2022/23 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 Mel Foody – Integration and Delivery, NWL ICB
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

RECOMMENDATION

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 April to June 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.

A. Key Issues for the Board's Consideration

2023/25 Better Care Fund Plan Submission

4. The Board is reminded that a decision by the North West London Integrated Care Board (ICB) to undertake a preliminary review of BCF schemes across the eight boroughs meant that it was not possible to comply with the national submission deadline of 28 June 2023. The intention behind the ICB review was to establish a greater understanding of schemes across the eight boroughs, of which there was great variation. Non-compliance with the national submission deadline resulted in all eight boroughs going into escalation.

5. Hillingdon's plan was submitted on 18 July 2023, thereby enabling us to come out of escalation. A resubmission was required following a query from the Better Care Support Team and this took place on 9 August 2023 and thereby enabled Hillingdon to avoid going back into escalation. The plan was formally approved on behalf of the Board under delegated arrangements approved at the June 2023 meeting on 31 August 2023 thereby ensuring compliance with a national BCF condition.

6. The key aspects of Hillingdon's BCF submission can be accessed via the Council's website via this link Better Care Fund - Hillingdon Council . This includes the following documents covering the 2023 to 2025 period of the BCF plan:

- Narrative Plan
- Income and Expenditure Breakdown
- Intermediate Care Demand and Capacity Template
- Discharge Fund Spending Plan

7. The Board is advised that, as in previous years, NHS England's Better Care Support Team made available an offer to review BCF plans prior to submission to ensure that the key lines of enquiry in the planning requirements were addressed. Officers took advantage of this opportunity and feedback was reflected in the narrative plan document referred to above.

HHCP Service and BCF Scheme Review

8. The following summarise the parameters of the intended review of schemes being undertaken by ICB for 2024/25:

- The BCF will include sufficient schemes that meet the minimum requirement and that the aim of the review is not to destabilise services for the Council or the ICB.
- Minimum NHS commissioned out of hospital and minimum adult social care spend from the ICB contributions will continue to be met.
- Only schemes that are in-line with the revised BCF guidance and NHS NWL ICS priorities will be included.
- Only schemes that are supported by activity data than can be monitored and reviewed in year will be included.
- A consistent approach will be taken across the North West London sector (NWL) in terms of

what and what is not included within the BCF.
- If schemes do not meet the revised guidance or priorities and cannot continue an appropriate notice period will be given, e.g., 6 months.

9. A review of HHCP services is being undertaken that will encompass BCF schemes as there is much cross over. This is intended to support the NWL review and the outcome of the process will be reported to the Board's meeting in December 2023.

B. Workstream Highlights and Key Performance Indicator Updates

10. **Appendix 1** summarises for the Board some of the key challenges facing Hillingdon's health and care system now and into the future as well as the approaches to addressing these. These were subject to discussion at the Board's meeting in June 2023. Table 1 below is intended to remind the Board of the alignment between BCF schemes and transformation workstreams.

Table 1: Alignment of BCF Schemes and Transformation Workstreams	
BCF Scheme	**Transformation Workstream**
Scheme 1: Neighbourhood development.	**Workstream 1:** Integrated Neighbourhood Working.
Scheme 2: Supporting carers.	Enabler
Scheme 3: Reactive care	**Workstream 2:** Reactive Care
	Workstream 3: Planned Care
Scheme 4: Improved market management and development.	Enabler
	Workstream 4: Children and Young People
Scheme 5: Integrated support for people with learning disabilities and/or autistic people.	**Workstream 5:** Care and support for adults with mental health challenges and/or people with learning disabilities and/or autism.

11. 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.

