage*: The Q4 (January to February 2022) average was 6.7%

28. The Board may wish to note that BCF targets covering length of stay of 14 and 21 days and over are addressed in paragraphs 5 and 6 and **Appendix 1A** of this report, which also addresses the discharged to usual place of residence target.

Workstream 3: End of Life Care

Workstream Highlights

29. ***End of life dashboard:*** The March Board meeting asked to receive the information included within the end of life dashboard. This includes:

- Average % of deaths occurring in preferred place of care.

- % of deaths occurring in hospital.

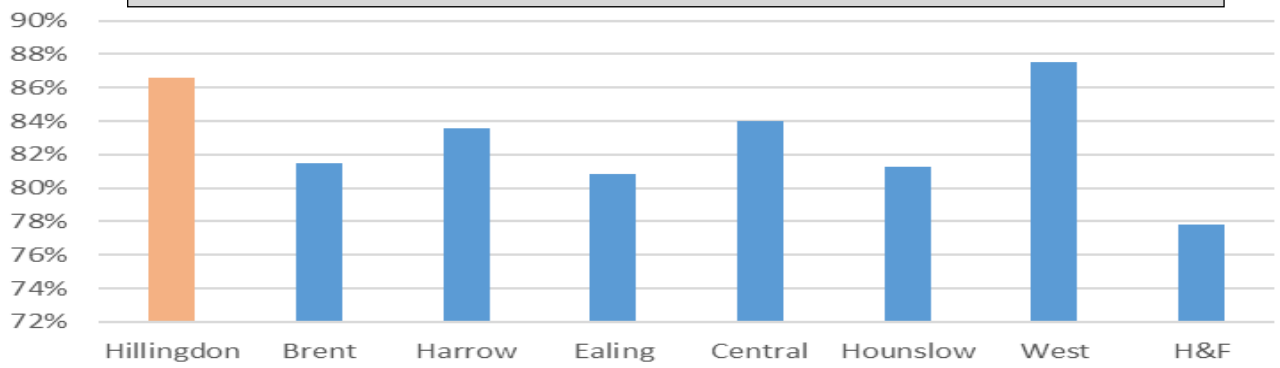
- % of deaths occurring in the community. This data is not available for this report.

- % of people with 3+ emergency admissions in last year of life

- Average number of bed days following an emergency admission in 90 days prior to death.

30. Chart 3 below shows the average % of deaths of people on the advanced care planning tool called Coordinate My Care (CMC) where the preferred place of death was achieved. This shows that Hillingdon was second in NWL in enabling people to achieve their wishes about preferred place of death. It is important to reiterate a point raised at the Board's March meeting that this is particularly significant because Hillingdon is the highest user of CMC in NWL.

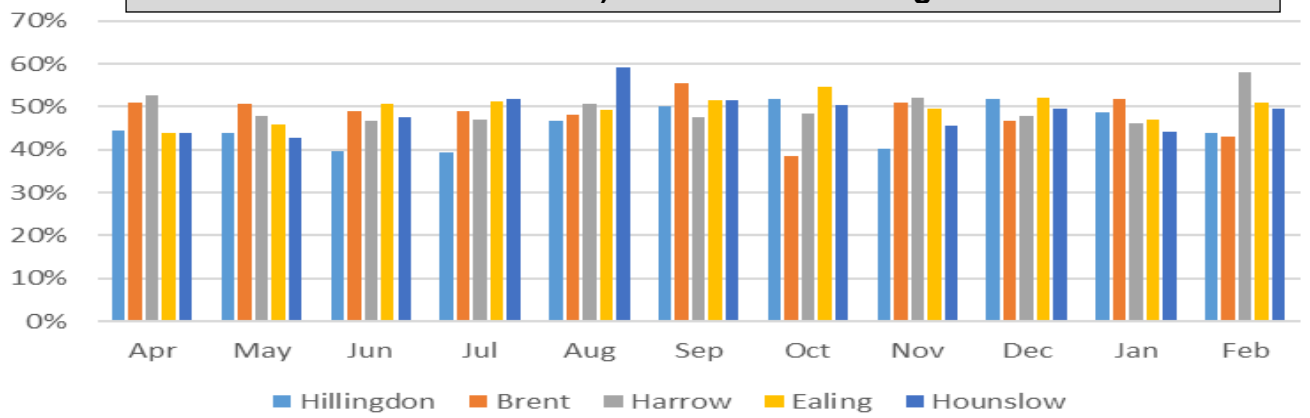
Chart 3: Average % of deaths on CMC record with preferred place of death achieved (April 2021 – Feb 2022)



Source: CMC. **Key**: Central – Westminster (excluding Queen's Park and Paddington); West London – Kensington & Chelsea and Queen's Park and Paddington; H & F – Hammersmith and Fulham.

