2023/24 INTEGRATED HEALTH AND CARE PERFORMANCE REPORT

Relevant Board Member(s)	Councillor Jane Palmer Keith Spencer
Organisation	London Borough of Hillingdon
Report author	Gary Collier – Adult Social Care and Health Directorate, LBH Sean Bidewell – 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. The report also seeks approval for the Quarter 2 Better Care Fund performance template submitted to NHS England in accordance with national requirements.
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

RECOMMENDATIONS

That the Board:
a) approves the BCF Quarter 2 performance template.
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 July to September 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 Hillindon'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

2023/24 BCF Plan Quarter 2 Performance Template

4. All health and wellbeing board areas in England were required to submit their Quarter 2 (Q2) 2023/24 performance template on 31st October 2023. A draft template has been submitted subject to the Board's sign-off. The template is an excel spreadsheet containing seven 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 Better Care Fund - Hillingdon Council .

5. **Appendix 1: National Conditions** – This asks if Hillingdon continues to meet the four national conditions for the 2023/24 BCF, which it does.

6. **Appendix 1A: Metrics** – This is seeking the end of year status against the targets for avoidable admissions ambulatory care sensitive conditions, discharge to usual place of residence, falls-related hospital admissions, 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 Q2 position against these metrics was:

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

7. **Appendix 1B: Capacity & Demand Assumptions Summary** – This provides responses to specific questions raised by the Better Care Team and links to the data from the template summarised in **Appendix 1C: Hospital Discharge and Community Capacity & Demand**. References to discharge pathways are explained below. The key points for the Board to note are:

- Demand figures were based on ICB estimates and have not been refreshed as they only date back to August rather than June, which was the case with most other areas. This relates to the circumstances leading to the late submission of BCF plans in NWL.

- Adjustments have been made to Pathway 1 (P1) reablement demand to reflect the fact that approximately 40% of cases supported by the Bridging Care Service proceed into the Reablement Service.

- There is an issue with under-utilisation of key P1 services, i.e., Bridging Care and the CNWL Homefirst Service. The key reasons for this can be attributed to medication provision delays, community equipment and patient transport provision. Work is underway to address these and utilisation rates are increasing.

- P3 capacity presents a significant challenge. Hillingdon has the second highest number of care home beds in NWL but average occupancy rates are around 96%, or higher when provision for specific markets is taken into consideration, such as self-funders who account for approximately 45% of the care home market. Actions to address P3 capacity issues include exploring additional block contract options as well as looking at the scope to address need in different ways to divert demand, e.g., delirium pathway support service. The Board is advised that an issue with blocking additional beds for short-term use creates a potential issue with the supply of longer-term provision, which can then impact on the length of stay in the block beds.

Homefirst/Discharge to Assess Pathways Explained

- ***Pathway 0 (P0): 91.4% of discharges -*** Simple discharge, no formal input from health or social care needed once home.

- ***Pathway 1 (P1): 5.4% of discharges*** - Support to recover at home; able to return home with support from health and/or social care.

- **Pathway 2 (P2):** ***0.8% of discharges*** - Rehabilitation or short-term care in a 24-hour bed-based setting.

- ***Pathway 3 (P3): 2.4% of discharges*** - Require ongoing 24-hour nursing care in a bedded setting. Long-term care is likely to be required for these people.

8. The Board may wish to note that the ICB has mandated that the Hillingdon P1 model be rolled out across the whole of NWL.

Out of Hospital Services and BCF Scheme Review

9. The ICB (Local Care) is undertaking a review of out of hospital spend and BCF schemes and has commissioned Grant Thornton to undertake the data analysis and stocktaking component of the exercise. The spend review and BCF review will be linked but separate parts of the same process. The Board is reminded that the purpose of the review is to:

- identify duplication of service provision;
- Identify good practice that can be replicated and shared to benefit NWL residents;
- identify areas of saving which will eliminate this deficit; and
- Identify areas where productivity can be increased.

10. A data collection/stocktake phase started in mid-October and is expected to conclude in December 2023. Implementation of the outcomes of the review is expected to take place from April 2025, although there is an expectation that opportunities to align with the final recommendations of the review will be taken earlier where they arise before this date, e.g., where contracts end. A separate BCF reference group co-chaired by Rob Hurd, ICB CEO and Alex Dewsnap, Managing Director of Harrow Council and including the Council's Corporate Director, Adult Social Care and Health and the HHCP Managing Director has been formed to

oversee the BCF component of the review.

Implementing Right Care, Right Person in London

11. From 1st November 2023 the Metropolitan Police changed the way they respond to calls related to people with mental health needs. From this date police call handlers will receive a new prompt when they answer a call relating to welfare checks or when a patient goes absent from inpatient care. The prompt will ask call handlers to check that a police response is required or whether the person's needs may be better met by a health or care professional. Staff have received training on the impact and how to escalate concerns if police are unable to support. Daily monitoring of the impact and regular discussions with the Met Police are taking place.

