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Health and Social Care Select Committee

Councillors on the Committee

Councillor Nick Denys (Chair)
Councillor Reeta Chamdal (Vice-Chair)
Councillor Tony Burles
Councillor Philip Corthorne
Councillor Kelly Martin
Councillor June Nelson
Councillor Sital Punja (Opposition Lead)

Date: **TUESDAY, 25 FEBRUARY 2025**

Time: **6.30 PM**

Venue: **COMMITTEE ROOM 5 - CIVIC CENTRE**

Meeting Details: The public and press are welcome to attend and observe the meeting.

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Terms of Reference

Health & Social Care Select Committee

Portfolio(s)	Directorate	Service Areas
Cabinet Member for Health & Social Care	Adult Services & Health	Adult Social Work (incl. Direct Care and Business Delivery, Provider & Commissioned Care)
		Adult Safeguarding
		Hospital & Localities
		Adult Learning Disabilities & Mental Health
		Adult Social Services transport and travel
		Health & Public Health (incl. health partnerships, health inequalities & Health Control Unit at Heathrow)
		Health integration / Voluntary Sector
	Homes & Communities	The Council's Domestic Abuse services and support (cross-cutting)
		Services to asylum seekers

STATUTORY COMMITTEE	<u>Statutory Healthy Scrutiny</u> This Committee will also undertake the powers of health scrutiny conferred by the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. It will: • Work closely with the Health & Wellbeing Board & Local Healthwatch in respect of reviewing and scrutinising local health priorities and inequalities. • Respond to any relevant NHS consultations. <u>Duty of partners to attend and provide information</u> The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, imposes duties on 'responsible persons' to provide a local authority with such information about the planning, provision and operation of health services in the area of the authority as it may reasonably require to discharge its health scrutiny functions through the Health & Social Care Select Committee. All relevant NHS bodies and health service providers (including GP practices and other primary care providers and any private, independent or third sector providers delivering services under arrangements made by clinical commissioning groups, NHS England or the local authority) have a duty to provide such information.

	Additionally, Members and employees of a relevant NHS body or relevant health service provider have a duty to attend before a local authority when required by it (provided reasonable notice has been given) to answer questions the local authority believes are necessary to carry out its health scrutiny functions. Further guidance is available from the Department of Health on information requests and attendance of individuals at meetings considering health scrutiny.

Agenda

5 Adult Social Care Early Intervention and Prevention - First Witness Session

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ADULT SOCIAL CARE EARLY INTERVENTION AND PREVENTION REVIEW – FIRST WITNESS SESSION

Committee name	Health and Social Care Select Committee
Officer reporting	Kelly O'Neill – Adult Social Care and Health, Hillingdon Council Gavin Fernandez – Adult Social Care and Health, Hillingdon Council Gary Collier – Adult Social Care and Health, Hillingdon Council
Papers with report	None
Ward	All

HEADLINES

1. At its meeting on 12 November 2024, the Committee approved the terms of reference for the review of Adult Social Care Early Intervention and Prevention. This report provides the Committee with information about demand, approaches to prevention (early intervention is a form of prevention), describes the interface with health partners and expands on some of the preventative services commissioned by the Council.

2. The importance of tackling prevention across health and social care and shifting away from treatment is one of the three priorities of the NHS 10 year forward plan, and the expectation is that, through health and care systems, we work together to invest in evidence-based prevention services, driven by building health education that leads to sustained behaviour change.

3. Local authorities are the place-makers of healthy communities, the local system provider organisation responsible for public health and the interventions and services that have the greatest impact on improving health, reducing the risk of long-term ill-health. Elected Members are the decision makers who influence health as a key outcome in all policy decisions. Whether this is through community development and inclusion, neighbourhood regeneration, new planning and infrastructure development where there is an overt focus on creating a healthy borough where the healthiest option is the easiest option.

4. The health impact of local authorities, through early years services, education, training and employment, is building the local economy to the benefit of residents to increase incomes, that leads to more affordable quality homes in safe areas, where residents have access to leisure and parks as safe spaces.