31. Chart 4 below shows that the average number of deaths in hospital over 2021/22 was slightly lower in Hillingdon than in other outer NWL boroughs.

Chart 4: % of deaths that occurred in hospital during 2021/22 (April 2021 – Feb 2022) – Outer NWL boroughs



32. Tables 1 and 2 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 1: % of people with 3+ emergency admissions in last year of life

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

Source: NWL BI EoL Dashboard

Table 2: Average number of bed days 90 days prior to death (Emergency admissions)			
Borough	**2019/20**	**2020/21**	**2021/22**
Brent	19.12	14.49	15.76
Ealing	18.94	14.41	14.44
Hounslow	18.09	14.71	15.85
Hammersmith & Fulham	18.20	16.34	19.43
Harrow	17.54	15.39	16.46
Hillingdon	18.12	14.27	15.06
West London	17.83	15.67	14.59
Central London	17.81	14.18	17.76
NWL Average	**18.30**	**14.79**	**15.80**

Source: NWL BI EoL Dashboard

33. **End of life strategy:** Work has started on the development of a new strategy that will support delivery of an integrated care model. Partners across health and social care have completed the NWL End of Life Ambitions self-assessment Toolkit that will feed into the development of a local strategy.

34. **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 104 people are currently being supported by this service.

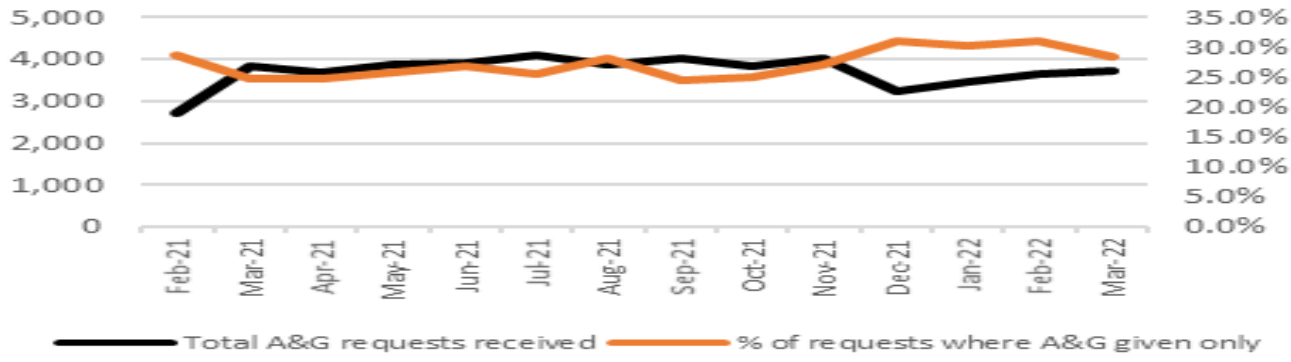
Workstream 4: Planned Care

Workstream Highlights

35. **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. The redesign initiatives are at different levels of development, but the expectation is that implementation will take place in 2022/23 and the Board will be updated on progress via the performance report.

36. **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 3,561 and the period from January to March 2022 saw an average of 3,610. Data suggests that the service is being effective in reducing unnecessary referrals to the Hospital and that the period between January 2021 and March 2022 some 11,567 inappropriate referrals have been avoided. Chart 5 below illustrates the total A & G requests received during the period from February 2021 to March 2022 and the proportion that have been A & G only.

Chart 5: Hillingdon Hospital Advice and Guidance Requests



Workstream 5: Children and Young People (CYP)

Workstream Highlights

37. **Community step-up/step-down model:** The Providing Assessment & Treatment for Children at Home (PATCH) service went live in June 2021 and has now been in operation at year. In the period between June 2021 and April 2022 974 children have been seen by the service and 58% were aged under 2.

38. **Child Healthy Weight:** The Board has requested more details in this report on progress in improving healthy weight of children and work with schools and the key activities in progress are described below.