B. Workstream Highlights and Key Performance Indicator Updates

12. 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.

13. The Board is reminded that the intention was to establish six integrated Neighbourhood Teams anchored to the six Primary Care Networks (PCN). The key objective is to maintain 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.

- Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs including, those with multiple long-term conditions.

- Streamlining same day access to primary care and advice for people who get ill but only use health services infrequently.

Workstream Highlights

14. **Implementation of leadership and governance arrangements for Integrated Neighbourhood Teams:** Since the Board's September meeting discussions have taken place regarding neighbourhood boundaries and it has become apparent that mapping neighbourhoods to PCNs would create inefficiencies. The Confederation, CNWL and Adult Social Care have agreed that it would be beneficial to have three rather than six neighbourhoods. The new alignment would be as follows:

- North Neighbourhood (North Connect PCN and Metrocare & Celandine PCN).

- South Neighbourhood (Long Lane PCN and Hayes & Harlington PCN).
- South West Neighbourhood (Colne PCN and Synergy PCN).

15. The PCN geography in Hillingdon is illustrated in **Appendix 2**. The implications of the change to three Integrated Neighbour Teams (INT) include:
- Each INT includes two PCNs.
- No GP practice would be in a different neighbourhood to its PCN.
- There is closer alignment between INT and borough ward boundaries.

16. CNWL has started the process of aligning their community services to the new neighbourhood arrangements.

17. **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, i.e., St Catherine's Farm Court, James Court, Mandela Court and Roberts Close. Co-production meetings about the pilot took place at these schemes between the 16th and 20th October and also provided an opportunity to undertake basic health checks and provide flu and covid vaccinations.

18. **Hypertension Diagnosis Programme**: Hillingdon has the second highest prevalence of hypertension in the North West London sector and there are three aspects of the programme to address this and these are:

- *Increasing knowledge and awareness* – The Confederation's website has been updated to include a calendar of events viewable to residents and has also been publicised through all HHCP and wider partner channels. The Council has agreed to launch a hypertension campaign through *Hillingdon People* once a directory services on the JOY social prescribing platform has been finalised. Hillingdon Hospitals has also agreed to publicise hypertension resources in wards and waiting areas across the hospital.

- *Improving access to testing/patient self-measurement through engagement* – The launch of the CNWL engagement bus on 3rd October in Heathrow Villages provided an opportunity to offer health checks as well as a range of health, wellbeing, and social support. Confederation staff also attended a Black History Month event on 14th October that provided an opportunity to deliver targeted blood pressure checks.

- *Case finding and pathway management* – A lead pharmacist and project support officer started in October and have begun the case audit process based on numbers of GP practice patients in deprived areas identified from the Whole Systems Integrated Care System (WSIC) database.

19. Some key achievements during the review period include:

- Approximately 1,800 blood pressure checks carried out through community engagement, roadshows, and local partner events.

- Over 500 people have been registered onto the hypertension+ digital app which is being piloted in Celandine and MetroCare Primary Care Networks.

- There have been 117 visits to The Confederation '*patient information'* web page which hosts newly created hypertension content and resources.

20. **Same Day Urgent Primary Care Hubs:** As reported to the September Board, the target was to open two hubs during 2023/24 and the first opened earlier in the year at Mead House in Hayes. The opening of the second at the Pembroke Centre is subject to the completion of building works and the intention is that it will open in December 2023. The hubs are intended to create capacity in Primary Care to divert 18% and 28% of Hillingdon non-complex patients currently attending Hillingdon Hospital's Emergency Department and Urgent Treatment Centre respectively.

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

21. Workstream 1 performance indicators include:

- **Flu vaccinations:** The 2023/24 flu vaccination programme started on the 1st September 2023 and table 1 below shows performance to the 1st November.

Table 1: Flu Vaccinations Performance - Hillingdon and NWL Compared

Indicator	Target	NWL Average	Hillingdon Performance
% of Eligible Population Vaccinated	N/A	26.3%	**29.2%**
65+ cohort	75%	54.4%	**62.8%**
At risk 6m - 64yrs cohort	75%	22.3%	**25%**
Pregnant cohort	75%	18.3%	**17.7%**
11-16 (not at risk)	75%	3.2%	**4.0%**
4-10 (not at risk)	75%	7.9%	**4.1%**
3 (not at risk)	75%	24.7%	**26.4%**
2 (not at risk)	75%	26.3%	**28.4%**
Care home (may be in other cohorts)	75%	47.9%	**52.3%**
Carer cohort	75%	17.8%	**19.5%**

Source: WSIC Dashboard (01/11/23)

- **Covid booster vaccinations:** The 2023/24 covid booster programme started on the 11th September and table 2 below shows that Hillingdon's performance in respect of all priority groups exceeds the NWL average in the period to 5th November 2023.

