2024/25 Q1 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	Sean Bidewell – Integration and Delivery, NHS NWL Gary Collier – Adult Social Care and Health Directorate, LBH
Papers with report	None

HEADLINE INFORMATION

Summary.	This report provides an update on the delivery of the transformation workstreams established to deliver the priorities within the Joint Health and Wellbeing Strategy. This includes progress with the delivery of the 2024/25 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 2024/25 is £100,025,164 made up of Council contribution of £70,173,307 and an ICB contribution of £29,658,745.
Ward(s) affected.	All

RECOMMENDATIONS

That the Health and Wellbeing Board:

1. **approves the 2024/25 Quarter 1 BCF reporting template;**
2. **delegates authority to approve Better Care Fund reporting templates to the Corporate Director of Adult Social Care and Health in consultation with the Co-Chairs, the ICB Borough Director and the Chair of Healthwatch Hillingdon;**
3. **reaffirms arrangements for the monitoring of, and reporting on, activity and spend against the agreed BCF plan as outlined in the report (paragraph 9); and**
4. **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 2024 period (referred to as the '*review period'*), unless otherwise stated. Reference to 2024/25 means April 2024 to March 2025.

2. This report is structured as follows:

A. Key Issues for the Board's consideration.
B. Work stream highlights and key performance indicator updates.

3. Reference in this report to HHCP means Hillingdon Health and Care Partners; which 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 will become a signatory to the alliance agreement in 2024/25.

4. Reference to the ICB (or NHS NWL) means the North West London Integrated Care Board. NWL means a reference to the local authorities' areas within the North West London sector and this includes the London Boroughs of Brent, Hammersmith & Fulham, Harrow, Hillingdon and Hounslow, the Royal Borough of Kensington & Chelsea, and Westminster City Council.

A. Key Issues for the Board's Consideration

2024/25 Quarter 1 BCF Reporting Template

5. All health and wellbeing board areas in England were required to submit their BCF Q1 reporting template on 29 August 2024 and Hillingdon's response was submitted as a draft pending formal sign-off by the Board. Sign-off by the Board, or on its behalf, is one of the national conditions for the BCF. Information required from the Q1 template is limited to spend and activity against the Discharge Fund. For ease of reference the 2024/25 spending plan for the Discharge Fund is attached to this report as **Appendix 1**. The completed reporting template can be found on the Council's website via the following link Better Care Fund - Hillingdon Council.

6. The key point to bring to the Board's attention is that schemes are currently in development to relieve additional demand during the winter period and these are due to go live in October. These will be funded from the £934k allocation to relieve pressure on discharge pathway 3 (P3) and will address the underspend currently being reported against this aspect of the spending plan. Please see below for an explanation of the discharge pathways.

Hospital Discharge Pathways Explained

- **Pathway 0 (P0):** Discharges home or to a usual place of residence with no new or additional health and/or social care needs.
- **Pathway 1 (P1):** Discharges home or to a usual place of residence with new or additional health and/or social care needs.
- **Pathway 2 (P2):** Discharges to a community bed-based setting, which has dedicated recovery support. New or additional health and/or social care and support is required in the short-term to help the person recover in a community bed-based setting before they are ready to either live independently at home or receive longer-term or ongoing care and support.
- **Pathway 3 (P3):** Discharges to a new residential or nursing home setting, for people who are considered likely to need long-term residential or nursing home care. Should be used only in exceptional circumstances.

2024/25 BCF Reporting Templates and Expenditure and Activity Reporting

7. The Board is asked to note that the national deadlines for reporting on BCF spend and activity are as follows:

- Quarter 2: 31/10/24
- Quarter 3: 31/01/25
- Quarter 4 and End of Year: 31/05/25

8. As the scheduled Board meetings for 2024/25 are 26th November 2024 and 4th March 2025, it is recommended that sign-off of templates be delegated to the Corporate Director of Adult Social Care and Health in consultation with the Co-chairs, the ICB Borough Director and the Chair of Healthwatch Hillingdon.