39. **0-19 Healthy Child Service (Health Visiting and School Nursing):** The 0-19 Healthy Child Programme is a universal offer to all families with children who live in Hillingdon. Through health surveillance pre-birth and at key developmental stages in the early years, babies, young children and their families are supported so that children are ready, and able to learn by the time they start school.

40. School Nurses provide health screening for school aged children which includes the National Child Measurement Programme which in turn identifies children who are overweight or obese and are offered the "*My Choice*" treatment programme (for primary phase) and offer drop-in advice sessions and individual support in secondary phase. Delivery of these programmes has been significantly impacted by the pandemic period.

41. The Council's Cabinet will shortly be requested to extend a number of contracts to January 2024, and this will include the 0-19 service. The extension will provide an opportunity to review the impact of the pandemic and have conversations with our residents that lead to improved ways of delivering services, supporting better outcomes, experience and access. This approach will feed into revised specifications with recommendations for the contractual processes that will achieve the best outcomes for residents. Joint work continues on service transformation across health and social care in line with the ambitions in the Health and Wellbeing Strategy and ensuring alignment with the development of the family hub programme and also *The Best Start for Life* offer that came out of Dame Andrea Leadsom's review and includes a focus on breastfeeding support and oral health as linked to child healthy weight (CHW).

42. **Holidays and food programme:** The Holidays and Food (HAF) programme was introduced so that children and young people who attend provision may:

- 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.

43. The programme also ensures that families participating:

- develop their understanding of nutrition and food budgeting
- are signposted towards other information and support, for example, health, employment, and education.

44. HAF is available to children from reception to year 11 (inclusive) aged 5-16 years (including 4-year-olds if in Reception) who are eligible for and receiving benefit related free school meals (FSM), and their families. The age for children with special educational needs and disabilities (SEND) is extended to 18 years. Hillingdon has approximately 10,400 children in receipt of benefits related free school meals (FSM) who are therefore eligible for HAF funded provision. In addition, up to 15% of the grant can be used for non-FSM children who are regarded as vulnerable i.e., Looked After Children, children with SEND and children on Child Protection, Child in Need or Early Help plans.

45. In October 2021 the Government announced an investment over the next three financial years. The programme will cover the Easter, Summer, and Christmas holidays in 2022. The Easter programme in Hillingdon went well and supported nearly 5,000 children. For Easter we commissioned 1,785 spaces, of which 1439 were booked and 73.5% (1,312) of available spaces were taken up (attended at least one of four-day offer). Feedback was positive and plans are underway to deliver the summer programme building on learning from the Easter programme and utilising local facilities and providers wherever possible.

46. **SMILE programme:** The SMILE programme was developed with Colham Manor school to support families and children in schools and to teach basic cooking skills, increase knowledge of foods high in sugar, salt and fat, to learn how unhealthy choices impact on health and to understand the relationship between food and physical activity.
This has been on hold as schools have been wary of extra-curricular activities post pandemic and the intention was to ensure that the pilot phase would stand a good chance of success. The proposal now is to recruit six participating schools and to fully start the programme from September 2022.

47. **Healthy start scheme:** From March 2022, paper vouchers have been replaced by a Healthy Start pre-paid contactless card which can be used instore only, in some UK shops that accept Mastercard. Money is automatically updated onto the Healthy Start Card each week to spend on certain food, milk and can also be used as proof of entitlement when collecting vitamins from their local children's centre.

48. Since the re-launch of the scheme in June 2021, Hillingdon's take up of 53% has improved to 65% at the end of March 2022.
49. To highlight the new procedure and even further improve our uptake, children's centres and

the Council's website have been updated to ensure that clear details of the changes to the scheme are available to existing and other eligible residents.

50. **Dental health:** The supervised brushing programme continues to be rolled out in schools and nurseries. The programme is currently running in 5 schools and 3 nurseries. Start dates are to be confirmed in another 6 schools and a further 12 schools have expressed an interest in taking part.

51. **16 – 25 mental health pathway:** The Hillingdon Young Adult Mental Health and Wellbeing Implementation Group was set up in November 2021 and meets monthly. Membership includes representatives from NHS mental health services (CYP and adult), CCG, primary care, Local authority, University, voluntary and community sector (VCS) and young adult ambassadors and parent/carers. Each service has presented on their work with young adults, data on service use and development opportunities. The group is leading development and mobilisation of the model, tailoring it to meet local needs

52. The NWL 16-25s Steering Group (CCG led) and 16-25s Clinical Senate (mental health practitioners adolescent and adult services) continue to meet monthly to support developments across NWL. The Young Adult Ambassador Group (15 young adults) meets every 3 weeks to oversee implementation and guide developments. Recent work includes interviewing Pathway Lead and Psychiatrist and developing the job description for the Young Adult Community Navigator role.