Table 2: Covid Booster Vaccination Performance - Hillingdon and NWL Compared

Indicator	NWL Average	Hillingdon Performance
Care Home Resident Residents who have received their AW 23 Booster (as % of Population).	65.3%	**75.1%**

Table 2: Covid Booster Vaccination Performance - Hillingdon and NWL Compared		
Indicator	**NWL Average**	**Hillingdon Performance**
80+ Residents who have received their AW 23 Booster (as % of Population).	44.8%	**53.8%**
65-79 Residents who have received their AW 23 Booster (as % of Population).	36.1%	**44.1%**
At Risk (Aged 5 plus) Residents who have received their AW 23 Booster (as % of Population).	11.5%	**12.7%**
Social Care Workers who have received their AW 23 Booster (as % of Population).	8.6%	**12.3%**
Frontline Healthcare Workers who have received their AW 23 Booster (as % of Population).	17.0%	**17.3%**
Unpaid carers (self-declared) who have received their AW 23 Booster (as % of Population).	6.9%	**7.2%**
Patients Eligible for the AW 23 Booster Campaign (65+,Care Home Residents, At Risk, Immunosuppressed Compromised with SMI or on the LD Register, Social Care Workers, Carer, Health Care Worker etc) (as % of Population).	21.8%	**26.2%**

Source: NHS National Data Platform Foundry (05/11/23)

- **People with severe mental illness (SMI) receiving a full physical health check:** On track (Green) – September data for 2023/24 shows a performance of 64.9% against a target of 60%.

- **People over age of 14 on a doctor's learning disability register who have had an annual health check:** *On track (Green)* - September data for 2023/24 shows a performance of 36% against a target of 35%.

- **People with diabetes who have received nine care processes in the last 15 months:** *Slight slippage (Amber)* - September data for 2023/24 shows a performance of 59.6% against a target of 60%.

- **Eligible female patients who have received a Cervical Cancer Screening within the last 3.5 years for ages 25-49:** *Slippage (Amber)* **–** October data shows a 2023/24 performance of 63.5% against a target of 80%. However, the Board may wish to note that the NWL average is 57.2% and the London average 60.9%, thus indicating that Hillingdon has a better comparative performance.

Workstream 2: Reactive Care

22. The Board is reminded that the priorities for this workstream are:
- Implementation of a new end of life operating model.

- Implementation of an integrated active recovery service.
- Implementation of a '*Maximising Homefirst'* programme to reduce length of stay of residents in hospital.

Workstream Highlights

23. **Implementation of a new end of life operating model:** A new 24/7 Palliative Integrated Care Service (PICS) that brings together staff from CNWL, Harlington Hospice and Hillingdon Hospital's Palliative Care Team went live on 13th November 2023 with the soft launch. This will co-ordinate end of life services for the 3,000 adults per year who are in this cohort.

24. **Implementation of an Integrated Active Recovery Service:** As previously reported to the Board, 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 to move closer to the average target pathway delays shown in table 3 below.

Table 3: Hillingdon Hospitals Average Length of Stay by Discharge Pathway

Discharge Pathway	2022/23 Full Year		Target 2023/24	Rolling 6 Month Average Apr – Oct 2023
	Full Year Admissions	Average Pathway Delay (Bed Days)	Average Target Pathway Delays (Bed Days)	Average Pathway Delay (Bed Days)
Pathway 0	11,464	1.4	0.5	0.3
Pathway 1	1,781	2.5	1	1.6
Pathway 2	273	4.1	2	3.4
Pathway 3	661	7.4	5	7.9
Unknown	70	2.9	0.5	0.5
All	**14,249**	**2.3**	**1.3**	**2.1**

Source: THH

25. **Care Home Support Service:** We are currently reviewing the operating hours and standard operating procedures of this service to reduce the number of ambulance conveyances to the Hospital. Care homes have on average 4 attendances at A & E per day, of which 50% are converted to admissions. 60% of care home attendances occur after 5pm and over the weekend. This has shifted significantly over the last 12 months. Our current Care Home Support offer across both health and social care operates 09:00 to 17:00 Monday to Friday. As only 27% of conveyances are blue lighted, i.e., actual emergencies, this suggests that there is scope for alternative pathways.

About the Care Home Support Service

This is a multi-agency team established in 2017 that includes six care home matrons who each have responsibility for supporting specific care homes. The team is also supported by GPs, a dietician, a speech and language therapist (SALT), a mental health nurse and tissue viability specialist. Specialist medical advice and support is also provided by a care of the elderly consultant at Hillingdon Hospital. The team works closely with the Council's Quality Assurance Team that discharges its market monitoring responsibilities under the Care Act, 2014.

