Appendix A

Hillingdon Health and Care Partners:

Review of 2022/23 Health and Social Care Select Committee

Keith Spencer
Managing Director, HHCP

Sue Jeffers
Joint Borough Director, NWL ICB

2022/23 Hillingdon Health and Care Partners Report

1. Report Purpose

The purpose of this report is to review Place Based work and performance during 2022/23

2. Strategic Context

Hillingdon Health and Care Partners (HHCP) is the 'Place Based' alliance of health and care organisations that seeks, through collaboration and co-design, to make significant improvements to the quality and cost of care in Hillingdon. HHCP is made up of Hillingdon Hospitals NHS Foundation Trust, Central and North West London NHS Foundation Trust (CNWL), H4All (a partnership of voluntary sector health care providers) and Hillingdon's Confederation (which brings together all of Hillingdon's GPs). HHCP works together closely with the London Borough of Hillingdon and North West London ICB to deliver 3 key strategic aims:

1. Improving the outcomes for our population - delivering Hillingdon's Joint Health and Wellbeing Strategy
2. Delivery of sustainable, person-centred, joined up models of care aligned to the new hospital plans and activity assumptions
3. Delivering the NW London Integrated Care System priorities through local care models building from a population health management approach

Our shared delivery models are through 6 integrated Neigbourhood Teams and a range of joined up Borough wide teams across health and care

3. Focus of our Work in 2022/23

The focus of our work as a Place Partnership in 2022/23 has been as follows:

1. Embedding population health management and addressing our areas of inequality
2. Ensuring best use of resources to address the Hillingdon Health Place Based financial deficit
3. Developing and progressing the clinical models and activity shifts for the new hospital development programme
4. Delivering the 3 main priorities in our Place based transformation programmes:

2022/23 Hillingdon Health and Care Partners Report

3. Focus of our Work in 2022/23 continued

- **Integrated Neighbourhood Development**: maintaining whole population health and wellbeing by helping people to stay well for longer as part of a more ambitious and joined up approach to population health and prevention. Increasing capacity for Primary Care to see more patients requiring urgent care on the same day
- **Reactive Care**: Innovative, transformational approach to tackling unwarranted ED attendance through the development of a new 24/7 Place Based Out of Hospital Reactive Care delivery model for those with complex needs and multi morbidity
- **End of Life Care:** joining up an integrating care for people at the end of their life

5. Defining place governance and accountability within the wider NWL Integrated Care system

In order to strategically progress these five key objectives , we have undertaken a wide ranging review of how we currently deliver services as a Place through a series of workshops with partners across Hillingdon's health and care system in order to define a future state operating model with the ultimate goal of delivering more care closer to people's homes in 6 integrated Neighbourhoods, preventing unnecessary hospital attendances through greater same day primary care capacity , promoting earlier hospital discharge and delivering the activity assumptions underpinning the hospital redevelopment programme. The outcome of this work is a draft future state operating model for place-based health and care; the key features of which are set out in appendix 1.

Slide 4 onwards sets out the key achievements, key areas of future work and key NWL Place Performance metrics for 2022/23.

2022/23 Hillingdon Health and Care Partners Report

4. Key Areas of Achievement:

- **Primary Care:** There are more face to face GP attendances taking place in 2022 (690,900) when compared to 2021 (587,811), **an increase of 17.4 %.** There are less virtual GP consultations taking place in 2022 (444,145) when compared to 2021 (478,552), **a decrease of 7.7%.** Overall there have been more appointments attended in 2022 (1,135,045) when compared to 2021 (1,066,363), **an increase of 6.4%.** This demonstrates the pressures on general practice due to the level of appointments practices have had to make available to meet demands
- **Continuing to be one of the highest performers in NWL ICB for encouraging uptake of vaccinations** (e.g., Covid-19 first and booster jabs; polio for previously unvaccinated children; influenza, particularly for pregnant women and high-risk older people).
- **Admission rate for people 65 years with severe frailty** - Hillingdon has the lowest rate across NWL at 667.1 admissions per 1,000 population. Services in place: Pilot Frailty Assessment Unit at THH and Rapid Response Team, Care Connection Teams (CCT) that proactively supports the most complex patients. Evaluation has demonstrated that this active case management in the community and at hospital has significantly reduced: nos. of LAS conveyances, ED attends and NEL admissions.
- **Admission avoidance:** this metric measures 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 was 874 admissions per 100,000 18 plus population. As at the end of Q3, our performance was 572 admissions giving a likely forecast outturn of 763 admissions per 100,000.