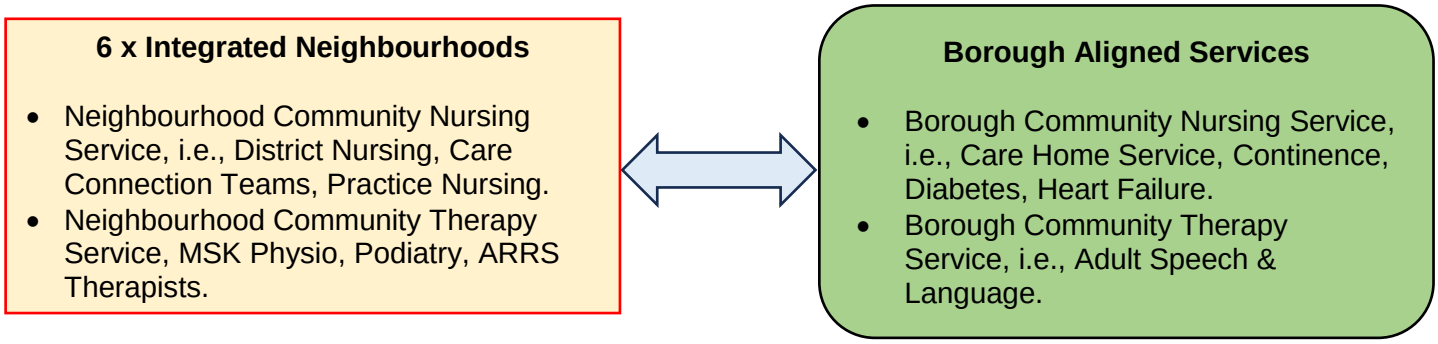
Workstream Highlights

12. **Implementation of leadership and governance arrangements for the six Integrated Neighbourhood Teams:** A new governance structure for the Integrated Neighbourhood Teams has been discussed with Primary Care Network (PCN) clinical directors and will be considered by the HHCP Delivery Board in September. If agreed this will require consultation with staff prior

to implementation.

13. **Development of Proactive Care Model:** The diagram below outlines the future proactive care model, which will integrate community nursing and therapy services at the heart of the neighbourhood structure. These will be interlinked with community health services provided at a borough wide level.

Neighbourhood Proactive Care Model Illustrated



Key: ARRS - Additional Roles Reimbursement Scheme; MSK – Musculoskeletal

Additional Roles Reimbursement Scheme (ARRS) Explained

ARRS was introduced in England in 2019 with the aim of the scheme was to support the recruitment of 26,000 additional staff into general practice through the provision of additional funding. The range of additional roles covered by the scheme includes:

- Care co-ordinators.
- Clinical pharmacists.
- Social prescribing link workers.
- Pharmacy technicians.
- Dieticians.
- First-contact physiotherapists.
- Health and wellbeing coaches.
- Mental health practitioners.
- Nursing associates and trainee nursing associates
- Occupational therapists.
- Paramedics.
- Physician associates.
- Podiatrists.

There are 30 ARRS roles in PCNs in Hillingdon.

14. **Integrated Neighbourhood Frailty Pilot:** Frailty is a condition mainly associated with old age and is a major contributor to falls in the 65 and over population. As part of a more proactive approach to preventative care, a pilot is being established between Neighbourhood Teams, the Council and up to 181 residents in four of the borough's sheltered housing schemes. The aim of the pilot is to support residents to '*age well'* and continue to live in their own home by preventing or delaying the onset of severe frailty. Another key intended outcome is cost avoidance for the health and care system. The components of the pilot, which will start in the autumn, include:

- Systematically embedding the use of the Frailty Index scoring across the health and care system.
- Creating a multi-disciplinary team (MDT) offer for residents living in the four sheltered housing schemes in order to provide oversight whilst upskilling health and care staff.
- Delivering a series of retirement workshops, open to all Hillingdon residents aged 65 and above to provide them with help and resources to minimise their risk of frailty in future.

15. **Aligning Community Social Care to Neighbourhoods:** Updated Adult Social Care contacts have now been provided to Neighbourhood Teams.

16. **Same Day Urgent Primary Care Hubs:** The target is to open two hubs during 2023/24. The first opened during the review period at Mead House in Hayes. The second is on target to open in the autumn.

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 .

Key Performance Indicator Updates

17. The following is an update on workstream 1 indicators where data is available:

- **Avoidable admissions:** *Slippage* (Amber) - This BCF metric is intended to measure a reduction in adults admitted to hospital for ambulatory care sensitive conditions (ACSC). 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). In Q1 there were 671 admissions for ACSC against a ceiling of 638.

  Commentary: *The Board will note that performance was only slightly above the ceiling for the review period. It is important to also make the Board aware that Population Health Management (PHM) initiatives intended to address some of the conditions referred to above are in their early stages of implementation and will take time to impact on metrics.*

- **Falls-related emergency admissions 65 + population:** *On track (Green)* – The 2023/24 ceiling of falls-related admissions is based on a standardised rate per 100,000 of the 65 and over population and the Q1 outturn data suggests, on a straight line projection, that the 2023/24 performance will be below the planned ceiling of 865 admissions. However, this is caveated by emphasising that it is only based on one quarter's data.

Workstream 2: Reactive Care

Workstream Highlights

18. **End of Life Coordination Hub:** The Coordination Hub is a key component of the new operating model for end of life care and is intended to initiate care planning and coordinated holistic care for new referrals and provide a point of contact for the GPs and other community health and care partners as well as care homes. A pilot started in May and was supporting 8 people by the end of June.