9. Under the governance arrangements contained within the agreement between the Council and the ICB under section 75 of the National Health Service Act, 2006, the BCF Core Officer Group has day to day responsibility for monitoring activity and spend against the funding streams in the BCF and the agreed plan. The Board is asked to reaffirm that the information it wishes to receive is the high level messages arising from activity as well as reporting by exception where its intervention is required to address blockages. It is suggested to the Board that this not exclude successes and achievements of partners in meeting the needs of residents and addressing the priorities within the Joint Health and Wellbeing Strategy. The intention is that the reporting route for Board consideration will be integrated performance report, which is a standing agenda item.

10. For the Board's information, the membership of the BCF Core Officer Group currently includes the Corporate Director of Adult Social Care and Health, the Managing Director of HHCP (and Board Co-chair), the ICB Borough Director and the BCF Programme Manager. Membership of the Core Officer Group is currently under review.

Hospital Activity

11. Table 1 below illustrates the Q1 position.

Table 1: Hospital Activity Dashboard

Metric	Target	Apr - July 2024 Average	Rating
Emergency admissions (weekday) - Average daily adms	54	35	Green
Emergency admissions (weekend) - Average daily adms	23	30	Amber
Discharges (weekday) - Average daily discharges	59	49	Amber
Discharges (weekend) - Average daily discharges	25	24	Amber
No criteria to reside	34	43	Amber

B. Workstream Highlights and Key Performance Indicator Updates

This section provides the Board with progress updates for the five workstreams, where there have been developments.

Transformation Workstreams

Workstream 1: Integrated Neighbourhood Working.

Workstream Highlights

Key Performance Indicator Updates

Workstream 1 performance indicators include:

- **People with severe mental illness (SMI) receiving a full physical health check:** *Exceeded (Green)* – The 2023/24 ICB target is 60% and the Hillingdon position during the review period was 77.2%

- **People over age of 14 on a doctor's learning disability register who have had an annual health check:** *Exceeded (Green)* - The 2023/24 ICB target is 50% and Hillingdon achieved 73% during the review period.

- **People with diabetes who have received nine care processes in the last 15 months:** *Exceeded (Green)* – The 2023/24 ICB target was 50% and Hillingdon achieved 67.8% during the review period.

- **Eligible female patients who have received a Cervical Cancer Screening within the last 3.5 years for ages 25-49 (Core20Plus5 measure):** *Slippage (Amber)* **-** The 2023/24 ICB target was 80% but 64.5% was achieved during the review period. Hillingdon's performance in May 2024 was 65% which is 6.5% higher than the NWL average. Key actions to improve performance include RM Partners (one of the 21 Cancer Alliances established by NHS England to lead on the delivery of the cancer care recommendations in the NHS Long-term Plan) meeting with all six PCNs to share performance data and provide instruction on accessing data on screening dashboards. There has been targeted 1:1 support for the two practices with the lowest to discuss actions for improvement.

- **Eligible female patients who have received a Cervical Cancer Screening within the last 5.5 years for aged 50 and over (Core20Plus5 measure):** *Slippage (Amber)* **-** The 2023/24 ICB target was 80% but 76.9% was achieved during the review period. The Board is reminded that action to improve performance against this measure and the equivalent above for the 25 to 49 age group includes 1:1 meetings between the cervical cancer clinical lead and lower performing practices to identify issues and offer support; through proactive signposting and text message reminders to patients across our neighbourhoods; and through the clinical lead attending upcoming PCN meetings to present on performance to date and discuss further ideas for overcoming barriers to attending for cancer screening.

- **Patients aged 79 years or under with hypertension who have a blood pressure reading of 140/90 mmHg or less**: *Exceeded (Green)* – The 2023/24 outturn was 60.2% against a NWL target of 44.7%. However, the Board may wish to note that this is rated as amber in the

Joint Health and Wellbeing Strategy update as Hillingdon has the second highest hypertension rates of NWL borough, and cardiovascular mortality is higher than London and England.

- **Patients aged 80 years and over with hypertension who have a blood pressure reading of 150/90 mmHg or less**: *Exceeded (Green)* – The 2023/24 outturn was 76.8% against a NWL target of 59.7%

- **Admission rate for people aged 65 and older by severe frailty index per 1,000:** *Exceeded (Green)* – The ceiling rate for 2023/24 was 719 and the outturn was 643.