5. There are a broad range of interventions and services that are the responsibility of local authorities that make a greater contribution to prevention, early intervention and improving health and wellbeing of residents of all ages than any service provided by the NHS or wider health and care services. These include:
   - Universal services for families that protect the vulnerable and prevent children being at risk and coming into care services.
   - Taking action to prevent violence against individuals and communities.
   - Helping to reduce the risk of homelessness.

- Preventative action that delays the onset of frailty, through falls prevention programmes.
- Funding of the voluntary, community and social enterprise (VCSE) sector to provide support for older people and preventing them becoming lonely, isolated and marginalised.

6. As the population ages, people are living longer lives but with more years being unhealthy, which increases demand on health and long-term care services. A key challenge is that. if action is not taken to support residents to live healthier, more independent lives, to prevent or delay the onset of ill-health, the cost of health and social care will be increasingly unaffordable.

RECOMMENDATIONS

That the Health and Social Care Select Committee:

a) notes the content of the report; and

b) question officers on any aspect of the report.

SUPPORTING INFORMATION

Strategic Context

7. Table 1 shows the changes in Hillingdon's population between 2011 and 2021 and projected to 2021.

Table 1: Hillingdon's Changing Population 2011 - 2031			
Age Range	**2011**	**2021**	**2031**
All ages	273,936	305,910	341,709
18 - 64	172,638	193,369	214,109
65 +	35,178	41,175	48,194
80 +	9,871	11,677	13,813

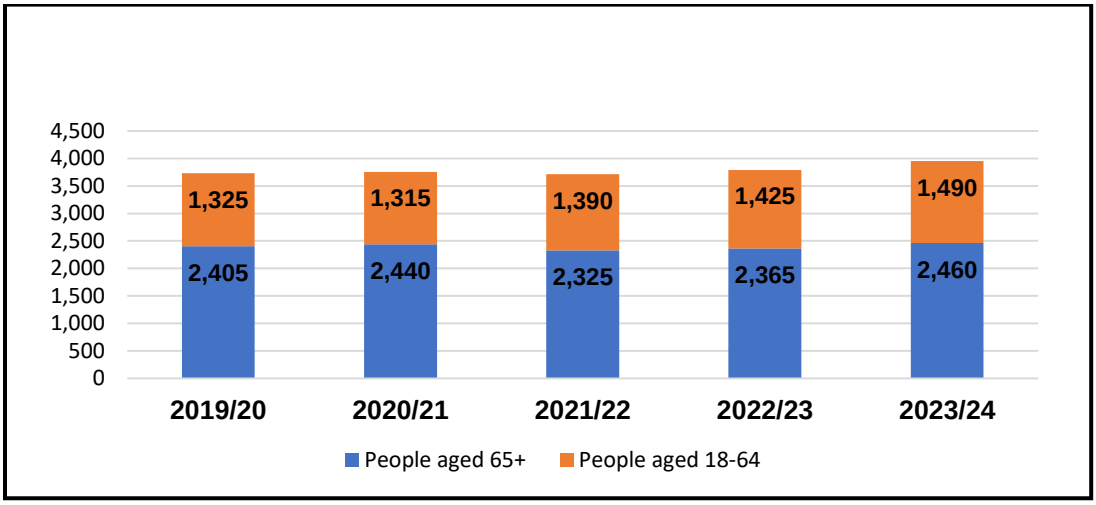
8. Some key headlines for the Committee's information include:
   - Health data shows that 48% (127,264) of the 18+ population registered with a Hillingdon GP are living with one or more long-term health conditions, which makes Hillingdon comparable with Harrow for having the highest weighted average percentage of people with long-term conditions in North West London (NWL)[1].
   - The top five long-term health conditions in the Borough are hypertension, anxiety, depression, obesity and diabetes. Hypertension accounts for approximately 50% of all unplanned hospital admissions in older adults and 20% in adults of working age, which is increasing year on year. It is common to see people affected by more than one of these five conditions at the same time.
   - Data shows that people aged 65 and above account for approximately 13% of the resident Hillingdon population, and as higher health and care services users their activity makes up over 30% of GP and unplanned and urgent acute (Accident and Emergency) attendances and 40% of emergency hospital admissions.
   - 4,400 residents (approximately 1.4% of the population in 2023) account for 50% of

[1] NHS North West London's Whole Systems Integrated Care (WSIC) database. Weighted average means that the calculation is based on data 'weighted' to its importance as a contributing factor.

all emergency admissions to hospital.