26. **Winter Planning:** In addition to actions already referred to in paragraph 7 above, winter plans include the following actions:

- *Improving the weekend discharge rate by increasing the workforce at the weekend, specifically doctors, therapists, and pharmacists*: This is a joint initiative between the Hospital, CNWL and The Confederation.
- *Increase palliative/fast track bed capacity*: The intention is to increase the number of beds available at Michael Sobel House to 14 for the period to 31st March 2024.
- *Strengthening support offer to care homes with highest number of hospital admissions*: This includes exploring the implementation of a Frailty Assessment Unit *'call before convey' pilot with the London Ambulance Service (LAS)*, which is intended to reduce the number of avoidable conveyances to the Hospital from care homes.

Key Performance Indicator Updates

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

- **A & E Attendances:** *Slippage* (Amber) -The number of attendances (all ages) increased during the period April to October 2023 by nearly 7% to 43,871 from 40,737 in the same period in 2022/23. The number of attendances for the 65 and over age group during the April to October 2023 period increased by nearly 13% to 11,768 from 10,433 in the equivalent period in 2022/23.

- **Emergency Admissions:** *Slippage* (Amber) - The number of emergency admissions (all ages) during the April to October 2023 period increased by nearly 12% to 17,000 from 15,186 in the same period in 2022/23. Emergency admissions of people aged 65 and over also increased by 8.3% to 6,522 from 6,019 during the same period in 2022/23; however, the 2023/24 figure is slightly above that for the same period in 2021/22, although this may be a coincidence.

- **% 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.

- **Hillingdon Hospital bed occupancy:** *Slippage (Amber)* **-** The target average for 2023/24 is 92%. The average for 2023/24 (April to October) is 93%, which reflects the 2022/23 position.