19. **Implementation of an Integrated Active Recovery Service:** Establishing this service entails integration of therapy services and wrapping services around the Integrated Neighbourhoods, closer alignment between Community Rehabilitation Services and Reablement and maximising the Homefirst/Discharge to Assess programme to reduce length of

stay. The intention is to expedite the rate of discharge on pathways 1 to 3 of the Homefirst/Discharge to Assess pathways explained below.

Homefirst/Discharge to Assess Pathways Explained

- ***Pathway 0:*** 80% of hospital discharges – simple discharge, no formal input from health or social care needed once home.
- ***Pathway 1:*** 15% of hospital discharges – support to recover at home; able to return home with support from health and/or social care.
- **Pathway 2:** 4% of hospital discharges – rehabilitation or short-term care in a 24-hour bed-based setting.
- ***Pathway 3:*** 1% of hospital discharges – require ongoing 24-hour nursing care in a bedded setting. Long-term care is likely to be required for these people.

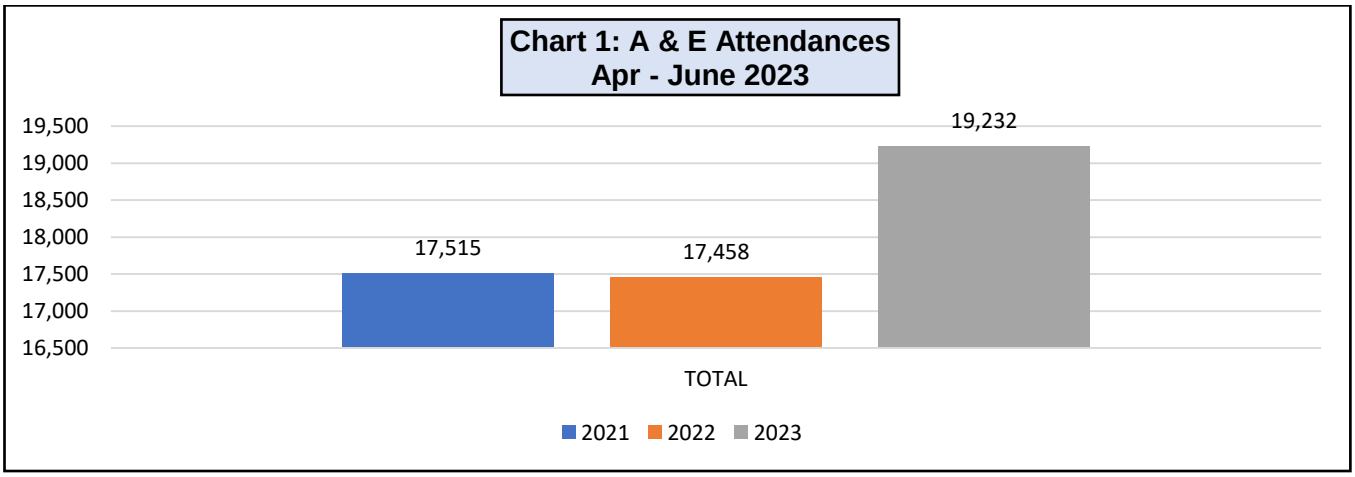
20.**Winter Planning:** The planning process for an increase in demand over the winter period is in progress. Actions being taken include procurement of an additional 5-bed nursing dementia block contract.

21. The Board may wish to note that the Government has established a new grant called the Workforce Fund, the aim of which is primarily to increase the adult social care workforce capacity and retention and reduce adult social care waiting times during the period to 31st March 2024. Hillingdon's allocation is £1.5m, which has to be spent by 31st March 2024 and a spending plan is under development.