- Nearly 29% of the 22,465 unpaid carers (2021 census) provide 50 or more hours of care a week and therefore a greater risk to their health and wellbeing.

9. Figure 1 shows the increase in the numbers of people receiving long-term care by two age groups between 2019 and 2024. The activity data shows a 4.5% increase in people aged 18 -64 requiring long-term care between 2022/23 and 2023/24 and a 3% increase for residents aged 65 years and over. Overall, there was a 2.2% increase in the number of people aged 65 years plus requiring long-term care from 2019/20 to 2023/24 and a 13% increase for people aged 18 to 64.



Source: LG Inform – NHS England, Adult Social Care Activity and Finance Report

10. During the period 1 April to 31 December 2024, 3,967 people received Adult Social Care services. 57% (2,256) were people aged 65 and above. The demand for long-term Adult Social Care is driven by the needs of:

- *Older people living with dementia:* 21% of older people in long-term care have dementia as their primary need and 66% of their care needs are to manage physical health and activities of daily living.
- *Working aged adults, aged 18-64 with mental health needs:* there has been a 450% increase in referrals between 2019 and 2024: from 285 referrals in 2019 to1,286 in 2024.
- *People with learning disabilities/autism:* the Council provides care support for approximately 40 people a year who transfer from children to adult social care services.
- *People with an autism only diagnosis*: there has been approximately a 20-fold increase in the number of people supported from 18 people in 2019 to 350 in 2024.

11. The significant increase in referrals and care being delivered reflects not only an ageing population but an increasing number of people living with long-term conditions. Other factors are likely to include families being less available to provide support, people living longer without a carer and changing diagnoses.

12. This reinforces the importance of greater focus on prevention and early intervention to keep people healthier and independent for longer to maximise the opportunities for residents to live fulfilling lives and manage the unprecedented increased demand for health and social care services.

13. The Health and Wellbeing Board, which brings together health and care system leaders, is currently reviewing how partners within Hillingdon's health and care system can collectively achieve more investment into evidence-based prevention and early intervention. This is being done as part of the process of refreshing the statutory joint local health and wellbeing strategy, which will set out a joint approach to tackling the complex issues that affect Hillingdon's population both now and in the near future.

14. The focus of this report is on prevention and early intervention that supports residents to improve health, delay the onset of ill-health and frailty, and reduce demand on Adult Social Care.

Preventative Approaches

15. Improving health and wellbeing that enables people to live independent lives and reduce the prevalence of long-term conditions such as hypertension, cancers, cardiovascular disease, diabetes and tackle the rising risk of frailty for older residents, thereby reducing demand for long-term social care services, is a priority. It is also one that will be the primary focus of the revision of the Hillingdon Older Person's Plan. Fundamental to keeping people living healthier lives for longer is the need for more ambitious approaches to prevention and early intervention, where all statutory public sector organisations understand their roles and responsibilities and how this contributes to that outcome. This will allow Hillingdon residents to be more engaged in taking responsibility for their own health and have the health education that leads to healthier choices. It will also give access to universal and targeted prevention services that risk assesses their health and wellbeing and is a gateway to early intervention services.

16. Prevention and early intervention services at population level target population groups at their most vulnerable based on risk – some are based on helping people to live healthier lives. Examples include:
    - Healthy eating and the programmes that support supplementation of women's diets during pregnancy and in the first stage of a child's life, promoting breast and infant feeding.
    - Infant non-cancer health screening, i.e., physical examination and newborn blood spot screening that screens for genetic conditions.
    - The universal vaccination programme for children and young people.
    - Cancer screening and NHS Health Checks for adults, which is a key screening programme for identifying risk of long-term conditions.
    - Seasonal vaccinations for older people.
    - Core strengths-based programmes to encourage older people to stay steady and active to reduce the risk of falls that can lead to access to long-term care.

