2022/23 INTEGRATED HEALTH AND CARE PERFORMANCE REPORT

Relevant Board Member(s)	Keith Spencer Councillor Jane Palmer
Organisation	Hillingdon Health and Care Partners London Borough of Hillingdon
Report author	Gary Collier - Social Care and Health Directorate, LBH
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 seeks approval for the content of the 2022/23 Better Care Fund 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 2022/23 was £111,570k, made up of a Council contribution of £58,900k and an NHS contribution of £52,670k.
Ward(s) affected.	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

a) **approves the content of the 2022/23 end of year template; and**
b) **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 January to March 2023 period (referred to as the '*review period*'), unless otherwise stated. The report also seeks approval for the content of the 2022/23 Better Care Fund (BCF) end of year template.

2. The focus on development of the BCF plan in time for the 28 June 2023 submission date means that this report focuses on key issues and achievements.

3. This report is structured as follows:
   A. Key Issues for the Board's consideration.
   B. Achievements and challenges.

A. Key Issues for the Board's Consideration

2022/23 End of Year Better Care Fund (BCF) Template

4. All health and wellbeing board areas in England were required to submit an end of year template summarising 2022/23 activity on 23 May 2023. A draft template has been submitted, subject to the Board's sign-off. The template is an excel spreadsheet containing five worksheets. **Appendix 1** includes the detail of some of these tabs for the Board's consideration; however, the key points are highlighted below. The draft completed template can be accessed via the Council's website using this link: https://www.hillingdon.gov.uk/bcf.

5. **Appendix 1: National Conditions** – This asks if Hillingdon met the four 2022/23 national conditions for the BCF, which it did.

6. **Appendix 1A: Metrics** – This is seeking the end of year status against the targets for avoidable admissions ambulatory care sensitive conditions, 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. In summary, Hillingdon's end of year position against the metrics was:

- Avoidable admissions – on track.
- Discharge to usual place of residence – not on track by a small margin.
- Residential admissions to care homes – data not available.
- Reablement still at home 91 days after discharge – on track

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

8. **Income and Expenditure Actuals** – The full financial breakdown can be found via the link shown in paragraph 4 above. In summary, the total expenditure was £113.6m which comprised of a combination of £111.6m against core BCF and £2m against the Adult Social Care Discharge Fund.

9. The actual expenditure by the ICB BCF was £53.5m, which shows an over performance of £2m compared to the planned ICB expenditure. This over performance was largely due to increase in costs of £2.4m for 75 new clients for physical disabilities, and 45 new clients for Funded Nursing Care, off-set by under-spend of £0.4m against Population Health Management. This funding will roll forward into 2023/24 in accordance with section 75 provisions. Actual expenditure by the Council was in-line with the plan. Discharge Fund expenditure was also in-

line with the plan. Detail of how this fund was spent can be accessed using the Council website link referred to above.

B. Achievements and Challenges

2022/23 Achievements Aligned to BCF Scheme

10. Some key achievements of Hillingdon's health and care system in 2022/23 are shown below.

11. ***Workstream 1 (Neighbourhood development)*** achievements include:

- **Primary Care:** There were 690,900 face to face GP attendances taking place in 2022/23, compared to 587,811 in 2021/22, which is a 15% increase. There was also a 6.4% increase in GP appointments attended, i.e., 1,135,045 in 2022/23 compared to 1,066,363 in 2021/22. This demonstrates the pressures on general practice due to the level of appointments practices have had to make available to meet demands.

- **Admission rate for people 65 years with severe frailty:** Hillingdon has the lowest rate across NWL at 667.1 admissions per 1,000 population.

- **% 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%.

- **Annual health checks for people with learning disabilities >14:** Hillingdon exceeded the NWL target of 50% with a performance of 81%.

- **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%.

12. ***Workstream 2 (Reactive Care)*** achievements include:

- **Discharge from Hospital**: Achieving best performance across London for the highest proportion of hospital discharges by 5pm each day, as well as for the lowest overall period of stay for patients needing to stay longer than a week.

- **Same day urgent primary care hubs:** It is intended that there will be three hubs established with the objective of creating increased capacity in primary care to see more patients on the same day and diverting activity away from Hillingdon Hospital's Emergency Department. Joint work with the Council has led to the identification of premises that means that two of the three will be able to open in 2023/24.

13. ***Workstream 3 (Planned Care)*** achievements include:

- 78 week waits for elective treatments have been eliminated.