Workstream 3: Planned Care

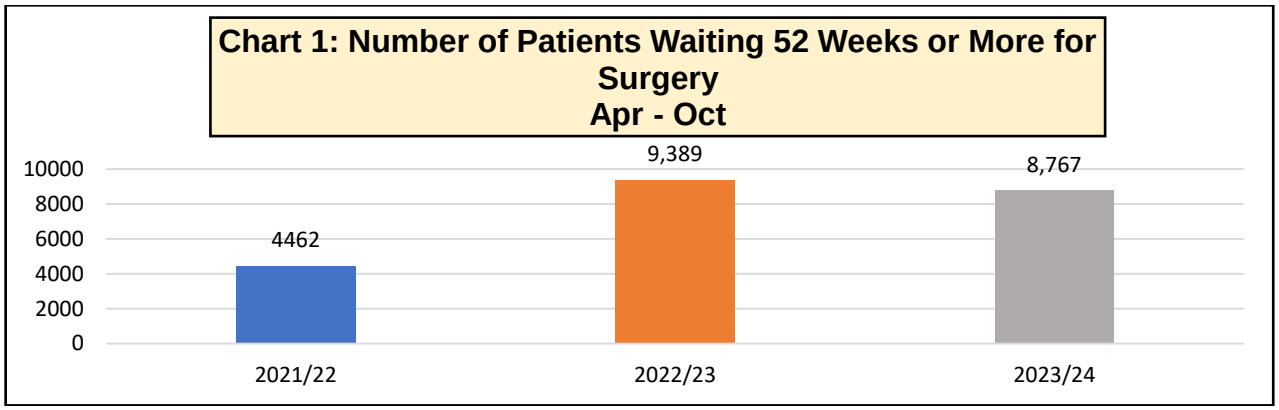
Workstream Highlights

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

Key Performance Indicator Updates

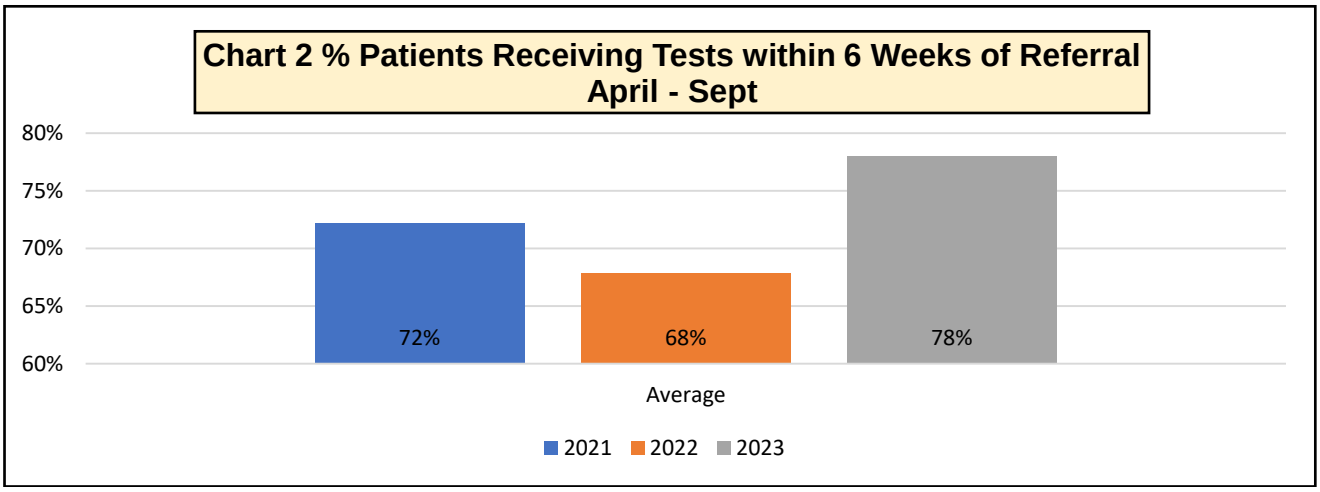
29. The following is an update on workstream 3 indicators where data is available:

- **Patients waiting 52 weeks or more for surgery:** Chart 1 below shows an improvement in the number of people waiting 52 weeks or more for surgery during the April to October 2023 period compared with the same period in 2022/23.

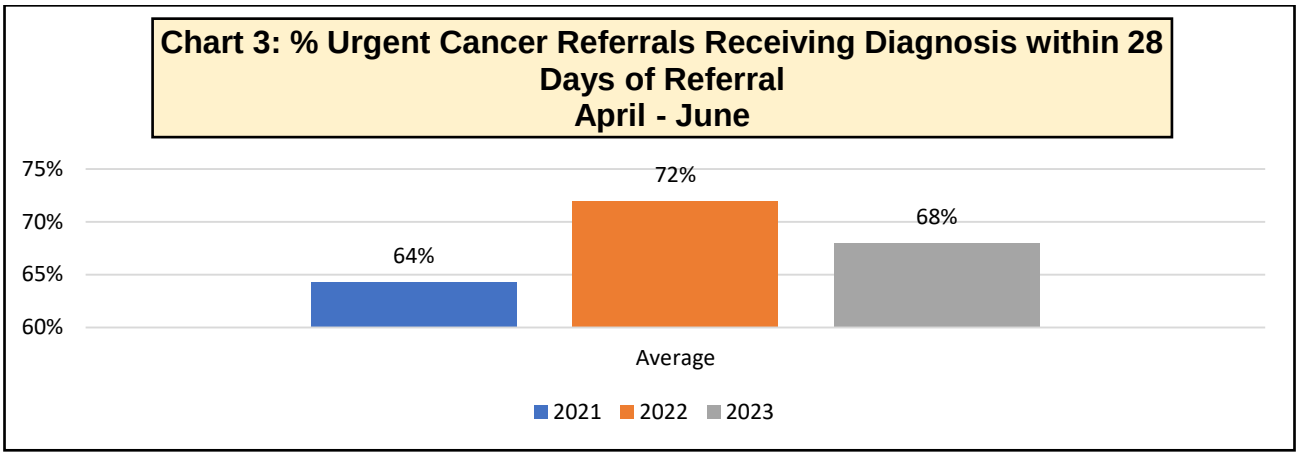


Source: NWL BPI.

- **% Patients receiving tests within 6 weeks of referral:** Chart 2 below shows improvement on the percentage of patients receiving tests within 6 weeks of referral between April and September 2023 compared to the same period in 2022/23 and 2021/22.



- **% Urgent cancer referrals receiving diagnosis within 28 Days:** Chart **3** below shows a slight reduction in the percentage of urgent cancer referrals receiving a diagnosis within 28 days of referral.



Workstream 4: Children and Young People

Workstream Highlights

30. **16-25 Young Adult Mental Health and Wellbeing Partnership Model:** Joint working is in progress between CAMHS, Talking Therapies, Hillingdon Mind and the Council to improve management plans for young adults. A young adults psychiatrist for Hillingdon has now been appointed and is due to start in December. A Young Adult Community Navigator post hosted by Hillingdon Mind is now in place to provide focused support.

31. **CYP ASD Waiting Well Initiative:** £141k was secured in Q2 for a one-year pilot to test the right support offer for CYP and their families whilst they await an ASD assessment. The Hillingdon borough ICB team has worked with Brent to submit a joint business case to continue funding the services under the pilot, i.e., Doodle Den, Arts for Life and Hillingdon Autistic Care and Support (HACS).