17. In addition, there is the importance of tackling loneliness and social isolation, that supports inclusion and mental health, keeping people engaged with their neighbourhoods and communities, through the developing of carer networks that support people with dementia and other progressive diseases. The Council's investment into VCSE organisations provides focused support to enable people to lead better lives. The important action is to ensure that those who most need this service are accessing it, and this is achieved through localised teams of health and social care professionals working together as Integrated Neighbourhood Teams (INTs).

18. There are three INTs in Hillingdon that work in defined geographical areas and are working together to improve health and wellbeing outcomes; risk stratifying people most at risk of ill health and of associated hospital admission, at risk of increasing dependence as they become unable to self-care, which results in poorer lives and greater demand for costly care services is undertaken within the three INTs.

19. A partner from the Hillingdon Health and Care Partnership has been asked to attend the March witness session to explain this to the Committee in more detail.

Current Prevention Services

20. There are a range of services commissioned by the Council with the primary outcome to prevent or delay the need for care services, including more intensive (and therefore restrictive) levels of care and support. In 2024/25, the total cost of these services is £6,341,000. The main funding sources for these services are the Public Health Grant (PHG) and the Better Care Fund (BCF). The PHG is an annual grant from the Office of Health Improvement and Disparities (OHID) and the Department of Health and Social Care (DHSC) that supports non-statutory services where the primary function is improving health and wellbeing outcomes. The BCF is a Government initiative intended to facilitate local health and care systems to work closer together to enable people to remain independent in their own homes for as long as possible and to expedite discharge from hospital following an admission.

21. The Committee is advised that, over the last two years, there has been a proactive programme of moving services from being grant funded to contracts with clear deliverables that contribute to outcomes. This shift from an annual funding cycle to formal contracts gives providers more stability and it has particularly affected services delivered by VCSE organisations. For the Council, this has provided the opportunity to bring services together and to create partnerships that are more efficient. In 2024/25, competitive tenders have taken place for contracts with providers for up to eight years and Cabinet in March 2025 will be asked to approve contract award recommendations.

Information, Advice and Guidance (IAG)

22. Access to IAG is critical to enabling residents to making informed choices about how they stay healthy and independent and has targeted those needing care and support and their carers.

23. There are currently four different third sector organisations (Age UK, Bell Farm Christian Association, Citizens' Advice Bureau and the Disablement Association Hillingdon) delivering IAG services through five separate contracts at a total cost of £1,020,000. These providers were previously funded through annual grants from the Public Health Grant. These budgets have been combined into a single service contract and, in March 2025, Cabinet will be asked to approve an award of contract to one provider. The new service model reinforces the need for outreach, going out to residents in their communities and improving access through technology. The new provider will be asked to attend the witness session at the Committee's June meeting to explain how the new model will work in practice and effectively reach neighbourhoods and communities who are the most vulnerable.

Community Equipment Service

24. The Community Equipment Service (CES) provides the following services to children and adults:
    - *Equipment loans service (ELS):* This service supplies equipment ranging from raised toilet seats to electric profiling beds and hoists.
    - *Minor adaptations:* This provides adaptations to residents' homes, e.g., grab rails by a door or a toilet and/or bath, valued up to £1k.
    - *Door entry systems:* These facilitate authorised access to the homes of residents where the resident is unable to directly open their front door because of a disability.

25. The CES has a critical part in supporting the independence, safety and quality of life of Hillingdon's residents of all ages who are living with a physical disability and/or a sensory impairment. The service predominantly focuses on people aged 65 and over. The scope of the contract includes the supply, delivery fitting and installation, adjustment, servicing and testing, collection, refurbishment, recycling and disposal of items of equipment. The £2,202,000 budget for the service is funded from the BCF and, during the period April to December 2024, 9,944 Hillingdon people were supported.

Reablement Service

26. Reablement, is a non-chargeable, goal-focused intervention that involves intensive, time-limited assessment and therapeutic work over a period of up to six weeks (but possibly for a shorter period), generally provided in the person's own home.