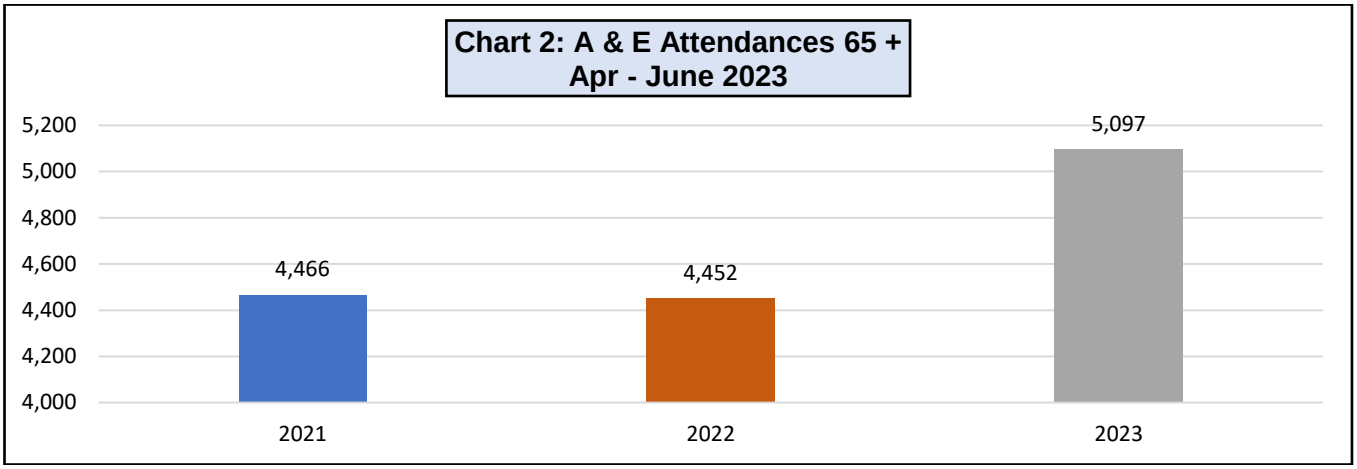
Key Performance Indicator Updates

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

- **A & E Attendances:** *Slippage* (Amber) - Charts 1 and 2 below show a nearly 9% increase in attendances from all age groups during the review period compared to the same period in 2022 and a nearly 13% increase in the number of people aged 65 and over.