53. The Hillingdon Young Adult Mental Health Pathway Lead (1 WTE 8A mental health practitioner) has been appointed and started in post May 9th. The Hillingdon Young Adult Psychiatrist has yet to be appointed and will provide 2 sessions a week.

54. The application process for the Hillingdon Young Adult Community Asset scheme launched in April 2022 and closed May 19th. Grants will support a range of VCS mental health and wellbeing projects totalling £65k and looking to address inequalities, better identify unmet need and improve equality of access to early intervention and build the partnership approach.

55. A NWL University/College Connect schemes was launched in January 2022 and funding was awarded to Middlesex University, Westminster University, Brunel University, Buckinghamshire New University and Harrow and Uxbridge College with the aim to develop better links between NHS mental health services and university and college wellbeing service. A NWL wide Uni/college mental health group meets every quarter to share progress and partnership working. Projects include:

- HUHC – in-house counselling service with trainees.
- Brunel - a campaign to support men access their mental health service.
- Middlesex - a stepped-care framework and social prescribing tools.

56. The Young Adult community navigator role has been contracted with Hillingdon Mind and will provide young adult focused support to develop coping and mental health self-management, navigation of services and improved engagement.

57. A CNWL trust-wide Lived Experience Worker (B7) will soon be employed to lead on 0-25s peer support. Once in post 5 WTE Young Adult Peer Support Workers (Band3-4) will be recruited, one for each borough. The practice model is in development.

Key Performance Indicators

58. 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 2021/22, 84% of assessments were completed within 20 weeks compared to 50% for 2020/21. As previously reported, the provision of statutory advice from partners, i.e., therapists, within the mandated 6-week timeframe is also supporting delivery of the 20-week target.

Workstream 6: Mental Health, Learning Disability and Autism

Workstream Highlights

59. There is a separate report on the Board's agenda entitled *Adult Mental Health Crisis Pathway Update*.

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

Enabling Workstreams

61. 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

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

63. **Enabler 1: Supporting Carers**: The Council is the lead for this enabling workstream, which seeks to support carers of all ages to continue in their caring role for as long as they are willing and able to do so.

Workstream Highlights

64. The annual update report on the implementation of the carers' strategy delivery plan will be considered by the Health and Social Care Select Committee at its meeting on the 22nd June, which precede consideration by Cabinet and the HHCP Senior Operational Leads Team (SOLT) in July 2022. The Board may wish to note that some of the key issues that have arisen from the pandemic include:

- People assuming roles as carers without identifying themselves as carers.
- People with multiple caring responsibilities
- The mental health impact of caring during the pandemic

65. An updated joint carers' strategy is in development that will seek to address these, and other issues faced by carers. It is also the intention of officers to bring the results of the strategy development process to the Board's attention in the performance report to its March 2023 meeting.

66. **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

67. **Care homes:** The Board may be aware from previous performance reports that there has been considerable investment in supporting Hillingdon's care homes with the development of the Care Home Support Service. This team provides clinical advice and support to Hillingdon's 45 care homes with the aim of reducing hospital attendances and admissions. The team includes six care home matrons who act as named contacts for Hillingdon's care homes as well as our four extra care housing schemes - the team is actually based at Grassy Meadow Court extra care scheme. The team also includes GP, pharmacy and dietetic support and is closely aligned with the Quality Assurance Team, who are responsible for delivering the Council's market management responsibilities under the Care Act, 2014.