27. The service is delivered by Comfort Care Services Ltd and provides out of hours support for the telecare service (see below) where residents do not have a responder or where they cannot be contacted.

28. The service identifies and assesses a person's own strengths and abilities by focusing on what they can safely do instead of what they cannot do anymore. The service is funded by the NHS via the BCF and in 2024/25 the budget is £1,198,000. Between April and December 2024, the service supported 821 people, 74% (606) of whom were people discharged from hospital. The remaining 26% (215) were people referred from the community needing support to maintain independence and avoid hospital admission.

29. A key measure of the services' effectiveness is the extent to which recipients leave the service without need for long-term care and continue not to require care 90 days after discharge from the service. From April to December 2024, 548 people left the service without the need for ongoing care, and did not require care within 90 days: an estimated cost avoidance of £1,836,000.

30. The Adult Social Care Outcomes Framework (ASCOF) includes a national performance measure that applies to Reablement. The measure is: *Proportion of new service users that received a short-term service during the year where the sequel to service was either no ongoing support or support of a lower level (%).* The goal is a high percentage and Hillingdon's score in 2023/24 was 89.1%, which compares to 77.6% for London and 79.4% and is an increase of 9.1% from 80% in 2022/23.

31. ASCOF includes a second performance measure which is: *Proportion of older people (aged 65 and over) who received reablement services after discharge from hospital*. As above, the goal is a high percentage and, in 2023/24, this was 2.4%, which was an improvement on the 2022/23 outturn of 1.9% but was below the London regional average of 4.3% as well as that for England, which was 3%.

Carer Support Service

32. The Carer Support Service contract aims to support both young carers and adult carers in Hillingdon and is currently delivered by the Carers Trust Hillingdon and Ealing, the lead provider for the Hillingdon Carers Partnership.

33. This contract provides information, advice and access to home-based replacement care and externally delivered short break opportunities. The annual update report was considered by the Committee as part of the Joint Carers Strategy on 24 July 2024. The report showed how successful the provider had been in securing additional income for carers and in generating externally funded carer-led activities outside of the contract. The report can be accessed via the following link: https://modgov.hillingdon.gov.uk/ieListDocuments.aspx?CId=421&MId=4774&Ver=4

34. Between April to September 2024, the Hillingdon Carers Partnership supported 492 new adult carers and 142 new, young and young adult carers, i.e., carers aged 16 to 24, and provided 1:1 support to 2,867 carers.

35. The Committee is advised that, in March 2025, Cabinet will be asked to approve an award of a new contract following a competitive tender. As with the IAG service referred to above, the successful provider will also be asked to attend the witness session at the Committee's June 2025 meeting to explain how the new model will work in practice.

Mental Health Early Intervention/Prevention Programme

36. During the period April to December 2024, 91 new adults with mental health needs were referred into the service, 325 people were supported in group activities, there were 750 outreach contacts and 1,200 emotional support calls. During this reporting period, 66% people supported reported improved mental wellbeing, whilst 21% reported that their wellbeing had been maintained. 68% reported improvements in community engagement and 55% in their living skills.

37. This service has also been the subject of a competitive tender and Cabinet, in March 2025, will be asked to make an award of a contract decision.

Technology Enabled Care

38. Technology enabled care (TEC) is the use of technology to provide health and care services to people in their own homes to assist them to live independently and safely. Telecare is an example of TEC. This is a monitoring and alert system that supports people to live independently in their own homes. It works through the telephone system and links alarms, sensors and equipment in a person's home to an adviser in a control centre. The funding for the service (£380,000) is from the BCF. There were 720 new installations between April and December 2024.

39. The Committee is asked to note that the Hillingdon service offer is currently under review and it proposed that the TEC plan be considered at a future witness session as part of a broader exploration of the opportunities presented by tech enabled care.