32. **CYP Mental Health and Emotional Wellbeing Resilience**: Two-year Population Health Management funding has been granted by the ICB to enable timely and targeted person-centred support to be offered to address the needs of young people, including those from Black, Asian and minority ethnic and LGBT+ groups. Healthwatch will be undertaking research with CYP to identify the most effective delivery approaches. Hillingdon Mind, P3 and HACS have put forward a joint proposal to establish a sustainable CYP voluntary sector consortium.

33. **Mental Health Support Workers in Schools:** 10 schools are currently supported by this team and it is intended to approach a further 16 to bring the total number to 16. Challenges with recruiting to posts in schools has presented difficulties with extending this initiative and it will be expanded as new people are recruited. The Board may wish to note that two new waves of funding have been secured for 2024/25, which presents opportunities for support to be extended to more schools.

34. **Providing Assessment and Treatment of Children at Home (PATCH) Service:** This was established in June 2021 to provide care to children and young people at home once discharged from hospital. Short-term funding provided in 2022/23 has not been renewed for 2023/24 resulting in the staff team reducing to three nurses from five, an effect of which is to reduce operating hours to 6pm instead of 8pm.

35. **SEND Strategy**: A new strategy has been co-produced and is awaiting formal approval by

the Council's Cabinet Member for Children, Families and Education.

Key Performance Indicator Updates

36. The following is an update on workstream 4 indicators where data is available:

- **Children and Adolescent Mental Health Service 18 week wait from referral to first consultation:** *On track (Green)* **–** Hillingdon's performance for the period to October 2023 was 91% against a target of 85%.

- **Talking Therapies (also known as Improving Access to Psychological Therapies or IAPT) percentage accessing service within 6 weeks of referral**: *Slight slippage (Amber)* – Hillingdon's performance against the for the period to September 2023 was 99.8% against a target of 100%. Once again this was the highest performance in NWL.

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

Workstream Highlights

37. **Wellbeing Bus:** This replaces an earlier proposal to establish a static one stop shop for residents with mental health and wellbeing issues to visit. The bus model was devised as a fifteen week pilot to address transport inequities and to reach out to communities. The pilot started on 3 October and it operates on Tuesdays between 10am to 5pm and rotates across the Heathrow Villages. All five villages have now been visited, with six sessions held and 123 residents supported to date including two sessions with vaccinations with the Roving Vaccination Team. Collaborative user involvement continues to take place to inform routes taken.

38. **Mental health assessment lounge:** This new space supporting people with mental health concerns in A & E at Hillingdon Hospital opened on the 31st July 2023 and is called the '*Lighthouse*'. It is operating as a pilot and is open Monday to Sunday from 8am to 8pm. The purpose of the Lighthouse is to prevent admission. It is suitable for 4 patients and offers psychosocial support, 1:1s and signposting to the community. The service includes clinical oversight and there is a dedicated staff in A & E identifying referrals but it currently does not support people who require a Mental Health Act assessment. A business cases to consider expanding provision to 24/7 and to support people with a higher level of complexity is under consideration by the ICB. From December 2023 the service will be co-provided with Hestia, the provider of the Coves Café.

39. **Hillingdon Coves 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 shares a site with the crisis recovery house. It became operational from the new premises in July.

40. **The Retreat:** This six-bedded unit is co-located with the Hillingdon Coves Café and the Board is reminded that its purpose is to support people in crisis to prevent acute admissions. Utilisation has increased significantly over the last 6 months as it becomes an embedded part of the service offer, and the acceptance criteria has been expanded. An evaluation of this service, which the Board may recall was established as a pilot, is due to take place in January 2024.

41. **NHS 111 *2 implementation**: This is a telephone number intended to give 24/7 access to mental health support for anyone experiencing a mental health crisis. Technology and staffing arrangements have been put in place, including with support from Hestia, and the service went live on 14 November. It links in with the CNWL single point of access.

Enabling Workstreams

Enabler 1: Supporting Carers

42. 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

43. **2023 – 2028 Joint Carers Strategy:** A report on the implementation of the carers strategy delivery plan was considered by the Council's Health and Social Care Select Committee at its meeting on the 21st November 2023. The Committee undertakes statutory scrutiny functions prescribed under the 2012 Health and Social Care Act and reports can be accessed via this link London Borough of Hillingdon - Browse meetings - Health and Social Care Select Committee

Enabler 2: Improved market management and development

44. 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

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

Enabler 3: Digital, including Business Intelligence

46. HHCP leads on this workstream.

Workstream Highlights

47. **Care home access to London Care Record (LCR):** The LRC is a secure web-based system that enables health and care professionals involved in a person's care to access key information about them, e.g., long-term conditions, test results, prescribed medicines, allergies, and care arrangements, to support effective care planning and delivery and it being promoted by a collaborative of ICSs in London and the LAS called OneLondon. Extending access to care homes is part of a roll out programme intended to improve the safety and quality of treatment

and care received by ensuring access to the right information at the right time. All NHS trusts and GP practices in Hillingdon are connected to the LCR and ten care homes have signed up for the pilot, which goes live in February 2024 following the conclusion of information governance and training. The goal is to extend to homecare providers in due course but this is likely to be dependent on the evaluation of the care home pilot.