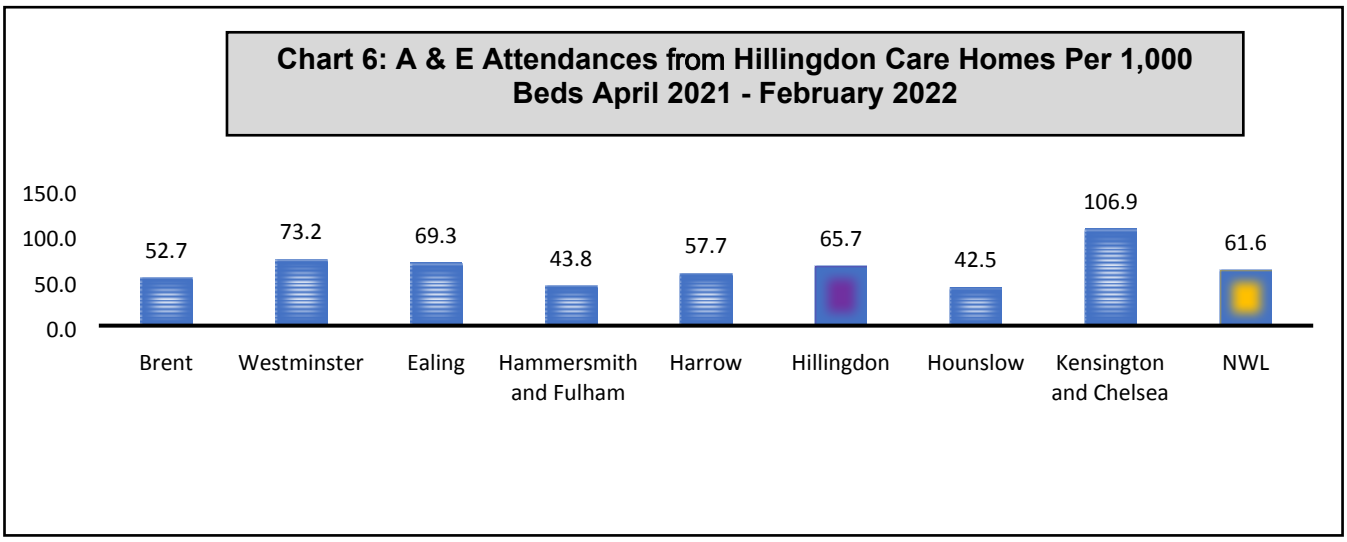
68. 89% (1,246) of Hillingdon's care home beds (1,395) are supporting older people. Table 3 below suggests that the approach to supporting care homes is having a positive impact in reducing both hospital attendances and admissions.

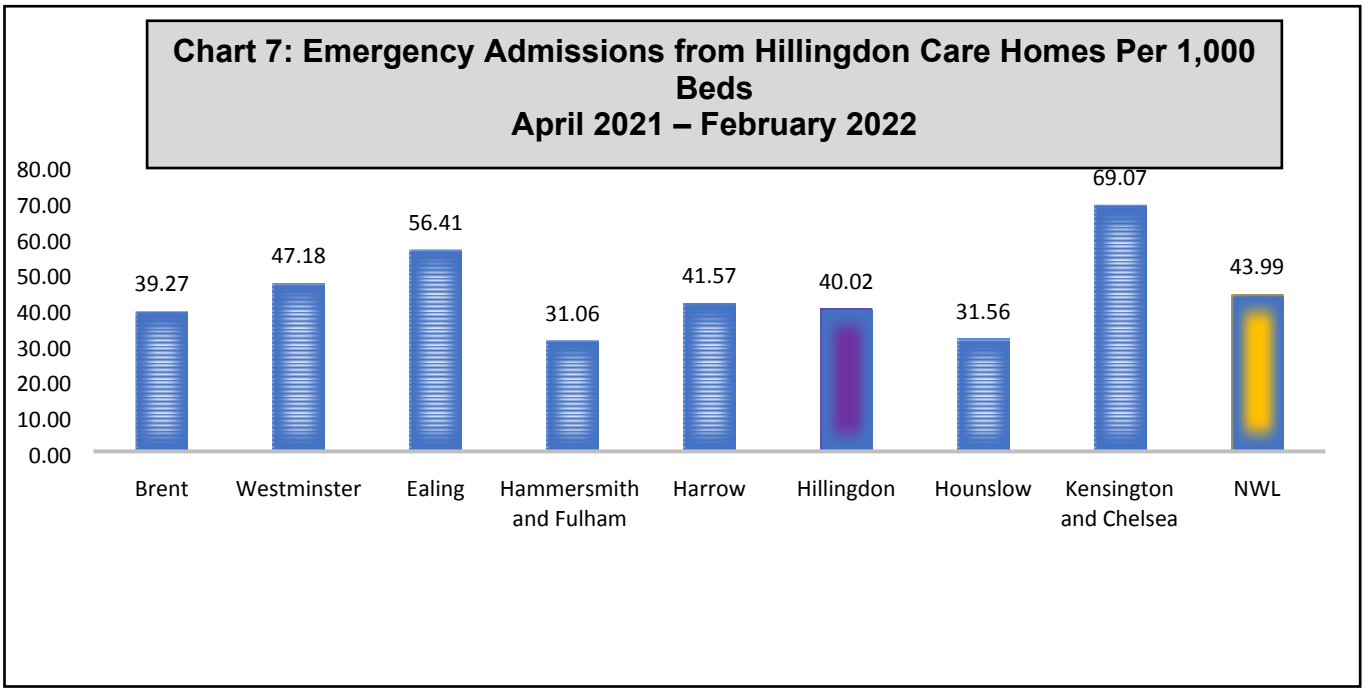
Table 3: 65 + Attendances and Emergency Admissions from Care Homes 2019 - 2022