2022/23 Hillingdon Health and Care Partners Report

4. Key Areas of Achievement continued:

- **Discharge from Hospital**: Achieving best performance across London for the highest proportion of hospital discharges by 5 pm each day, as well as for the lowest overall period of stay for patients needing to stay longer than a week. Patients, by and large, prefer to return home as soon as it is safe for them to do so, and our community networks between CNWL community services, the voluntary sector and LBH social care continue to support patients and families after being discharged from hospital – and often as an alternative to a hospital admission
- **% of People with a Serious Mental Illness receiving a Physical Health Check** – Hillingdon has improved its performance from 66% to 70.4%. for the six mandated health checks against a NWL target of 60%.
- The Borough team have set up a **Quarterly Crisis Concordat** meeting with the police, THH, CNWL and WL MH Trusts, LBH social care, as well as reps from Ealing and Hounslow to better manage the amount of police time taken up by bringing Section 136 clients to THH A & E
- **Organising the opening of 'The Retreat',** a safe and non-institutional environment for individuals facing mental health crisis, run jointly between CNWL, the London Borough of Hillingdon and Comfort Care. Since opening, over fifty clients have used the service, thereby receiving professional and supportive care while avoiding the stress and disturbance of a hospital emergency department
- **Diabetes delivery of 9 care processes** – Hillingdon's performance is 52% of people with diabetes receiving the 9 care processes against a NWL target of 50%.
- **LD Annual Health Checks > 14** –currently exceeding NWL target of 50% with a performance of 81% for Hillingdon. Key actions taken include: Masterclass training sessions with GPs. Building on work from Covid to support people with LD, CNWL LD team delivery continue to work with LD health champions, PCNs and the Local authority to support with annual checks.

2022/23 Hillingdon Health and Care Partners Report

5. Key Areas for Future Work

- **ED Attendances:** This is an HHCP transformation priority to reduce avoidable ED attendances in line with the hospital redevelopment assumptions through the development of 3 x Same Day Primary Care Neighbourhood Hubs which will begin to come on stream during 2023
- Further work to improve even further **hospital discharge to deliver the hospital redevelopment assumptions. This is an extant HHCP priority .**
- **Bowel Cancer Screening** – Hillingdon's performance is 51%. Lower rates in the south of the borough with higher BAME population. Actions to increase uptake include: free text message reminders sent to patients who do not return the FIT testing kit after 6 weeks. Work by Community Links who contact patients approaching their 56th and 60th birthdays who have not responded to screening invitations
- **Dementia** - Changes to the National Data collection policy in January 2023 currently mean all boroughs' data show an undercount of people diagnosed with dementia. Currently working with NHS England, and practices to ensure dementia data is being accurately recorded by practices and counted by NHS England. In addition, the Hillingdon Dementia Alliance is working together to improve waiting times for assessment and associated diagnostics such as MRI scans and offer support to carers.
- **Hypertension** – hypertension is a HHCP priority and for all PCNs with high nos. of patients with hypertension in the borough. There is a primary care contract in place to address inequalities that includes hypertension. NWL PHM funding has been directed at opportunistic testing of patients with undiagnosed hypertension e.g. community roadshows, BP monitors at libraries and in other community areas. Also, active case finding through GPs audits. These are in addition to other existing schemes i.e. Community Pharmacy Blood Pressure Checks Service and the GP Confed ABPM service.