Workstream 2: Reactive Care

The Board is reminded that the priorities for this workstream are:

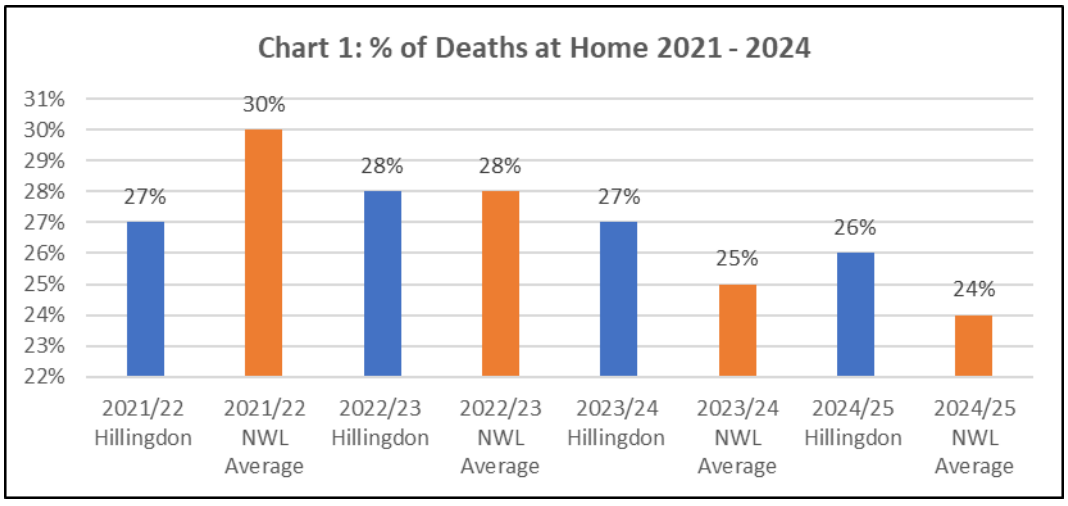
- Implementation of a new end of life operating model.
- Implementation of an integrated active recovery service.
- Implementation of a '*Maximising Homefirst'* programme to reduce length of stay of residents in hospital.

Workstream Highlights

Key Performance Indicator Updates

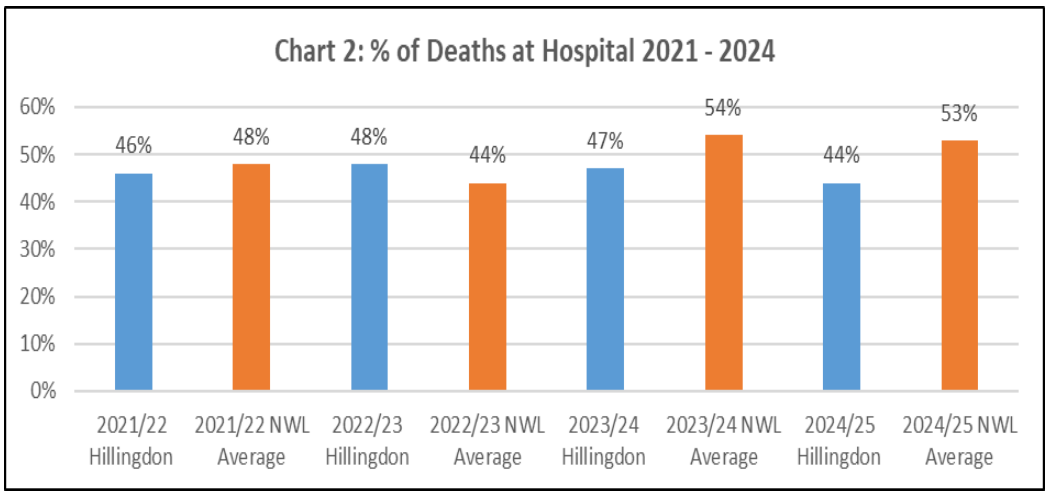
The following is an update on workstream 2 indicators where data is available:

- **% of deaths of people that occurred at home in the last twelve months:** A higher proportion of deaths of people occurring at home is desirable and the data in chart 1 below shows that in 2023/24 Hillingdon's performance was just above the NWL average and performance over the last three years has been close to the NWL average, although there has been a slight drop in the average for 2024/25 to date.