Care Home Activity	A & E Attendances Per Year		
	2019/20	2020/21	2021/22
A & E attendances (65+)	1,268	948	890
Total A & E attendances (All 65+)	16,462	14,983	16,360
% Attendances from care homes	7.7%	6.3%	5. 4%
	A & E Admissions Per Year		
Emergency admissions from care homes (65+)	795	677	534
Total emergency admissions (65 +)	7,539	6,591	6,428
% emergency admissions from care homes	10.5%	10.3%	8.3%

Source: LAS and NWL BI Team

69. Charts 6 and 7 below help to give the Board context for Hillingdon's position in respect of A & E attendances and admissions from care homes in comparison with other NWL boroughs. The Board is informed that Hillingdon has the second highest number of care home beds in the sector after Ealing (1,395 compared to 1,560) and the number of care home attendances are comparable. However, Hillingdon has managed to achieve a rate of admissions that is below the NWL average. Although the data suggests that there may be scope to reduce attendances it is also important to note that the average length of stay for people admitted to hospital from care homes in 2021/22 was 10.39 days, which compares to a NWL average of 7.93 days. This suggests that admissions were appropriate. A much short length of stay would indicate that individual needs could have been addressed within a care home setting.





70. The Board may wish to note that the main cause of London Ambulance Service (LAS) attendances at care homes during 2021/22 and subsequent conveyances and admissions to hospital was falls related injuries.

Finance

71. The CCG minimum contribution to the BCF has increased from £20,485k in 21/22 to £21,645k in 22/23 (5.66% increase). The Council's minimum contribution has been increased from £12,359k in 21/22 to £12,579k in 22/23 (1.8% increase). The breakdown of the minimum contributions is shown in table 4 below. The total proposed value of the 2022/23 BCF, namely additional contributions, is subject to further discussion with partners.

Table 4: BCF FUNDING SUMMARY 2021/23			
Funding Breakdown	**2021/22** ***(£,000)***	**2022/23** ***(£,000)***	**% Difference**
MINIMUM CCG CONTRIBUTION	**20,485**	**21,645**	5.7
Required Spend			
• Protecting Social Care	7,470	7,892	5.7
• Out of Hospital	5,821	6,150	5.7
• Other minimum spend	7,194	7,603	5.7
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	3.0
MINIMUM BCF VALUE	**32,844**	**34,244**	**4.2**
• Additional CCG Contribution	28,642	TBC	
• Additional LBH Contribution	44,968	TBC	
TOTAL BCF VALUE	**106,454**	**TBC**	

72. There are no direct financial implications of this report.

CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance Comments

73. Corporate Finance has reviewed this report and associated financial implication, noting the funding split laid out in the tables referenced above and confirm that this is consistent with both Council's Budget Monitoring and MTFF position. It is further noted that the 2022/23 figures quoted have not been finalised and are subject to change.

Hillingdon Council Legal Comments

74. There are no direct legal implications of this report.

BACKGROUND PAPERS

Joint Health and Wellbeing Strategy, 2022 – 2025

Appendix 1 – 2021/22 National BCF Conditions

National Conditions	Confirmation
National Condition 1: **A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006?** (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes
National Condition 2: **Planned contribution to social care from the CCG minimum contribution is agreed in line with the BCF policy?**	Yes
National Condition 3: **Agreement to invest in NHS commissioned out of hospital services?**	Yes
National Condition 4: **Plan for improving outcomes for people being discharged from hospital?**	Yes