Enabler 4: Workforce

48. The ICB leads on the health aspects of this workstream. The Council leads in respect of the Adult Social Care workforce, i.e., including its own workforce and the broader regulated care market.

Workstream Highlights

49. **HHCP workforce passports:** As an enabler to integration across NHS services within the borough, the development of the passports is intended to facilitate staff moving between partner organisations within HHCP.

50. **Adult Social Care Workforce Strategy:** An ASC workforce strategy is under development that will initially focus on securing a sufficient number of suitably qualified social workers to meet anticipated demand in the three year period to 2026. The intention over the period of the strategy is to expand its scope to support the broader ASC workforce within the regulated care market.

Enabler 5: Estates

Workstream Highlights

51. **Super-hub site options:** As part of the development of Hillingdon's care model it is intended to develop three super-hubs that will offer a broader range of services that the three Same Day Primary Care Hubs previously mentioned and discussions are in progress between HHCP and the Council concerning the identification of suitable sites.

Finance

52. Tables 4 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 4: 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 5: 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**

BACKGROUND PAPERS

Joint Health and Wellbeing Strategy, 2022 – 2025

Appendix 1

2023/25 Better Care Fund National Conditions

National Conditions	Confirmation
National Condition 1: A jointly agreed plan in place.	Yes
National Condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe, and independent at home for longer.	Yes
National Condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time.	Yes
National Condition 4: Maintaining NHS's contribution to Adult Social Care and investment in NHS commissioned out of hospital services.	Yes

Appendix 1A

2023/24 BCF Metrics

Metric	Definition	For information – Your planned performance as reported in 2023-24 planning				For information – actual performance for Q1	Assessment of progress against the metric plan for the reporting period.	Challenges and any support needs	Achievements – including where BCF funding is supporting improvements
		Q1	Q2	Q3	Q4				
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions.	229.4	183.5	228.4	238.4	253.2	On track to meet target	Concentration of community resources on discharge impacts on admission avoidance capacity. This is being addressed with transition to new operating model reflected within BCF plan. No support needs identified.	There were 1,063 spells in the review period compared to 2,022 in the same period in 2022/23. This would suggest that active care planning at Neighbourhood level is having an impact.
Discharge to usual place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence.	92.8%	91.7%	92.3%	90.9%	92.12%	Not on track to meet target	Increasing levels of frailty are necessitating step-down in bed-based provision that does not count as normal place of residence. No support needs identified.	P1 process working well and Hillingdon model seen as template for sub-region. Q2 performance an improvement on Q1, although only based on two months' data.
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per	2,018				427	On track to meet target	Staff turnover in care settings such as care homes and extra care housing means falls-related training	The 2022/23 fall prevention programme has been expanded in 2023/24 to include a

	100,000.				presents an on-going need. Demand can be minimised via a train the trainer approach but effectiveness also affected by staff turnover.	proactive care pilot project to reduce frailty and falls in residents in sheltered housing schemes. Training for care home and extra care housing staff delivered in 2022/23 has been continued in 2023/24.
Residential admissions	Rate of permanent admissions to residential care per 100,000 (65+).	604	-	Not on track to meet target	The figures submitted for this metric are based on anticipated sequel to action, i.e., what the social care professional believes is likely to happen. This means that the actual number of permanent admissions is below the numerator which will relate to the figure submitted for the Council's Short and Long-term Support (SALT) return to NHS Digital. Increasing numbers of older people with increased acuity being seen, which can be attributed to covid legacy. 75% of	Investment via BCF in range of intermediate tier services as well as provision of extra care and rigorous review process, ensures that permanent care home admissions the option of last resort to address assessed need.

					permanent admissions are conversions from short-term, which is an increase from 55% in 2022/23 and is associated with increased acuity and impact on the ability and willingness of carers to cope with their caring role. Number of actual placements projected to be 223 against projected 360 using ASCOF measure. No support needs identified.	
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.	94.9%	-	Data not available	A challenge with this metric is the increased acuity of older people being discharged. This is being mitigated with therapy input. It should be noted that people who may pass away during the review period are still included within the denominator.	Closer working between Bridging Care, reablement and the CNWL Homefirst Team is resulting in timely deployment of therapy input that should have a positive impact on proportion of people discharged remaining at home.