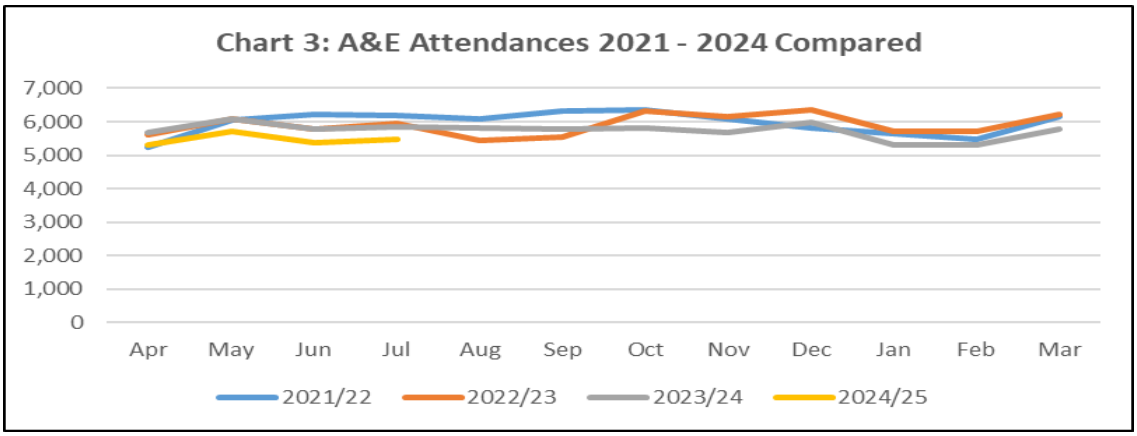


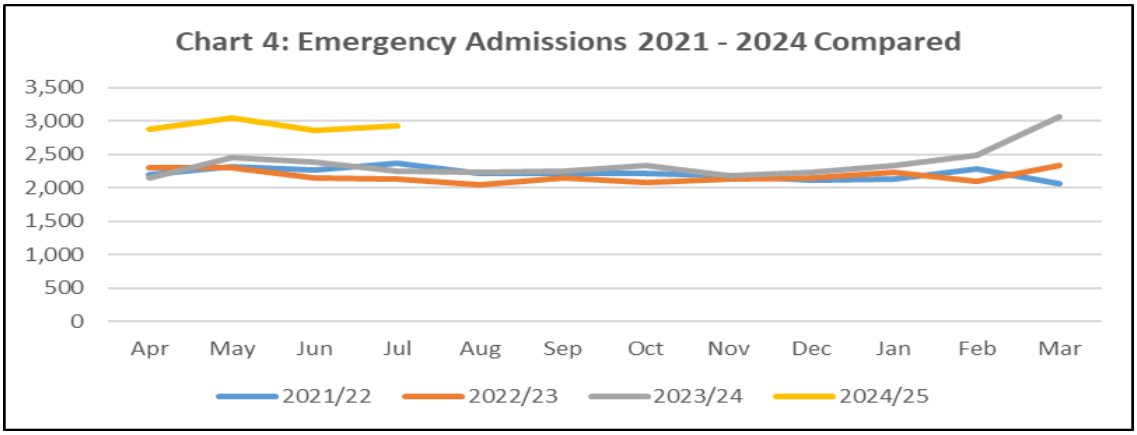
- **% of deaths of people that occurred in hospital in last twelve month period:** The objective is that the percentage of deaths that occurred in hospital should be at a minimum

and reflect the last place of care choice of residents. Chart 2 below shows that for the 2023/24 period Hillingdon's performance was better than our direct comparators within the NWL sector. So far to date in 2024/25 Hillingdon's performance is also lower than the NWL average.