Appendix 1A – Metrics

Metric	Definition	For information – Your planned performance as reported in 2021/22 planning				Assessment of progress against metric plan for reporting period	Challenges and Any Support Needs	Achievements
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions *(NHS Outcome Framework indicator 2.3i)*	2,550				Data not available to assess progress	• Workforce shortages due vacancies and sickness has presented a significant challenge in both the primary identification and treatment of chronic ambulatory care sensitive conditions. • COVID19 has increased clinical complexity across a number of conditions.	• A programme of work is in place to improve discharge to improve the flow out of acute hospitals to support planned and unplanned recovery. • Community teams have managed increasingly complex acuity patients within their caseloads.
Length of stay	Proportion of inpatients resident for: i. 14 days or more ii. 21 days or more	14 days or more (Q3)	14 days or more (Q4)	21 days or more (Q3)	21 days or more Q4	On track to meet target	Length of stay has been impacted by: • reduced ability to discharge to designated settings (due to closures of care homes, lack of social care capacity, specialist and community care capacity). • staffing challenges (high staff turnover, sickness and vacancies). • covid19 – services being stood down and staff being redeployed, impact of COVID on day to day	• NW London ICS performs above average compared to other areas in London. • After challenges in January there have been some gradual improvements in Feb and March - with all Trust discharge teams reviewing and improving discharge processes across all pathways (including better P2 occupancy
		10.9%	12.6%	5.6%	6.2%			

							operations.	rates and work on P0) - which all helps to reduce length of stay and avoidance admissions across all boroughs. • The ICS has funded a 24/7 discharge hub model as part of this work.
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence.	91%				On track to meet target	This has been impacted by: • periodic closures in care and residential settings due to covid outbreaks. • lack of consistency in admission and re-admission criteria within care/residential settings.	• Programme of work in place around discharge, led the DASS as SRO. • Better joint working between local authorities and NHS. • All trusts continually reviewing and improving discharge process, with standardisation and sharing of good practice in place.
Residential admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	791				On track to meet target	• 2021/22 has seen an increase in the number of short-term placements to support carers, who were reluctant to be parted from the people they were caring for during the pandemic. 58% of permanent placements comprise of conversions from short-term	• Funded via CCG additional contribution to the BCF, the Council continued to use six flats within extra care as intermediate care. This has been particularly useful in aiding discharge of people unable to

				placements to permanent. Permanent placements are subject to rigorous management scrutiny to ensure that there are no alternative solutions, e.g., extra care housing or a return to their own home.	return to their usual place of residence due to, for example, need for deep cleans repairs or creation of a micro environment. Older residents continue to be supported in Hillingdon's four extra care housing schemes and close working with NHS partners enables need to be appropriately met to avoid moves to more restrictive settings.
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement	90.6%	On track to meet target	• Service underwent transfer of provider during 2021/22 following a competitive tender and, as with many services, has experienced difficulties in recruiting to vacant posts.	• Integration of reablement into a range of services delivered by a single provider to support the independence of residents in community settings. Transfer of the service was seamless from the service user perspective, i.e., no disruption to service delivery.

Appendix 1B – Income and Expenditure Actual

Better Care Fund 2021-22 Year-end Template

Selected Health and Wellbeing Board: Hillingdon

Income

	2021-22	
Disabled Facilities Grant	£5,111,058	
Improved Better Care Fund	£7,248,248	
CCG Minimum Fund	£20,485,057	
Minimum Sub Total		£32,844,363

	Planned	
CCG Additional Funding	£28,642,000	
LA Additional Funding	£44,968,000	
Additional Sub Total		£73,610,000

Actual		
Do you wish to change your additional actual CCG funding?	No	
Do you wish to change your additional actual LA funding?	No	
		£73,610,000

	Planned 21-22	Actual 21-22
Total BCF Pooled Fund	£106,454,363	£106,454,363

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2021-22	

Expenditure

	2021-22
Plan	£106,454,363

Do you wish to change your actual BCF expenditure?	Yes

Actual	£107,193,420

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2021-22	Actual expenditure by the CCG is £49.9m, which shows an over performance of £0.7m compared to the planned CCG expenditure. This over performance is largely due to increase in costs for Continuing Care placements. Actual expenditure by the LA is £57.3m, which is in line with the planned expenditure budget.

Appendix 1C – Year End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF. Covid-19 had a significant impact on services and schemes on the ground which may have changed the context. However, national BCF partners would value and appreciate local area feedback to understand views and reflections of the progress and challenges faced during 2021/22. There are a total of 5 questions, and these are set out below.