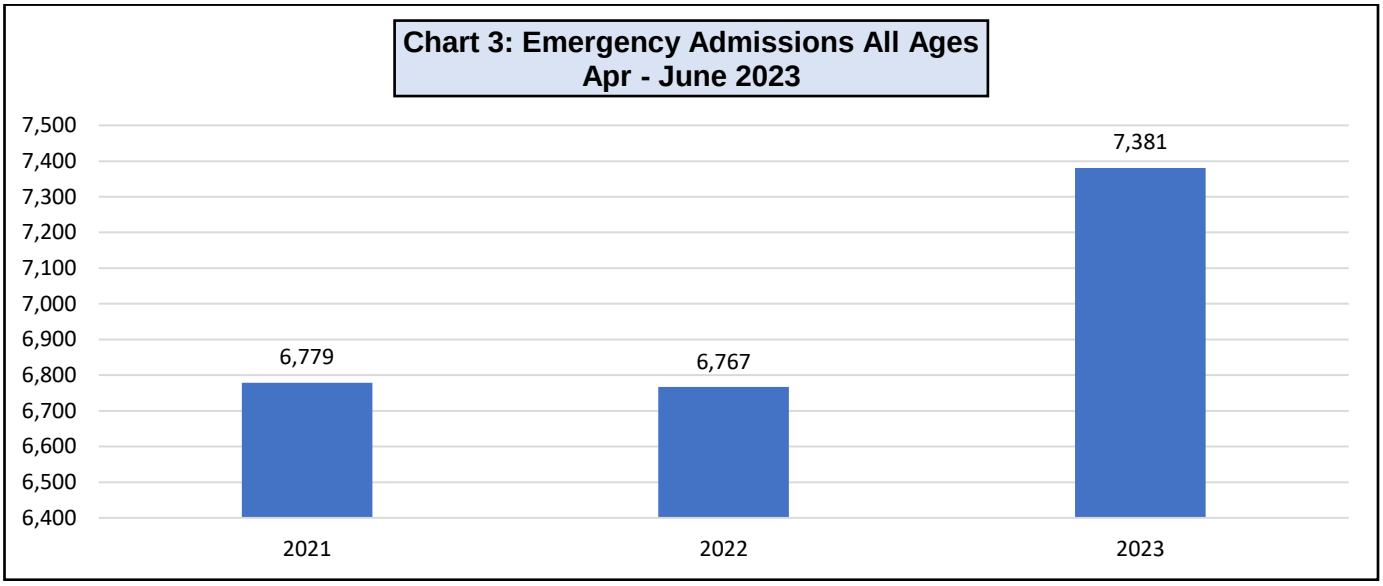


Source: BI Data 23/08/23

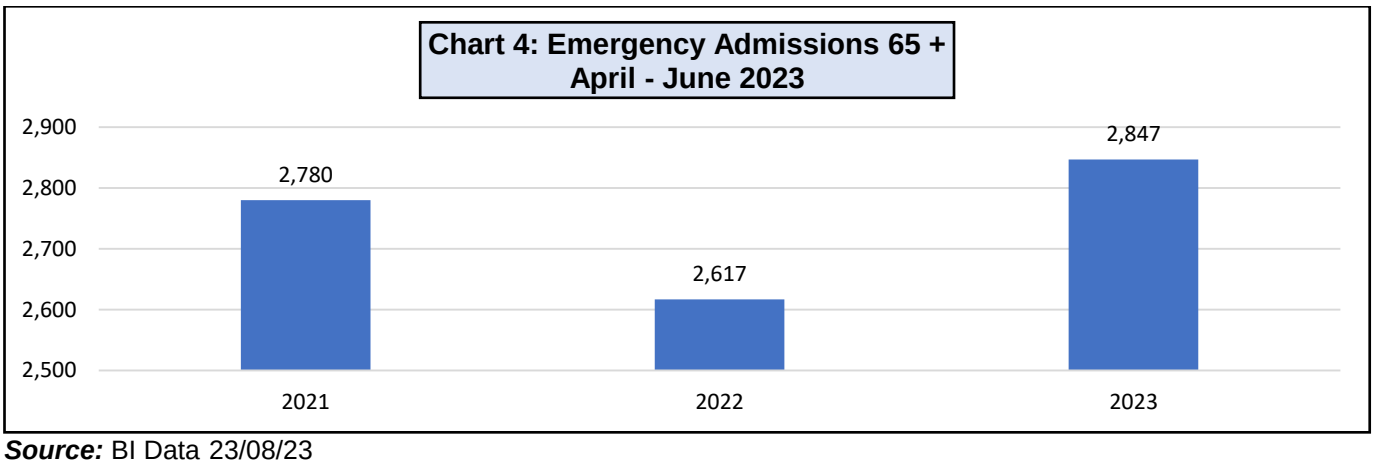


Source: BI Data 23/08/23

- **Emergency Admissions:** *Slippage* (Amber) – Charts 3 and 4 below show a near 8% increase in emergency admissions of people of all ages during the review period compared to the same period in 2022 and an equivalent increase for people aged 65 and over.



Source: BI Data 23/08/23



Source: BI Data 23/08/23

Commentary**:** *Activity in 2022/23 was down approximately 3% on 2019/20, i.e., pre-pandemic, and increases 2023/24 probably reflect some readjustment. The Board may wish*

to note that rises in all health-related activity are being seen, including attendances at GP practices. The latter is being followed up by regular visits by the ICB local team to practices to review their patient caseloads.

- **% of patients attending A & E seen within 4 hours:** During the review period an average of 72.9% of people attending A & E were seen within 4 hours for all types of activity, i.e., major and minor illnesses and injuries. This performance was achieved against a Hospital target of 76%. There have been significant 4 hour waiting time target improvements in 2023 for type 1 attendances, i.e., major injuries and illnesses. This was 36.7% in February 2023 and increased to 44% in March with a year to date (to August) rate of 47% being achieved.

- **Discharge to usual place of residence:** *On track (Green)* - This BCF metric measures the percentage of people discharged from an acute hospital to their normal place of residence, which will usually be the place where they were residing at the time of admission. The Q1 actual was 92.18% against a target of 92.8%.

- **Hillingdon Hospital bed occupancy:** *Slippage (Amber)* **-** Despite the increases in emergency admissions, flow has broadly been maintained due to reductions in average length of stay and discharge delays. Bed occupancy targets have been set aligned to assumptions about the bed capacity of the new hospital. The target average for 2023/24 is 92%. The average in 2022/23 was 93%. The average bed occupancy rate during the review period was 91%, which is lower than in the same period in 2022 and 2021; however, this is amber as the target for the review period is 85%.

- **Length of stay:** *On track (Green)* **-** Table 2 below shows the average length of stay in Hillingdon Hospital by discharge pathway in 2022/23. In 2022/23 there was an average delay across all pathways of 2.8 days. The intention in 2023/24 is to reduce the average delay figure across all pathways to 1.8 days by the end of June 2023, which was achieved, and 1.3 days by the end of September. This would move Hillingdon towards a trajectory aligned to capacity assumptions for the new hospital. It would also assist in bringing the health and care system into financial balance. The average delay figure for July 2023 was also 1.8 days. The figure for August is not available.