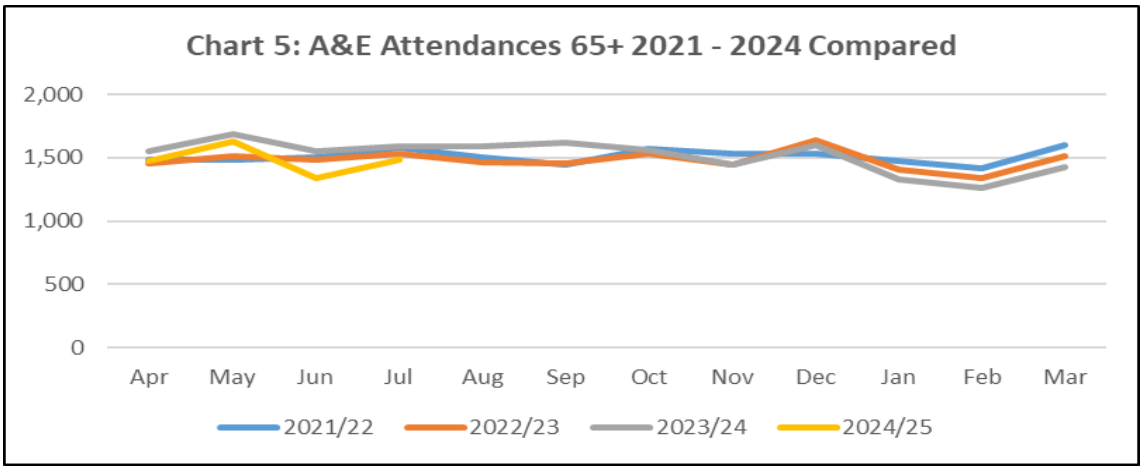


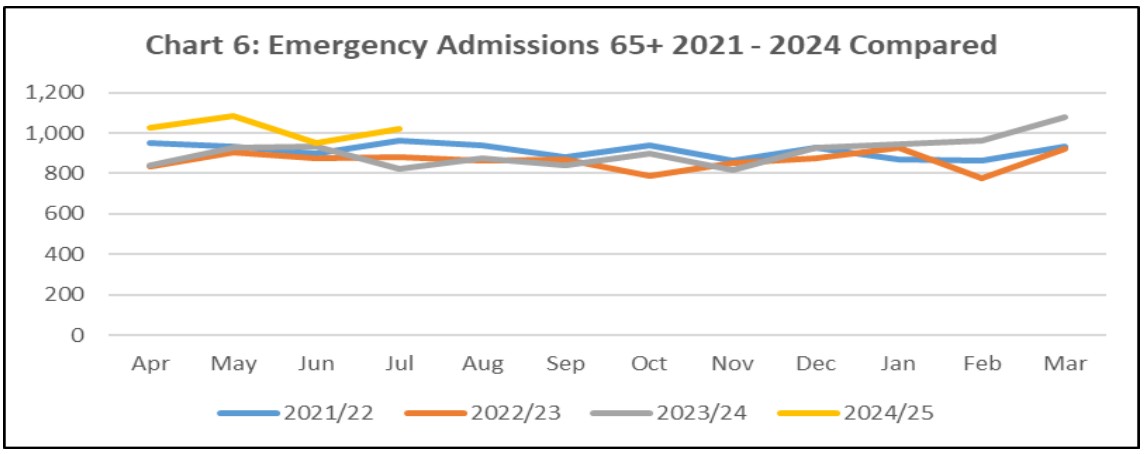
- **A & E Attendances and Emergency Admissions:** Between April 2023 and March 2024 there were 68,836 attendances, which is lower than in the two previous years. There were 28,367 emergency admissions during 2023/24, which exceeds the figures for each of the two preceding years and the conversion rate of attendances to admissions of 41% was slightly higher than the previous two years (37%). So far in 2024/25 the A&E attendances have continued to come down with 5,463 (Apr 24 – Jun 24) although the emergency admissions have remained higher with 2,930 so far to date in 2024/25. Charts 3 and 4 below show the attendances and admissions trends over the last three financial years.





A & E Attendances and Emergency Admissions 65 +: There were 18,216 attendances of people aged 65 and over during 2023/24 review period, which is higher than 2022/23 but lower than 2021/22. The conversion rate of attendances to admissions of 60% was higher than in 2022/23 but lower than 2021/22. So far, in 2024/25 the attendances have remained lower than the previous year with Jun 24 being lower than the last 3 years attendances. Charts 5 and 6 below show the attendances and admissions trends over the last three financial years.





- **Hillingdon Hospital bed occupancy:** *Slippage (Amber)* – The target occupancy level over the winter period was 92% but the average for the period 1 September 2023 to 31 March 2024 was 99%. Moving into 2024/25 the bed occupancy average has remained at 99% from April 2024 through to July 2024.