Mental Health Floating Support Service

40. The mental health floating support service is provided by Ability Housing Association and the annual £323,000 cost funds the provision of 350 hours of support for people living with mental health needs who has been referred by a mental health professional and agreed with the Council's Service Manager for Mental Social Work. Support can be provided for up to two years and includes:

- Assistance in setting up and maintaining a home/tenancy, including support with maintenance, repairs, payment of rent and arrears.
- Advice, advocacy and liaison, including support to access and secure other services, signposting to specialist advice services and community groups, developing self-advocacy skills.
- Support with developing independent living skills, such as budgeting and paying bills, support to apply for benefits, support within funding and securing alternative accommodation and with moving home.
- Wellbeing and general support, including emotional support and advice, support with monitoring own health and wellbeing and signposting to health services.
- Prompting Service Users to take prescribed medication.

Hospital Discharge Mental Health Floating Support Service

41. This service is delivered by Ability Housing and was established as a pilot to provide transitional support for 32 hours a week for a total of 8 people from the point of initial hospital discharge planning through to moving into their own accommodation in the community. The service is intended to provide support for up to three months,

42. The service supported 14 people between 1 April and 31 December 2024. This low number is due to service mobilisation issues related to recruitment of staff and the consequent delay in raising awareness of the service within Hillingdon Hospital and Riverside Mental Health in-patient unit. The annual cost of £50,900 is funded by the NHS through the BCF. The contract has been extended until 30 November 2025 and a review will be undertaken early in 2025/26 to determine whether the pilot will be continued and mainstreamed.

Admiral Nurse Service

43. Admiral Nurses are specialist mental health nurses who support carers of people with dementia and their families, providing specialist advice and support that enables the carers of people living with dementia to maximise the amount of time they can continue in their caring role; to help carers attain and maintain their optimum health and welfare to support a person with dementia to continue to live in the community for as long as possible. The provision of this type of service is pivotal in preventing a breakdown in the relationship between the carer and the person being cared for which can result in the Council having to provide more expensive packages of care or placements into residential and nursing care.

44. The service costs £59,200 which provides one of two mental health nurses employed by the Central and North West London NHS Foundation Trust (CNWL), who deliver

the service under a licence issued by Dementia UK, who own the '*Admiral Nurse'* brand.

45. During 2023/24, the service received 212 new referrals each month and there was an average of 143 open cases each month leading to 1,924 activities to support families affected by dementia.

Home from Hospital

46. Home from Hospital Service supports older people to return to their usual home following a hospital admission where the person does not require a package of care. The support comes from Age UK volunteers visiting older people discharged from hospital three times a week for a six-week period and linking them into other support services based on their needs.

47. The service is part of a broader contract between North West London Integrated Care Board (ICB) and Age UK and is based in A & E at Hillingdon Hospital. The service aims to avoid hospital admission and support older people to return home following a hospital admission. 78% of the cost of the contract is funded by the ICB and the Council contribution is from funding within the BCF. Between April and December 2024, the service supported 155 residents to safely return home from hospital.

Contract Monitoring

48. The ASC Contracts and Supplier Relationship Team are responsible for monitoring contracted providers. The Council is currently in the process of strengthening its Adult Social Care commissioning infrastructure to include increasing contract management capacity. This will be funded in part from income streams within the BCF. A combination of increased capacity and a reduction in the number of contracts will facilitate proportionate monitoring and whether services are meeting the intended outcomes stated for residents.

RESIDENT BENEFIT

49. The approach and related services addressed in this report are intended to support the continued independence of residents, prevent ill-health and reduce or delay the demand for more intensive, restrictive and expensive types of care.

FINANCIAL IMPLICATIONS

Table 2 below summarises the income streams within the BCF that are referred to elsewhere in this report. An update on the BCF will be provided to the Committee in due course.

Table 2: Summary of Better Care Fund Income Streams 2024/25

Income Stream	Value (£)
Minimum NHS Contribution	24,164,009
Additional NHS Contribution	3,096,967
ICB Discharge Fund	2,590,881
NHS TOTAL	**29,851,857**

Minimum LBH Contribution	13,042,692
Additional LBH Contribution	55,385,658
LBH Discharge Fund	1,744,957
LBH TOTAL	**70,173,307**
TOTAL BCF VALUE	**100,025,164**

There are no direct financial implications arising from this report.

LEGAL IMPLICATIONS

There are no legal implications arising from this report.

BACKGROUND PAPERS

None.