Hillingdon Health and Care Partners:

Review of Quarter 1: 2023/24 Health and Social Care Select Committee

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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 Quarter 1 2023/24

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:

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3. Focus of our Work in 2022/23 continued

I. **Integrated Neighbourhood Team Development** building from a population health approach to tackle health inequalities:

- **Transformation of Same Day Urgent Primary Care** for people with non complex needs who regularly seek same day access to Primary Care (33% of all attendances)
- **Transformation of Proactive Care** for at risk population cohorts with an emphasis on multi morbidity/ **Frailty** in the first instance
- **Transformation of Preventative Care** for a range of population health JSNA priorities with an emphasis on **Hypertension, Anxiety/Depression and Obesity**

II. **Reactive Care:** Develop and Implement an 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. Move from 'Good to Great ' in hospital discharge in order to enable more people to return home

III. **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 , the Committee will be aware that 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 to define a future state operating model with the 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 reported at our last Health and Social Care Committee is a draft future state operating model for place-based health and care; the key features of which are set out in appendix 1 for information.

We have made significant progress against implementing this new operating model during quarter 1 as follows:

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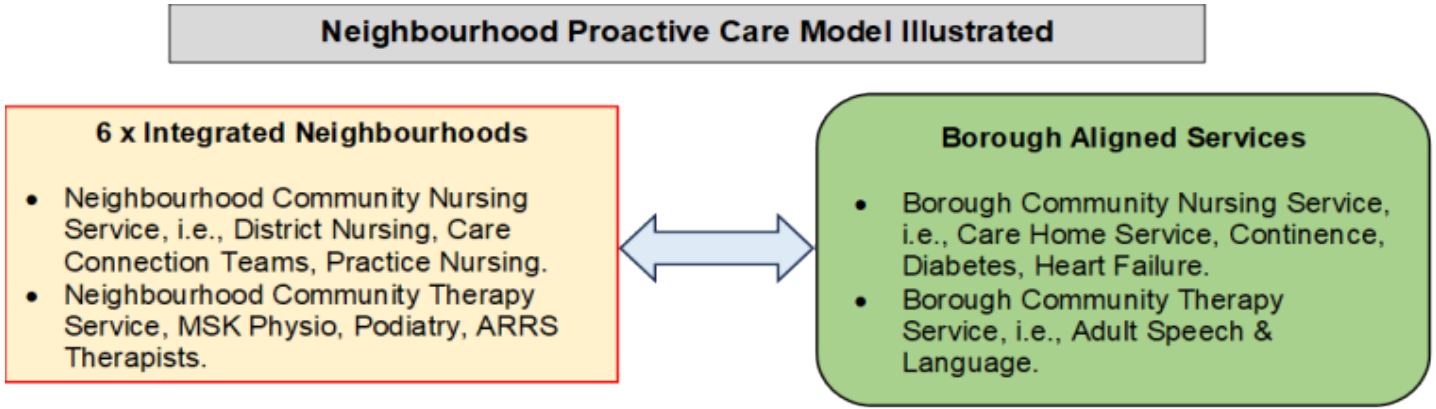
Integrated Neighbourhood Working:

- 2 Same Day Urgent Primary Care Neighbourhood hubs were scheduled to be implemented over the next 12 months. The First Hub went live in July 2023 at Mead House in Ruislip. We are currently in discussion with the local authority about the site for the second hub which is schedule to go live in the autumn in the south of the Borough. These will create extra capacity in Primary Care to divert 18% and 28% of Hillingdon non complex patients currently attending ED and UTC respectively.
- We have implemented a range of new Neighbourhood Based Services including ECG, Pessaries, Phlebotomy and Wound Management with a further service (anti –coagulant) to go live later in the year. These are services previously provided solely from The Hillingdon Hospital.
- A new approach to the diagnosis and management of people with uncontrolled hypertension (the major cause of ill health in Hillingdon) has been implemented in all Neighbourhoods across Hillingdon.
- A new model of Proactive Care set out below is currently being implemented which will integrate community nursing, therapy services and Primary Care at the heart of the neighbourhood structure with a single integrated leadership team. These will be interlinked with wider community health services provided at a borough wide level.