Workstream 3: Planned Care

Key Performance Indicator Updates

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

- **Patients waiting 52 weeks or more for surgery:** In March 2024 there were 479 people waiting 52 weeks or longer for surgery, which is a reduction of 749 (61%) on the same period in 2023. This is attributed to contracts that the ICB has established with the private sector.

- **% Patients receiving tests within 6 weeks of referral:** For the period April 2023 to March 2024 the average was 79.5%, which compares to 70% in 2022/23. So far in 2024/25 the average has increased to 90%.

- **% Urgent cancer referrals receiving diagnosis within 28 days:** For the period April 2023 to March 2024 the average was 71%, which is equal to the performance in 2022/23 and an improvement on 2021/22 (66%). So far in 2024/25 the average has increased to 81%.

- **Average waiting times in days for outpatients:** The average waiting time in days for 2023/24 was 140 days compared with 159 days in 2022/23 and 117 days in 2021/22, which indicates improvement but some distance to travel to get to

Workstream 4: Children and Young People

Workstream Highlights

Stronger Families Hub: The Council's Stronger Families Hub is the single point of contact for children, young people, and families in Hillingdon to access a wide range of support services 24/7. The model combines a social work led service, adult mental health service and the Hillingdon Multi-agency Safeguarding Hub (MASH). During the review period there were 5,868 enquiries with a wide range of reasons for the contact but the majority were socially unacceptable behaviour (10%), domestic Incident (8%), child's mental health (7%) and neglect (7%).

The main outcomes arising from the contact were information and advice (36%), statutory social care (27%) and referrals to other agencies (10%).

Key Performance Indicator Updates

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

- **Education, Health, and Care Plan (EHCP):** *Slippage (Amber)* - The national target for the completion of EHCPs is 20 weeks from referral. The local target is to achieve this in 80% of cases. The percentage of plans completed within 20 weeks between April – June 2024 was 52%. This is a 19% decrease over the same time period in 2023/24, which was 71%. **Keith/Sean** – I haven't been able to get explanation for the performance, which I suspect is down to staffing issues but don't know for certain. **Suggest removing.**

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

- **Estimated diagnosis rate for people aged 65 and over with dementia:** *Slippage (Amber)* – An outturn of 66.2% was achieved in 2023/24 against a target of 66.7%. The England average was 62.2%. The main reason for not meeting the target during this period, was due to temporary gaps in permanent staffing in the Memory Service. Locum support was in place but still impacted on diagnosis delivery at times. The learning from this is that some pathway changes are being developed to ensure there is sufficient workforce to cover during any staff absences.

Finance

There are no direct financial implications arising from this report.

BACKGROUND PAPERS

Joint Health and Wellbeing Strategy, 2022 – 2025

Appendix 1

Discharge Fund Spending Plan 2024/25

Table 1: 2024/25 Discharge Fund Allocation	
LBH Direct s31 Allocation	1,744,957
Total Provisional ICB DF Allocation to Hillingdon 2024/25:	2,590,881
TOTAL PROVISIONAL HILLINGDON HWB DF ALLOCATION 2024/25	**4,335,838**

Table 2: Updated Spending Plan	
LBH Direct Funding: s31 Grant	**Allocation**
Discharge-related residential	220,780
Discharge-related nursing	613,775
Discharge-related homecare	726,000
Block nursing dementia step-down	44,314
Deep clean & house clearance contract	8,000
Social Work 7-day Discharge	57,658
Additional Brokerage Capacity	63,960
Admin	10,470
LBH DIRECT FUNDING TOTAL:	**1,744,957**

ICB Contribution	**Allocation**
Additional Bridging Care Capacity	135,200
5 x Nursing Dementia step-down beds	278,128
P3 Block Nursing Step-down	56,235
Homefirst/D2A Rehabilitation (Therapy Bridging)	785,213
Rehab beds in Furness Ward, Willesden.	120,575
Supporting patients where there is unclear commissioning (non-CHC)	220,584
Central ICB Support for Borough based teams	50,500
Health funding for complex care patients in P3 beds/other settings. For conditions including dementia and challenging behaviour	934,446
Admin	10,000
ICB ALLOCATION TOTAL	**2,590,881**
TOTAL HILLINGDON 2024/25 DISCHARGE FUND ALLOCATION	**4,335,838**