Table 2: Hillingdon Hospital Average Length of Stay 2022/23 by Discharge Pathway

Discharge Pathway	Full Year Admissions	Average Length of Stay (Bed Days)
Pathway 0	11,464	6.8
Pathway 1	1,781	15.1
Pathway 2	273	19.2
Pathway 3	661	23
Unknown	70	11

Commentary: *The Hospital opened 48 extra beds over the 2022/23 winter period and still have 20 open. The average length of stay is reducing and pathway delays in some but not all areas are improving. Pathway 3 delays in particular (discharges to long term care) remain stubbornly high due to a range of factors including high occupancy rates in the local care home market of between 95 and 97% and a reluctance by some providers to accept*

placements of people with more complex needs. Additional capacity has been directed into this area to seek to remedy this.

Workstream 3: Planned Care

Workstream Highlights

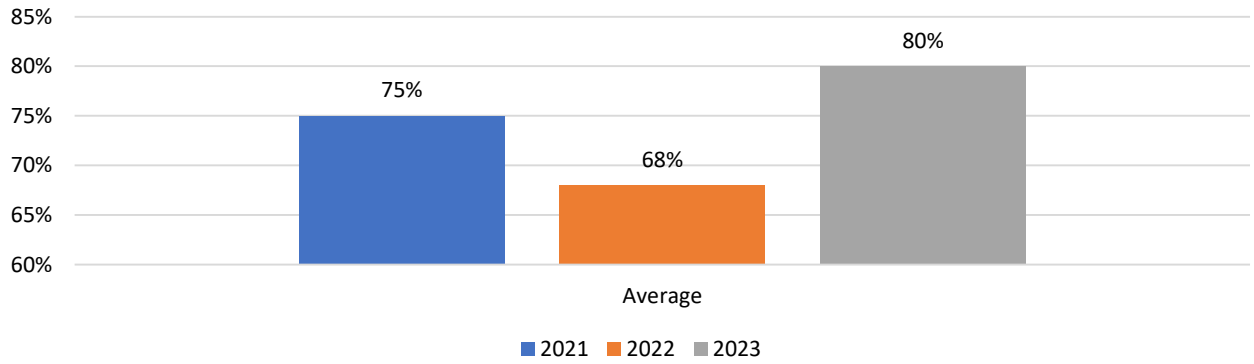
23. **MSK and dermatology procurements:** Procurement exercises have been undertaken by the ICB resulting in a new MSK contract for Hillingdon starting from 1 April 2024. A new contract for a dermatology service covering Brent, Harrow, Hillingdon and Hounslow will also be starting on 1 April 2024. An aim of the new services is to address waiting times.

Key Performance Indicator Updates

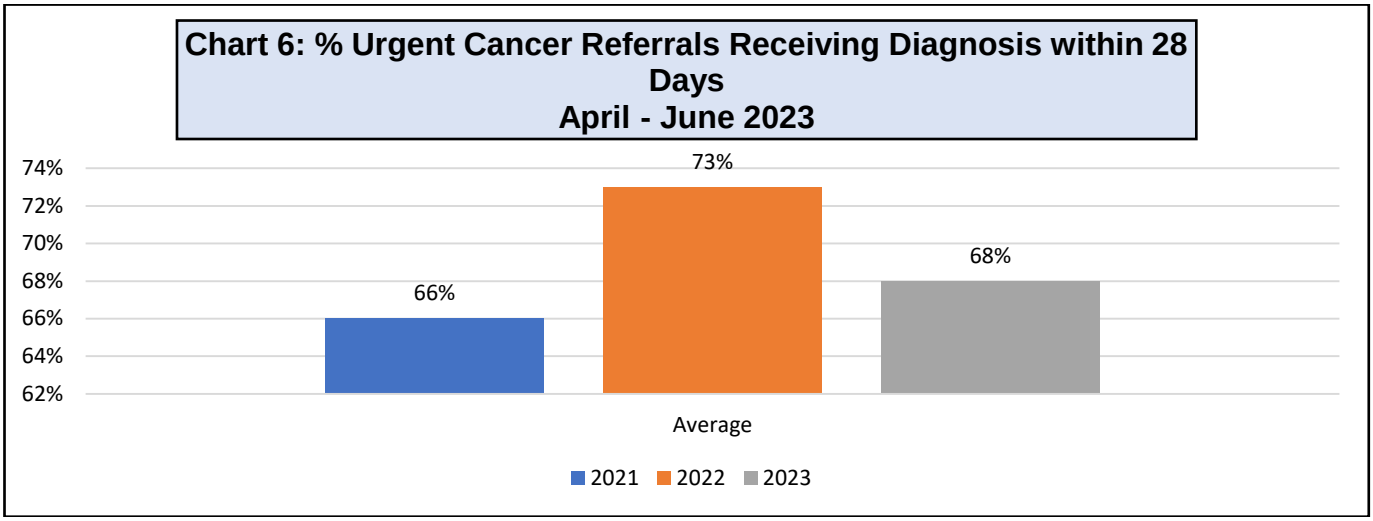
- **Patients waiting 52 weeks or more for surgery:** As of 31st August 2023, there were 1,152 people waiting 52 weeks or more for surgery. This represents a small increase since April 2023 but a reduction of 184 since August 2022.