14. ***Workstream 4 (Care and support for adults with mental health challenges and/or people with learning disabilities and/or autism)*** achievements include:

- **Crisis care pathway:** A six bed mental health crisis recovery house called The Retreat

opened in August 2022 under a pilot that will continue until August 2024 as part of the transformation of the mental health crisis pathway. This represents a collaboration between CNWL, the Council and an independent sector provider called Comfort Care Services. Since opening, 50 people have received support in a non-institutional environment and avoided admission to a hospital emergency department.

- **Mental Health Clinical Assessment Service (MHCAS):** This opened in November 2022 and offers a calm and therapeutic mental health setting to treat the majority of emergency mental health presentations. Patients requiring the service in Hillingdon Hospital A&E are transported there and offered full emergency mental health assessments and onward care planning in the department with a diverse and highly skilled mental health workforce incorporating nurses, doctors, support workers and access to drug and alcohol workers and psychology.

15. ***Workstream 5 (Care and support for children and young people)***

- **CAHMS:** In March 2023 there were 66 children waiting for their first appointment and 137 waiting for treatment. This represents reductions of 67% and 63% respectively on the same point in 2022.

16. ***Enabling workstream 1 (Supporting carers)*** achievements include:

- A new joint strategy for the 2023-2028 period has been drafted for consultation in 2023/24.

- The co-produced '*Are you a carer?*' information leaflet was completed and distributed to system partners to issue to carers.

- 39 out of the 42 GP practices now have an identified Carers Champion.

- Hospital discharge checklists and roles and responsibility descriptors in discharge guidance now include involvement of carers. Carer information booklets are provided in Hillingdon Hospital to show how carers can get support.

17. ***Enabling workstream 2 (Improved market management and development)*** achievements include:

- Short-term block care home bed provision was successfully procured to support the care system during the winter period.

- Market sustainability and fair cost of care plan was completed. Implementation will impact on care home providers for people aged 65 and above and homecare providers for people aged 18 and above in 2023/24 and 2024/25.

Challenges 2023/24 and Beyond

18. Challenges facing Hillingdon's health and care system have been discussed at previous Health and Wellbeing Board meetings and include:

- **Managing Population Health and its associated demand:** 6% of Hillingdon's population who have multiple conditions or are at the end of their life account for: 65%

of all Hillingdon GP appointments; 66% of all emergency admissions; 74% of all acute occupied bed days; 70% of all Adult Social Care resource and have average lengths of stay of twice as long as other population groups.

- **Tackling inequality and deprivation:** 87% of the Hillingdon's population with more than one long term condition are from the White and Asian or Asian British ethnic groups. The most prevalent long term conditions in Hillingdon are hypertension, anxiety and depression and obesity.

- **Underlying health and care system deficit:** As discussed at the Board's March meeting, addressing the underlying causes of the system deficit is critical to securing delegation of health budgets to place.

- **New Hillingdon Hospital business case activity assumptions:** The business case is predicated on the new hospital delivering a different level of capacity to what is currently in place. This is itself predicated on the implementation of new models of care that will manage demand.

- **Health and care workforce challenges:** Age of current workforce, e.g**.,** 16% of GP's, 30% of practice nurses are over 60; nearly 30% of Adult Social Care workforce aged 55 and above, and competition for limited pool of staff in some professions.

- **Fragility of the independent sector care market:** This is linked to workforce issues, increased costs of doing business and implementation of fair cost of care.

- **Constraints of the acute and primary care estates:** Age and design of existing buildings that are no longer fit for purpose to meet the current and future health and care needs of residents and/or located in the wrong place and impact on delivery of new models of care.

Addressing the Challenges

19. The approach to addressing these challenges has previously been discussed by the Health and Wellbeing Board and is summarised below. It includes:

- **Developing and implementing the new integrated care models** required to address growing service demand, deliver better services, tackle the place-based deficit, and deliver the activity shifts required for the new hospital development programme.

- **Embedding population health management** and addressing our areas of inequality.

- **Developing a place-based financial recovery plan** to ensure best use of resources to address the local health-based financial deficit.

- **Making change happen on the ground** through:

  - **Integrated Neighbourhood Team development** building from a population health approach to tackle health inequalities.

  - **Reactive care service development** that will result in a new 24/7 place based out of hospital reactive care delivery model for those with complex needs, including

people with multi long-term conditions and also moving Hillingdon from good to great in respect of hospital discharges.

- **Implementing an integrated end of life service model** that joins up services to care for people at the end of their life in their preferred care setting.

