2024/25 Better Care Fund Narrative Update

Please set out answers to the questions below. No other narrative plans are required for 2024-25 BCF updates. Answers should be brief (no more than 250 words) and should address the questions and Key lines of enquiry clearly.

2024-25 capacity and demand plan

Please describe how you've taken analysis of 2023-24 capacity and demand actuals into account in setting your current assumptions.

In previous planning submissions (including 2023/24) we have used acute SUS data combined with pathway proportions from the national discharge to calculate our discharge demand and capacity figures.

For the 2024/25 plan, we have used Oct 2023 to March 2024 discharge actuals from OPTICA (a discharge reporting and management tool) to inform our discharge demand modelling. As a sector, North West London ICS is focusing efforts into making the outputs of OPTICA the single source of truth. The tool was rolled out in 2023/24 but there were some issues around data over the first six months and this has therefore been excluded. Whilst we are confident of the pathway delineations in the discharge data, there is a cohort of data which has been recorded as unknown, which we have split out proportionally to actuals present. We have applied an 1 % growth to demand for 2024/25 in line with our local intelligence. Across the ICS there is an on-going process of data improvement and embedding of use OPTICA tool, so we expect that this will become more accurate over time, but would note that as this is a new tool there could be under-reporting and or misallocation of discharge demand which could then represent the impression of a capacity surplus, which may not be accurate.

For 2024/25 we have sourced our pathway 2 (P2) capacity data from our NHS community provider (CNWL), who has undertaken a data improvement exercise to more accurately report by borough; however, this has meant that we have used Feb to April 2024 data for our modelling, and are more confident in the integrity of this position as a result.

Figures for social care P0 demand reflect demand on the H4All Wellbeing Service operating at Neighbourhood level and are based on a pattern of activity over the last two years.
P1: It should be noted that Reablement and Rehab are separate services, as is the Bridging Care Service (aka short-term domiciliary care). Bridging and Reablement are delivered by an independent sector provider. The Rehab therapy (aka Therapy Bridging) is delivered by our community health provider, CNWL. Demand and capacity assumptions reflect that 81% of people receiving Bridging Care will also receive Therapy Bridging. 19% of P1 referrals will receive Therapy Bridging only. Length of stay in Bridging Care is approx 7 days and in both Reablement and Therapy Bridging it is 21 days.

P2 (reablement & rehab in bedded setting): Capacity reflects provision via the Hawthorn Intermediate Care Unit (HICU).

P2 (other short-term): Capacity is provided via blocks with Michael Sobell House Hospice that can be flexed to support people on P2. Shortfall in supply for P2 provision would be met through NHS provided facilities across NWL identified by the ICS Intermediate Care Escalation (ICE) Hub, which is a new development since the 2023/25 plan submission and all boroughs are contributing to the cost of these facilities through their ICB Discharge Fund allocation. For Hillingdon provision would mainly be located at Furness ward in Willesden. Supply is referred to as spot but would mainly be placed in services subject to ICB block contracts, although extra contractual referrals may occur in the absence of contracted supply.

Have there been any changes to commissioned intermediate care to address any gaps and issues identified in your C&D plan? What mitigations are in place to address any gaps in capacity?

It should be noted that the approach of the ICB in extending models of good practice across the ICS can be seen with Hillingdon's P1 Bridging Care Service that was introduced in 2018/19 and has now been rolled out to all boroughs in North West London (NWL), which has made a positive difference to P1 delays within the sector.

At an ICS level work is in progress to maximise the NHS bed stock for P2 patients (see 'Approach to Discharge Fund' below). A three-year block contract to 2027 for 10 nursing care home beds (including non-weight-bearing) has been established. A direct award for a three-year contract for 5 short-term nursing beds beds is in progress. This follows an abortive competitive tender exercise during 2023/24.

P2 bedded setting: The contingency of using blocks commissioned for end of life provision creates a vulnerability as dependent on there being availability when required. There is no desire to increase the number of block short-term care home beds as this has the effect of reducing the availability of local provision for long-term placements.