Part 1: Delivery of the Better Care Fund
Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	**Response:**	**Comments: Please detail any further supporting information for each response.**
1. The overall delivery of the BCF has improved joint working between health and social care in our locality.	Strongly agree	Health and care partners are now actively exploring utilising the BCF section 75 as the vehicle for establishing a place-based health and care budget, which aligns with proposals set out in the health and social care integration white paper published in February 2022.
2. Our BCF schemes were implemented as planned in 2021/22.	Agree	As in 2020/21 the diversion of capacity into managing the impact of the pandemic has resulted in some deliverables not being implemented, which will impact on priorities for 2022/23, e.g., developing multi-agency relationships at a Neighbourhood Team level with a new model of homecare to prevent admission through early intervention. In addition, impact of pandemic has led to some previous successes being reversed, e.g., reduction in the number of carer champions in GP surgeries.
3. The delivery of our BCF plan in 2021/22 had a positive impact on the integration of health and social care in our locality.	Strongly agree	See 1 above.

Part 2: Delivery of the Better Care Fund
Please select two Enablers from SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing. Please provide a brief description alongside.

4. Outline two key success observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021/22.	**SCIE Logic Model Enablers Response category:**	**Response – Please detail your greatest successes**
Success 1	6. Good quality and sustainable provider market that can meet demand	Joint work across the Council, primary care, community health and the CCG has helped to support the care sector during the pandemic. Whilst many providers have faced considerable challenges Hillingdon has not faced issues on the scale of some other HWB areas. This is particularly significant when considering, for example, Hillingdon has the second highest number of care home beds in North West London.
Success 2	9. Joint commissioning of health and social care	As in 2020/21 commissioning arrangements to support timely discharge during the pandemic have worked well, e.g., D2A pathway 1 bridging care, step-down. This also includes strong working relationships between the acute hospital, community health and the Council's contracted provider for intermediate care services. Hillingdon's D2A model is perceived by NWL neighbouring LAs as the preferred model of delivery especially on Pathway 1. In addition, the Tri Borough are actively seeking to implement the same model with a commissioned bridging service.

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021/22.	SCIE Logic Model Enablers Response category:	Response – Please detail your greatest successes
Challenge 1	2. Strong, system-wide governance and systems leadership	The issue raised in 2020/21 about the challenges posed by uniform approaches being taken across the ICS and the impact on equality of access to services locally still prevails. The extent to which there will be placed-based delegation in line with the February health and social care integration white paper will become apparent during 2022/23 following the implementation of the Health and Care Act, 2022.
Challenge 2	6. Good quality and sustainable provider market that can meet demand	Financial challenges faced by providers as a result of the pandemic as well as issues with recruitment pose considerable risks to the local care market. There is also uncertainty about the impact of Adult Social Care funding reforms for care providers and also for rates paid by the NHS.

Footnote:
Questions 4 and 5 answers should be assigned to one of the following categories:

1. Local contextual factors, e.g., financial health, funding arrangements, demographics, urban vs rural factors.
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users.
4. Empowering users to have choice and control through asset based approach, shared decision making and co-production.
5. Integrated workforce: joint approach to training and upskilling of workforce.
6. Good quality and sustainable provider market that can meet demand.
7. Joined-up regulatory approach.
8. Pooled or aligned resources.
9. Joint commissioning of health and social care.

Appendix 1D – Adult Social Care Fee Rates

	For information - your 2020-21 fee as reported in 2020-21 end of year reporting *	Average 2020/21 fee. If you have newer/better data than End of year 2020/21, enter it below and explain why it differs in the comments. Otherwise enter the end of year 2020-21 value	What was your actual average fee rate per actual user for 2021/22?	Implied Uplift: Actual 2021/22 rates compared to 2020/21 rates
1. Please provide the average amount that you paid to external providers for home care, calculated on a consistent basis. (£ per contact hour, following the exclusions as in the instructions above)	£17.12	£17.12	£17.70	3.4%
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions as in the instructions above)	£663.65	£663.65	£686.88	3.5%

3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions in the instructions above)	£762.82	£762.82	£789.52	3.5%
4. Please provide additional commentary if your 2020-21 fee is different from that reported in your 2020-21 end of year report. Please do not use more than 250 characters.		Not applicable		