- **% Patients Receiving Tests within 6 weeks of Referral:** *Improvement* (Green) **–** Chart 5 shows that performance has improved during the review period in comparison to the same period in 2022/23. This is against a national target of 95%.

Chart 5: % Patients Receiving Tests within 6 Weeks of Referral April - June 2023



- **% Urgent Cancer Referrals Receiving Diagnosis within 28 Days:** *Slippage* (Amber) – The national annual target is 75% and chart 6 below shows that performance for the review period is down on the same period in 2022 but an improvement on the 2021 position. Workforce issues.



Workstream 4: Children and Young People

Workstream Highlights

24. **ASD waiting well initiative**: A pilot to test the right model of needs led support within NWL to offer children and young people (CYP) and families whilst they wait for an autism assessment that started in July 23 to March 24. A joint business case between Hillingdon and Brent local ICB teams will be submitted to the ICB to continue funding for support from April 2024, e.g., Doodle Den, Arts for Life and HACS.

25. **Mental Health and emotional wellbeing resilience**: Two-year PHM funding has been allocated to support the mental health and emotional wellbeing (EWB) of CYP. This will achieved by offering early, targeted and person-centred support to increase the number of CYP accessing support and reduce waiting times. A particular issue has been identified concerning addressing the needs of young people from Black, Asian and Minority Ethnic (BAME) groups and/or who those who identify as LGBTG+.

26. Hillingdon Mind, P3 and HACS have put forward a joint proposal to establish a CYP voluntary sector consortium to support delivery. Support is being provided by the ICB and Healthwatch to take this forward.

27. **CYP dental:** The Whittington Health NHS Trust has continued to support the Supervised Brushing programme (aka Aggie's Sparkle & Shine Tooth brushing Club) and the roll out has reached reaching 12 schools and Early Years in Hillingdon with a focus on areas of the greatest need.

28. **Virtual Multi-disciplinary teams (MDTs):** Monthly virtual MDTs are in place that alternate between PCNs in the north and south of the borough. A mechanism for capturing and sharing the learning from the case studies presented is under development.

29. It has been agreed across NWL to establish Child Health Hubs and discussions are in progress regarding potential alignment of these with the Family Hubs.

Child Health Hubs Explained

The hubs brings all health professionals involved in a child's care together in a multi-disciplinary team, including:

- GPs
- Consultants
- Health visitors
- Children and adolescent mental health (CAMHs)
- Early years teams
- School nurses
- Paediatric dietitians
- GP/paediatric trainees

30.**16 – 25 transition:** Improved transition pathways have been achieved between CYP and Adult services at Hillingdon Hospital and this can be demonstrated by a reduction in missed first appointments at the Adult Neurology Service. The Board may also wish to note that CNWL has successfully recruited to the transition nurse post for Looked After Children and complex young people.

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

Workstream Highlights

31.**Hillingdon Cove Café:** The café is a drop-in service where Hillingdon residents can go if they are experiencing a mental health crisis. Following a procurement process Hestia has been awarded a contract to continue to provide this service and the new contract started in April 2023. The service has now moved to new premises in Ruislip and share a site with the crisis recovery house. It became operational from the new premises in July.

Enabling Workstreams

Enabler 1: Supporting Carers

32. 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

33. **Draft 2023 – 2028 Joint Carers Strategy:** A draft new strategy has been developed and is now subject to consultation.

Enabler 2: Improved market management and development

34. The Council is also the lead organisation for this enabling workstream, the primary objectives of which are to support the sustainability of the market and also to integrate

commissioning arrangements where this will produce better outcomes for residents and the local health and care system.

Workstream Highlights

35. **Short-term nursing block contract:** The Council will be leading on a procurement exercise in the autumn to secure block contracts for 15 nursing care home beds to support pathway 3 discharges from hospital. Funding for this provision is included within the BCF. There is an existing interim block in place for 10 beds until 31st March 2024 and, as stated in paragraph 20, discussions are in progress with local providers to secure an additional block contract for 5 nursing care home beds until the end of 2023/24.