P3 beds: Supply includes two block contracts for a total of 15 beds with two providers. One three-year contract is in place and approval is being sought for the second, which will be 5 beds. Shortfall in supply will be met through spot purchases. The spot purchase of beds in 2023/24 secured provision eventually, but complexity of need was a significant factor in determining the gap between point of referral and placement. The average care home occupancy rate of 96% in Hilingdon is also a limiting factor. The challenges presented

by the reality of Hillingdon's care market is a driver for changes to the model of care in the borough reflected in the 2023/25 BCF submission and highlighted in the sections below.
What impacts do you anticipate as a result of these changes for:
i. Preventing admissions to hospital or long term residential care?
A key local focus is to prevent escalation of need leading to loss of independence and increase demand on acute care as well as services supporting people back into the community following an acute episode. This will be delivered through three Integrated Neighbourhood Teams anchored by PCNs delivering the Fuller Stocktake requirement to undertake more proactive case management of at risk cohorts and preventive work to maintain whole population health and wellbeing and to improve access to same day primary care for non-complex patients. Services will include community health services, community mental health hubs, third sector and community assets and aligned adult social care. The Neighbourhood Teams will use a PHM approach and mobilise local communities to tackle health inequalities with 3 core functions: 1. Same Day Urgent Primary Care Hubs for people with non complex needs - The three hubs are each expected to divert 28% of Hillingdon Hospital Emergency Department and 18% Urgent Treatment Centre attendees. 2. Proactive Care for at risk population cohorts with a emphasis on Frailty in the first instance. 3. Preventative Care for a range of population health JSNA priorities with an emphasis on hypertension, anxiety/depression and obesity in the first instance. Hillingdon lacks bed-based step-up provision and this will be mitigated through the deployment of Reablement and the Community Adult Rehab Service (CARS) and Urgent Community Response. There is no evidence of demand for step-up bedded provision as this is not recorded. To maximise opportunities for DFGs to enable more residents to remain in their usual place of residence a new policy revising the discretionary upper limit on grant thresholds will be introduced in 2024/25.
ii. Improving hospital discharges (preventing delays and ensuring people get the most appropriate support)?

The 2023/25 narrative plan described changes already in progress for 2024/25. Subsequent changes to this are reflected in this narrative tab in support of the use of the Discharge Fund shown below. It is important to note that Hillingdon is in the process of changing its operating model to develop an integrated Reactive Care Service that will bring together over 70 different commissioned health and care services with an annual contract value in excess of £70m (excluding Mental Health and Learning Disability Services) into a single service operating under a common core specification, single common leadership structure, lead organisation model and workforce passport (to enable flexible staff deployment across organisation). The aim is to deliver the same functions more cost effectively with the same or better outcomes through improved productivity and in so doing eradicating duplication and waste, breaking down barriers and silo working.	
Please explain how assumptions for intermediate care demand and required capacity have been developed between local authority, trusts and ICB and reflected in BCF and NHS capacity and demand plans.	
For community bed capacity for P2 discharges, the ICB and NWL LAs have worked closely with the NHS Community Provider Collaborative to develop an accurate position on P2 capacity. This is reflective of the NHS operating plan. Please note that we have not reported NHS community demand within the capacity tab, to avoid double counting of capacity. Hillingdon does not have any NHS delivered step-up beds that solely receive referrals from the community and attempts by the Council to secure longer-term block step-up provision in a care home setting have not been successful. The content of this template has been considered via the governance structure for Hillingdon's borough-based partnership known as Hillingdon Health and Care Partners, which includes representation from the third sector consortium, H4All, which is a HHCP member. H4All includes Age UK Hillingdon, Carers Trust Hillingdon, Disablement Association Hillingdon, Harlington Hospice and Hillingdon Mind. Healthwatch Hillingdon has also been involved. The role of DFGs in maintaining the independence of residents and avoiding demand as reflected in tab 6a: Expenditure, has been developed with the Council's DFG lead. The Corporate Director of Resources, who is accountable for the discharge of the Council's housing responsibilities, has also been involved in the plan's development.	
Have expected demand for admissions avoidance and discharge support in NHS UEC demand, capacity and flow plans, and expected demand for long term social care (domiciliary and residential) in Market Sustainability and Improvement Plans, been taken into account in you BCF plan?	**Yes**
Please explain how shared data across NHS UEC Demand capacity and flow has been used to understand demand and capacity for different types of intermediate care.	