2022/23 Hillingdon Health and Care Partners Report

Key Performance Indicators

Most Recent Month	NWL Metric Name	ICS Objective	Measure	Goal (Increase or Decrease)	Target	Benchmark	NWL	Westminster	Kensington and Chelsea	Hammersmith and Fulham	Brent	Ealing	Hounslow	Harrow	Hillingdon
Jan-23	People with diabetes who have received nine care processes in the last 15 months	Improve outcomes in population health and health care	%	Increase	50.0%		56.0%	59.0%	57.0%	56.0%	52.0%	58.0%	62.0%	53.0%	52.0%
Jul-22	Eligible female patients who have received a Cervical Cancer Screening within the last 3.5 years for ages 25-49.	Prevent ill health and tackle inequalities in outcomes, experience and access	%	Increase	80.0%	London Average - 60.9%	56.0%	45.6%	48.1%	55.4%	53.2%	62.9%	60.7%	56.3%	64.0%
Jul-22	Eligible female patients who have received a Cervical Cancer Screening within the last 5.5 years for aged 50 and over.	Prevent ill health and tackle inequalities in outcomes, experience and access	%	Increase	80.0%	London Average - 71.7%	68.5%	58.1%	58.5%	63.6%	70.2%	73.3%	72.3%	71.2%	74.4%
Mar-23	Children (17 or under) with asthma who have completed an asthma check	Prevent ill health and tackle inequalities in outcomes, experience and access	%	Increase	68.0%		59.0%	61.0%	59.0%	60.0%	52.0%	68.0%	67.0%	53.0%	48.0%
Feb-23	People receiving access to psychological therapies	Prevent ill health and tackle inequalities in outcomes, experience and access	%	Increase	6.3%	England Average - 4.9%	4.8%	4.4%	4.2%	4.8%	4.1%	5.0%	4.7%	6.2%	5.6%
Mar-23	People with severe mental illness (SMI) receiving a full physical health check	Prevent ill health and tackle inequalities in outcomes, experience and access	%	Increase	60.0%	England average (14/15) - 34.8%	67.2%	69.2%	72.9%	57.8%	61.8%	63.6%	73.9%	73.3%	70.4%
Jan-23	People over age of 14 on a doctor's learning disability register who have had an annual health check	Prevent ill health and tackle inequalities in outcomes, experience and access	%	Increase	50.0%	England average (18/19) - 52.3%	65.6%	62.7%	64.9%	63.4%	75.4%	69.8%	69.1%	67.0%	63.0%
Jan-23	Population Dementia Diagnosis rate	Improve outcomes in population health and health care	%	Increase	66.7%	England Average - 62.2%	57.4%	54.1%	60.0%	40.2%	64.4%	48.7%	61.5%	61.9%	61.2%
Dec-22	Admission rate for people 65 years and older by severe frailty Index per 1,000	Improve outcomes in population health and health care	Number	Decrease	815.1		815.1	797.5	706.9	817.5	781.9	982.1	973.7	753.5	667.1
Feb-23	Two hour Urgent community Response Rate	Improve outcomes in population health and health care	%	Increase	90.0%	NHS Plan guidance for Dec22 - 70%	91.4%	90.0%	92.9%	93.8%	97.6%	73.5%	98.8%	100.0%	85.0%
Dec-22	Patients discharged to usual place or residence	Improve outcomes in population health and health care	%	Increase	94.6%	Q2 NWL Target - Defined by BCF	94%	93%	91%	95%	95%	95%	93%	94%	93%
Dec-22	Number of Avoidable Admission	Improve outcomes in population health and health care	Number	Decrease	2,914	Q1 NWL Target	2619	116	62	51	484	617	256	451	582
Jan-23	Emergency Department attendances from Carehome per 1,000 beds	Improve outcomes in population health and health care	Number	Decrease	TBC	TBC	64	61	31	77	67	79	49	65	61
Feb-23	Percentage of patients aged 61 to 74 with a Bowel Cancer Screening for patients in the last 30 months	Prevent ill health and tackle inequalities in outcomes, experience and access	%	Increase	TBC	TBC	61%	82%	80%	70%	66%	55%	55%	51%	51%
Feb-23	Patients aged 79 years or under with hypertension who have a blood pressure reading of 140/90 mmHg or less	Improve outcomes in population health and health care	Number	Decrease	TBC	TBC	109512	7126	8503	8613	18759	22639	15277	14250	14345
Feb-23	Patients aged 80 years and over with hypertension who have a blood pressure reading of 150/90 mmHg or less	Improve outcomes in population health and health care	Number	Decrease	TBC	TBC	30361	2146	2545	2106	4914	5458	3816	4736	4640
Dec-22	Admitted patients with Length of stay greater than 14 days	Improve outcomes in population health and health care	%	Decrease	TBC	TBC		15%	13%	11%	12%	13%	13%	11%	12%
Dec-22	Admitted patients with Length of stay greater than 21 days	Improve outcomes in population health and health care	%	Decrease	TBC	TBC		9%	7%	6%	6%	7%	8%	7%	7%

Appendix 1: Draft Future State Operating Model

Draft Future State Operating Model