Appendix 1B

Capacity & Demand Assumptions Refresh Summary

Assumptions
1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include how learning from the last 6 months was used to arrive at refreshed projections?
North West London boroughs revised their demand and capacity estimates in August and as such our figures remain unchanged to the August resubmission. The August refresh revised our figures according to realistic demand and capacity in particular around pathway 0 to reflect people who have support needs.
2. Please outline assumptions used to arrive at refreshed projections (including to optimise length of stay in intermediate care and to reduce over prescription of care). Please also set out your rationale for trends in demand for the next six months (e.g., how have you accounted for demand over winter?
Demand:
We have not changed our projections since August (apart from adding in spot purchasing). However, in the August submission, we used our acute hospital data in conjunction with known local authority and community service data where required to work out a realistic baseline for demand, factoring in winter pressures. P1 Reablement/Rehabilitation figures have been adjusted to reflect that only 40% of Bridging Care Service cases proceed into Reablement.
Capacity:
We have not changed our projections since August, apart from adding in P3 spot purchasing. Our capacity in August submission was largely based on available capacity within community NHS and local authority commissioned services. This was calculated largely by reviewing activity/referral data. Negotiations are in progress with a care home provider to secure an additional block nursing/nursing dementia beds. These beds have not been factored into our capacity figures as negotiations are at an early stage. We are currently exploring reintroduction of delirium pathway support service to divert people from P3 to P1 and reduce demand on limited care home supply.
3. What impact have your planned interventions to improve capacity and demand management for 2023-24 had on your refreshed figures? Has this impacted been accounted for in your refreshed plan?
For P1 short-term domiciliary care it should be noted that this is our Bridging Care Service and that only 40% of referrals into this service proceed into the Reablement Service, which is delivered by the same provider. It should also be noted that there is a current issue with under-utilisation of bridging and rehab capacity (CNWL Homefirst Service). This is related to issues such as TTAs, transport and equipment that are being addressed. Refer to comment under Q2 concerning discussions concerning arrangements to secure additional block care home beds.
4. Do you have any capacity concerns or specific support needs to raise for the winter ahead?
Care home capacity presents an issue. The sector in Hillingdon consistently has an occupancy rate of approximately 96% and higher when taking into consideration homes

that do not accept statutory sector placements or are available only to niche markets, e.g., nuns or actors. In addition, taking out supply for short-term placements limits availability for longer-term need. This has potential length of stay implications for people in short-term placements.
5. Please outline any issues you encountered with data quality (including unavailable, missing, unreliable data)
The national discharge data cannot be split by borough, therefore in our June submission this was cross triangulated with other data sources. Some issues were identified and we worked with the London BCF team to refresh this in August. Timeliness and accuracy of data is an issue, i.e., how up to date it is to be able to understand activity. The definition of terms can also present difficulties as they can have different meanings across and within systems and between health and social care.
6. Where projected demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?
Hillingdon considers that it has sufficient P1 capacity and it should be noted that many of the people proceeding through to Reablement and the Homefirst rehab service will initially be supported by the Bridging Care Service so that they are able to leave hospital with support. Some people identified as requiring P3 placements could actually be supported in their usual place of residence with an appropriate package of care. Where demand for reablement/rehab in the community exceeds capacity need can be addressed through domiciliary care provision, although this would be a chargeable service.

Appendix 1C

Hospital Discharge and Community Capacity & Demand

Hospital Discharge

Capacity – Demand (positive is Surplus)	Previous Plan					Refreshed capacity surplus. Not including spot purchasing.					Refreshed capacity surplus (including spot purchasing0				
	Nov - 23	Dec-23	Jan-24	Feb-24	Mar-24	Nov - 23	Dec-23	Jan-24	Feb-24	Mar-24	Nov - 23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (inc VCS) (pathway 0)	-1,939	-1,765	-1,942	-1,824	-2,027	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation (pathway 1)	-66	-81	-78	-87	-64	-33	-43	-42	-51	-29	-33	-43	-42	-51	-29
Short-term domiciliary care (pathway 1)	-1	1	0	-1	0	-1	1	0	-1	0	-1	1	0	-1	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	6	-9	-18	4	-6	6	-9	-18	4	-6	6	-9	-18	4	-6
Short-term residential & nursing care for someone likely to require a longer-term care home placement (pathway 3)	-53	-52	-56	-56	-56	-53	-52	-56	-56	-56	-45	-44	-48	-48	-48

Community

Capacity –Demand (positive is Surplus)	Previous Plan					Refreshed Capacity Surplus				
	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	-8	11	-19	-46	-55	-8	11	-19	-46	-55
Reablement & Rehabilitation at home	-47	44	-117	-68	-5	-47	44	-21	-68	-5
Reablement & Rehabilitation in a bedded setting	-8	-6	-2	-6	0	-8	-6	-2	-6	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0

Primary Care Network Geography