The urgent community response projection was uplifted by 5%, in accordance with the known increase in demand relating to UEC. Our NHS community beds projections have been based on 2024 data, as such we believe the real time impact of UEC has therefore been factored into planning. The Council is using its full £4,554k MSIP allocation in 2024/25 to support the sustainability of Adult Social Care providers and maintain supply. The challenge in Hillingdon is with nursing care home supply and direct Council provision options to increase local capacity are currently being explored.						
Approach to using Additional Discharge Funding to improve						
Briefly describe how you are using Additional Discharge Funding to reduce discharge delays and improve outcomes for people.						

The majority of the LBH ADF (£1,560k) will be used to fund additional care home and homecare costs associated with the Home First model. It will also contribute to:
a) Step-down nursing/dementia nursing block contract.
b) Additional social work and LBH brokerage capacity to ensure weekend and bank holiday cover.
c) A deep clean and house clearance contract.

The ICB ADF allocation to the Hillingdon HWB will be used as follows:
a) Delirium Support Service contract to prevent P3 delays and additional demand on care home bed capacity. A model that makes use of extra care provision and the specialist Dementia Resource Centre located at the Grassy Meadow Court scheme and funded via the BCF, is under development.
b) Community based IV drugs administration to support discharge.
c) Additional assessment and review capacity to support people with health needs who do not qualify for CHC but are complex.
d) Funding for a block contract for an NHS service to reduce delays for people on P2 (Furness Ward, Willesden).
e) Step-down flats in extra care.
f) Phlebotomy capacity for the Rapid Response Team.
g) ICS delivered strategic support, e.g., BI support to improve access to data and produce analyses of its implications.
h) Additional therapy bridging capacity (CNWL provided), i.e., 16 slots.
j) Additional Comfort Care bridging capacity, i.e., 100 hours per week.
k) Contribution to step-down nursing block contract.

ADF allocations (b), (e) and (f) above were identified from a local self-assessment against the refreshed Transfers of Care High Impact Change Model. The intention is that (e) will come on-stream in October. The detail of some of these schemes is currently under-development in discussion with partners, including those likely to deliver the services. The conclusion of this process is expected to result in changes to use the funding shown in row 285 in tab 6a (Expenditure), which will be diversion from use of P3 beds to reduce demand on limited care home supply in the borough.

Please describe any changes to your Additional discharge fund plans, as a result from

- **Local learning from 23-24**

o the national evaluation of the 2022-23 Additional Discharge Funding (Rapid evaluation of the 2022 to 2023 discharge funds - GOV.UK (www.gov.uk)
Learning from 2023/24 More of the LA Discharge Fund has been allocated to address discharge-related placement and homecare costs, which addresses financial pressures associated with the Homefirst model. At an ICB level extensive improvements in the NHS bed stock have been made, such as all referrals being routed through the ICS Intermediate Care Escalation (ICE) hub to ensure that our capacity in our units is maximised. The intention is to improve access to the Furness Ward in Willesden, which will have the effect of improving access for Hillingdon P2 patients, who currently primarily use HICU, which is located in the borough, and the Clayponds Rehab Hospital located in Ealing. The allocation of the ICB Discharge funding set out above reflects the lessons learned from 2023/24. National evaluation of 2022/23 Additional Discharge Funding. No changes have been made arising from the rapid evaluation exercise as the recommendations were high level and primarily for the Government's consideration. The key conclusion about its benefits in securing earlier discharge is acknowledged and is continuing. The affordability of the Home First model for local authorities and therefore health and care systems is dependent on its continuation from April 2025.

Ensuring that BCF funding achieves impact						
What is the approach locally to ensuring that BCF plans across all funding sources are used to maximise impact and value for money, with reference to BCF objectives and metrics?						

Performance reports on BCF deliverables and metrics are considered by the Health and Wellbeing Board on a quarterly basis. It is also an expectation that a review of BCF schemes being undertaken at an ICS level will lead to a refinement of measures to test outcomes and value for money, although the full results of this exercise are likely to be implemented in 2025/26.
At an ICS level there is standardisation of additional discharge funding reporting and metrics and locally developed implementation trajectories to ensure that schemes deliver impact and funds are used effectively. Strategically the impact of this is overseen by the ICB Discharge Steering Group and operational issues resolved through the Place-based system discharge escalation process.