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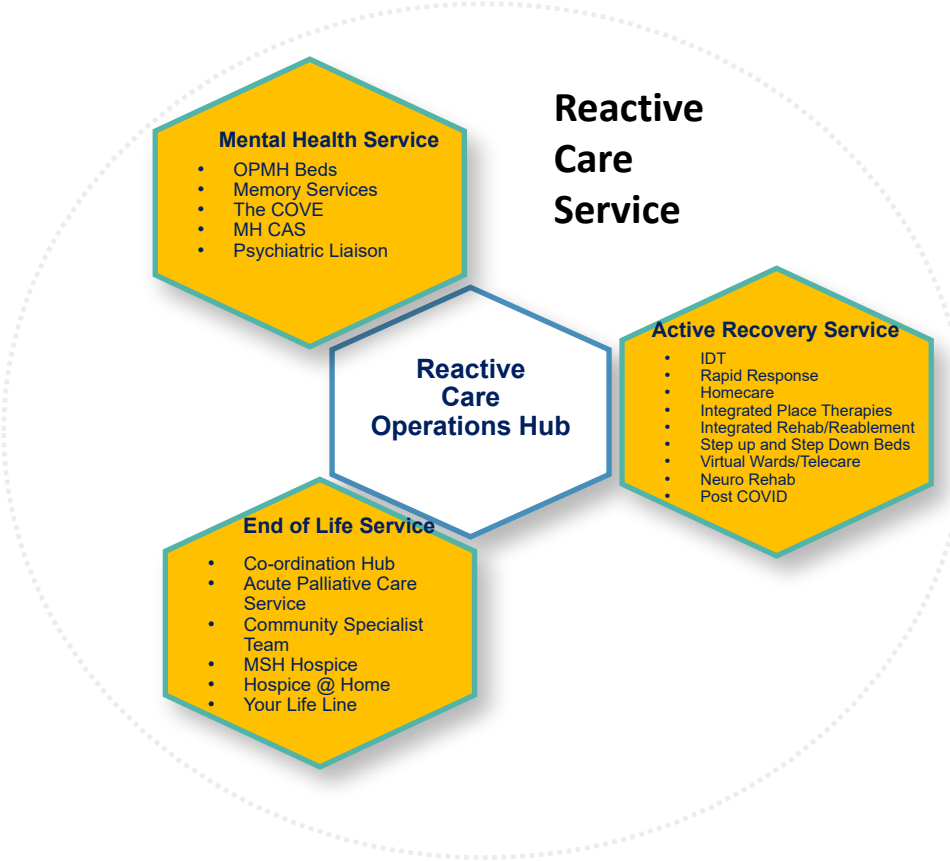
Reactive Care: Creating an Integrated Activity Recovery Service to maximise HomeFirst and Implementing a new End of Life model

- We continue to work together at Place to **address discharge delays, reduce average lengths of stay and implement a new Place based model of End of Life Care (**set out opposite) for the 3,000 Hillingdon residents who enter the last year of their life each year.
- **The new End of Life co-ordination hub went live on the 15 May .** 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. It became operational in May.
- **As part of our strategy to movie Hillingdon towards a trajectory aligned to capacity assumptions for the new hospital and to assist in bringing the health and care system into financial balance,** we have a Length of Stay programme to reduce average length of stay and discharge delays at THH by the end of September 2023. Currently, average length of stay is reducing and pathway delays in some but not all areas are improving. Pathway 3 (Discharges to long term care) remain stubbornly high due to capacity constraints in the care home sector. Working with LBH, we have recently released additional capacity into this area to remedy this.
- During Q3, we will also be implementing a new integrated Muscular Skeletal (MSK) Pathway incorporating Primary, Community and Secondary care Physiotherapy Service into a single Neighbourhood Based service



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4. Key Performance Metrics Commentary :

As table 1 below demonstrates Hillingdon benchmarks well against other NWL Boroughs. Key commentary is as follows:

- **Asthma Checks for Children** – latest data shows that performance has improved to 57.1% against a target of 59%.
- **Cervical cancer screening uptake**– although performance has decreased slightly from the previous month by 0.9%, Hillingdon has the second highest performance across NWL and is above the London average. Key Actions being taken include: our Cervical Screening Task Force work has focused on practices where performance is below 50%. Other on-going work includes use of SMS text message reminders and sharing data with practices on their performance.
- **Diabetes delivery of 9 care processes** –Hillingdon has a 0 .7% increase on the previous month and maintained its green rating for completion of the 9 Key Care Processes.
- **People with Serious Mental illness receiving a physical health check** – Hillingdon improved performance by 1.4% from the previous month, achieving 71.8% against a target of 60%. MIND and the GP Confederation continue to provide outreach support during 23/24 to increase attendance at the health checks.
- **People over the age of 14 on the LD register who have had an annual health check** —Hillingdon has seen performance improve from July to August. Key actions: GPs continue to build on the work from covid to support people with Learning Disabilities (LD). CNWL LD team work with LD health champions, PCNs and the Local authority to support with annual checks. The LA have also included LD health checks as a KPI in provider contracts. LBH Social Workers Care Act Review includes confirming whether patients have had their health check and to follow up on actions in their health action plan.
- **Dementia diagnosis rate for people over the age of 65** - Hillingdon achieved 65.1%, a slight increase of 2% on the previous month against a target of 62.9%. Changes to the National Data collection policy in Jan 2023 has impacted on all boroughs data showing an undercount of people diagnosed and this is still an issue. NWL working with NHSE to resolve. In addition, the Hillingdon Dementia Alliance is working together to improve waiting times for assessment and diagnostics e.g. MRI scans and offer support to carers.

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Admission rate for People over the age of 65 with Frailty (severe) – Hillingdon continues to perform well against this target. Services in place now include: Frailty Assessment Unit at THH and Rapid Response Team, Care Connection Team (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.