20. Hillingdon's approach to addressing some of the challenges facing its health and care system is reflected within the draft 2023/25 Better Care Fund, which is a separate item on the Board's agenda.

Finance

21. There are no direct financial 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 2022-23 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements
Avoidable admissions	**Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)**	874.0	On track to meet target	Target achieved based on SUS data M1 - M12. Outturn 871 Workforce shortages due to vacancies and sickness has presented a challenge in both the primary identification and treatment of chronic ambulatory care sensitive conditions.	Community teams at PCN level are managing increased acuity levels.
Discharge to normal place of residence	**Percentage of people who are discharged from acute hospital to their normal place of residence**	93.2%	Not on track to meet target	Based on SUS data M1 - M12 performance achieved is 92.11%	• 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+)**	776	Data not available to assess progress	Approximately 55% of permanent placements comprise of conversions from short-term placements to permanent. Permanent placements are subject to rigorous management scrutiny to ensure that there are no alternative	Older residents continue to be supported in Hillingdon's four extra care housing schemes

Metric	Definition	For information - Your planned performance as reported in 2022-23 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements
				solutions, e.g., extra care housing or a return to their own home. Increasing acuity levels being seen and demand from people living with dementia.	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 / rehabilitation services**	90.5%	On track to meet target	Reablement service provider has faced issues with recruitment.	Establishing a closer working relationship between Reablement service provider and District Nursing and Community Adult Rehabilitation Services delivered by NHS community health provider to support independence of residents in a community setting.

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.

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 continue to explore utilising the BCF section 75 (s75) 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. Under consideration is expansion of the scope of the BCF to include Adult Mental Health in 2023/24 and for an NHS provider to become a signatory to the BCF s75.
2. Our BCF schemes were implemented as planned in 2021/22.	Strongly agree	This is largely the case, although slippage in delivering some schemes during 2022/23 attributed to limited capacity within the local health and care.
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: Success and Challenges
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	9. Joint commissioning of health and social care	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.
Success 2	2. Strong, system-wide governance and systems leadership	Wide ranging review of how services are delivered at place undertaken to define a future state operating model with the goal of delivering care closer to people's homes in six integrated neighbourhoods, preventing unnecessary hospital attendances through greater same day primary care capacity, promoting earlier hospital discharge, and delivering activity assumptions underpinning the Hillingdon Hospital redevelopment programme.

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	1. Local contextual factors (e.g., financial health, funding arrangements, demographics, urban vs rural factors)	The under-lying system deficit poses a risk to local ambition as will influence the willingness of the ICB to delegate health budgets to place. However, this also poses an impetus to drive change and stop established practices producing the same results.
Challenge 2	6. Good quality and sustainable provider market that can meet demand	Inflationary pressures and recruitment and retention issues present challenges for regulated providers that influence behaviours, e.g., willingness of care homes to accept people with more complex needs. These are issues that are not easily addressed, especially as funding available to meet cost of inflation as well as support fees that reflect a fair cost of care is insufficient.

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 2 – NWL ICB Place-based Metrics

NWL Metric	ICS Objective	Population Group/Pathway	Place Function	Measure	Goal (Increase/ decrease)	Target	Benchmark	NWL Average Position	Hillingdon Actual
People with diabetes who have received nine care processes in the last 15 months.	Improve outcomes in population health and health care.	Long Term Conditions	Robust local care offer	%	Increase	50%	N/A	61.6%	61%
Children (17 or under) with asthma who have completed an asthma check.	Prevent ill health and tackle inequalities in outcomes, experience and access.	Children and Young People	Robust local care offer	%	Increase	68%	N/A	59%	48%
People with severe mental illness (SMI) receiving a full physical health check.	Prevent ill health and tackle inequalities in outcomes, experience and access.								
People over age of 14 on a doctor's learning disability register who have had an annual health check.									
Estimated diagnosis rate for people (aged 65 and over) with dementia.									

NWL Metric	ICS Objective	Population Group/Pathway	Place Function	Measure	Goal (Increase/ decrease)	Target	Benchmark	NWL Average Position	Hillingdon Actual
Two hour urgent community response rate.									
Percentage of patients aged 61 to 74 with a Bowel Cancer Screening for patients in the last 30 months.									
Patients aged 79 years or under with hypertension who have a blood pressure reading of 140/90 mmHg or less.									
Patients aged 80 years and over with hypertension who have a blood pressure reading of 150/90 mmHg or less.									