Enabler 3: Digital, including Business Intelligence

36. HHCP leads on this workstream.

Workstream Highlights

37. **Shared care plan:** An HHCP digital working group has been established to oversee the transition to a single shared care plan across health partners. Work involved includes a review of electronic patient record/care plan solutions and evaluating the shared care record data needed to support the proposed new ways of working.

Enabler 4: Workforce

38. The ICB leads on the health aspects of this workstream.

Workstream Highlights

39. **Primary Care Workforce Plan**: A primary care workforce plan is in draft, and due to be discussed by the HHCP Delivery Board by the end of September. Its recommendations include: the approval of the HHCP Passport that will enable qualified clinical staff to work across local organisations; the full recruitment to all Additional Roles in Primary Care by end December 2023; improved workforce development for the Integrated Neighbourhood Teams, and detailed mapping of our current team vacancies to improve recruitment and retention rates, particularly for roles identified as critical, e.g., GPs, podiatrists, and pharmacists.

40. **Adult Social Care Workforce Strategy:** A strategy intended to ensure the availability of a sufficient number of suitably qualified social work staff to meet the changing needs of Hillingdon's residents, including demographic changes, now and in the future is under development. This will also set out how we will build on our existing partnership arrangements across the private, voluntary and independent sectors to broaden its scope to cover the adult social care workforce across the borough.

Enabler 5: Estates

41. The ICB leads on the health aspects of this workstream.

Workstream Highlights

42. **Primary Care Estates Strategy:** The ICB (Estates Team and borough-based team) are

working with the Council to develop a strategy for up to five years. The '*One Public Estate'* approach is being applied, i.e., identifying how surplus property owned by local statutory organisations, e.g., the Council, the ICB, CNWL, can be repurposed to meet locally agreed priorities. The new strategy will show the schemes currently in development, e.g., Northwood & Pinner Health Centre, and how accommodation demands for the new ARRS roles (see paragraph 13) will be met. It will also identify proposed opportunities for developments with a number of local GP practices. Capital and revenue implications, including optimal use of s106 and CIL monies, will be fully explored with the Council and the ICB.

43. Delivery of the Same Day Urgent Primary Care Hubs referred to in paragraph 16 are examples of the positive outcomes from collaborative working on the development of the estates strategy. Two hubs will be delivered in 2023/24 and the third in 2024/25.

Terms Explained

s106 – The refers to agreement under section 106 of the Town and Country Planning Act, 1990 between a developer and the Council to make a development acceptable in Planning terms. These agreements can be used to support the provision of services and infrastructure, such as highways, recreational facilities, education, health, and affordable housing.

CIL – This is the Community Infrastructure Levy, which is a charge that is levied by the Council on new developments in the borough.

Finance

44. Tables 3 and 4 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 not expected to be confirmed until the autumn following the outcome of the review of BCF schemes mentioned previously in this report.

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**

*Provisional, please see para 44 above.

45. Table 5 below summarises the Council and NHS contributions for the period of the 2023 to 2025 plan by scheme.

Table 5: ICB and LBH Financial Contribution by Scheme Summary								
Scheme		**2023/24**			**2024/25**			
		LBH (£,000)	**NHS (£,000)**	**TOTAL (£,000)**	**LBH (£,000)**	**NHS (£,000)**	**TOTAL (£,000)**
1.	Neighourhood development	3,052	3,025	**6,077**	3,052	3,084	**6,136**
2.	Supporting carers	690	471	**1,161**	690	475	**1,165**
3.	Reactive care	5,489	19,990	**25,479**	6,180	20,964	**27,144**
4.	Improving care market management and development.	26,232	5,083	**31,315**	26,272	5,287	**31,559**
5.	Integrated care and support for people with learning disabilities and/or autistic people.	31,412	993	**32,405**	31,372	1,044	**32,416**
	Programme Management	0	97	**97**	0	100	**100**
	TOTAL	**66,875**	**29,659**	**96,534**	**67,566**	**30,954**	**98,520**

46. The additional voluntary contribution from the Council reflects existing budgets for the long-term residential and nursing care home provision for people aged 65 and above and also long-term homecare provision. It does not represent an additional cost pressure to the local authority.

BACKGROUND PAPERS

Joint Health and Wellbeing Strategy, 2022 – 2025

Appendix 1

Hillingdon Health and Care System Challenges and Solutions

Challenges 2023/24 and Beyond

- **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

- **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** p**lace-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.