2 hr urgent response rate – performance has improved by 2.5% is on the previous month. Performance at 85.6% is below the NWL target of 90% but above the 70% national KPI. CNWL have undertaken a soft launch of Doc Abode which is now live. Plans for full roll out in mid-Sep, once Rapid Response staff complete their training. It is anticipated that the new system will improve how demand and capacity (workforce) is managed and also performance in areas of activity and response times.

Hypertension Screening uptake rates: an increase in performance of 12.3%. Hillingdon has prioritised hypertension to improve diagnosis and management of uncontrolled hypertensives. Examples of programmes in place: PH campaign, hypertension in Hillingdon People magazine; community engagement e.g. roadshows and wellness events, library and living well hubs and library BP monitor loans scheme /BP stations and audits of GP practice systems for proactive/ targeted case finding of patients at risk. Hillingdon has greatly improved on both metrics since June. Practices are using WSIC to identify patients whose hypertension is not managed to target or who have not had a BP check in the last 12 months. A Hypertension WSIC training webinar was held 22nd August for all practices. Videos have been produced to support patients, available in a number of languages, with a translation facility, to better monitor and manage their hypertension. The hypertension+ digital app pilot is going well in Celandine and Metrocare PCN with over 500 patients registered on the platform.

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Key Performance Indicators Table 1

This section provides the Committee with an overview of key achievements and Place performance indicators**. These are set out in the table below**

Most Recent Month	NWL Metric Name	Measure	Goal (Increase or Decrease)	Target	Benchmark	NWL	Trend	Westminster	Kensington and Chelsea	Hammersmith and Fulham	Brent	Ealing	Hounslow	Harrow	Hillingdon
May-23	People with diabetes who have received nine care processes in the last 15 months	%	↑	60.0%		63.4%		67.2%	67.1%	62.4%	58.5%	65.3%	67.4%	61.9%	61.7%
Apr-23	Eligible female patients who have received a Cervical Cancer Screening within the last 3.5 years for ages 25-49.	%	↑	80.0%	London Average - 60.9%	58.2%		50.6%	54.6%	57.0%	53.3%	64.9%	62.8%	56.9%	64.6%
Mar-23	Children (17 or under) with asthma who have completed an asthma check	%	↑	68.0%		59.0%		61.0%	59.0%	60.0%	52.0%	68.0%	67.0%	53.0%	48.0%
Mar-23	People receiving access to psychological therapies	%	↑	6.3%	England Average - 4.9%	5.1%		4.8%	4.8%	4.8%	4.2%	5.2%	5.1%	6.1%	6.4%
Jun-23	People with severe mental illness (SMI) receiving a full physical health check	%	↑	60.0%	England average (14/15) - 34.8%	68.0%		68.3%	72.2%	60.7%	64.8%	67.0%	70.0%	71.7%	71.8%
May-23	People over age of 14 on a doctor's learning disability register who have had an annual health check	%	↑	9.0%	London average - 7%	8.5%		11.1%	21.4%	4.1%	8.7%	7.3%	5.0%	6.2%	8.4%
Apr-23	Estimated diagnosis rate for people (aged 65 and over) with dementia	%	↑	66.7%	England Average - 62.2%	62.9%		59.2%	61.8%	61.4%	65.8%	53.8%	70.1%	67.6%	63.1%
Jun-23	Admission rate for peroples 65 years and older by severe frailty Index per 1,000	Number	↓	783.6		783.6		739.1	644.0	769.5	749.5	879.8	879.6	802.4	717.1
May-23	Two hour Urgent community Response Rate	%	↑	90.0%	London average 82.7%	93.1%		97.2%	96.7%	92.6%	97.2%	83.6%	97.4%	96.6%	83.1%
Mar-23	Patients discharged to usual place or residence	%	↑	94.6%	Q2 NWL Target - Defined by BCF	94.4%		94.5%	93.7%	93.5%	95.0%	94.7%	94.4%	95.6%	92.9%
Jun-23	Patients aged 79 years or under with hypertension who have a blood pressure reading of 140/90 mmHg or less	%	↑	44.7%	5% increase from previous year	43.3%		43.2%	40.6%	41.3%	42.3%	46.4%	42.6%	44.4%	42.8%
Jun-23	Patients aged 80 years and over with hypertension who have a blood pressure reading of 150/90 mmHg or less	%	↑	59.7%	5% increase from previous year	57.9%		56.5%	54.1%	54.9%	57.7%	60.4%	59.3%	59.5%	57.1%
Mar-23	Admitted patients with Length of stay greater than 14 days	%	↓	11.2%	5% decrease from previous year	13.1%		13.7%	12.5%	12.0%	13.9%	12.4%	12.5%	13.2%	13.7%
Mar-23	Admitted patients with Length of stay greater than 21 days	%	↓	5.9%	5% decrease from previous year	7.3%		8.1%	7.3%	6.6%	7.8%	6.6%	7.2%	7.3%	7.2%

Appendix 1: Future State Operating Model

Draft Future State Operating Model