Public Document Pack

HILLINGDON
LONDON

A

Health and Social Care Select Committee

Councillors on the Committee

Councillor Nick Denys (Chairman)
Councillor Philip Corthorne Vice-Chairman)
Councillor Adam Bennett
Councillor Tony Burles
Councillor Reeta Chamdal
Councillor June Nelson
Councillor Sital Punja (Opposition Lead)

Date: **TUESDAY, 21 NOVEMBER 2023**

Time: **6.30 PM**

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

Meeting Details: Members of the Public and Press are welcome to attend this meeting

This agenda and associated reports can be made available in other languages, in braille, large print or on audio tape. Please contact us for further information.

Published: Monday, 13 November 2023

Contact: Nikki O'Halloran
Email: nohalloran@hillingdon.gov.uk

This Agenda is available online at:
https://modgov.hillingdon.gov.uk/ieListMeetings.aspx?CommitteeId=421

Lloyd White
Head of Democratic Services
London Borough of Hillingdon,
Phase II, Civic Centre, High Street, Uxbridge, UB8 1UW
www.hillingdon.gov.uk

Useful information for residents and visitors

Travel and parking

Bus routes 427, U1, U3, U4 and U7 all stop at the Civic Centre. Uxbridge underground station, with the Piccadilly and Metropolitan lines, is a short walk away. Limited parking is available at the Civic Centre. For details on availability and how to book a parking space, please contact Democratic Services. Please enter from the Council's main reception where you will be directed to the Committee Room.

Accessibility

An Induction Loop System is available for use in the various meeting rooms. Please contact us for further information.

Attending, reporting and filming of meetings

For the public part of this meeting, residents and the media are welcomed to attend, and if they wish, report on it, broadcast, record or film proceedings as long as it does not disrupt proceedings. It is recommended to give advance notice to ensure any particular requirements can be met. The Council will provide a seating area for residents/public, an area for the media and high speed WiFi access to all attending. The officer shown on the front of this agenda should be contacted for further information and will be available at the meeting to assist if required. Kindly ensure all mobile or similar devices on silent mode.

Please note that the Council may also record or film this meeting and publish this online.

Emergency procedures

If there is a FIRE, you will hear a continuous alarm. Please follow the signs to the nearest FIRE EXIT and assemble on the Civic Centre forecourt. Lifts must not be used unless instructed by a Fire Marshal or Security Officer.

In the event of a SECURITY INCIDENT, follow instructions issued via the tannoy, a Fire Marshal or a Security Officer. Those unable to evacuate using the stairs, should make their way to the signed refuge locations.

Terms of Reference

Health & Social Care Select Committee

To undertake the overview and scrutiny role in relation to the following Cabinet Member portfolio(s) and service areas:

Cabinet Member Portfolios	• Cabinet Member for Health & Social Care
Relevant service areas	1. Adult Social Work 2. Adult Safeguarding 3. Provider & Commissioned Care 4. Public Health 5. Health integration / Voluntary Sector

Statutory Healthy Scrutiny

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.

Duty of partners to attend and provide information

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.

Cross-cutting topics

This Committee will also act as lead select committee on the monitoring and review of the following cross-cutting topics:

- Domestic Abuse services and support

Agenda

CHAIRMAN'S ANNOUNCEMENTS

Minutes

HEALTH AND SOCIAL CARE SELECT COMMITTEE

10 October 2023

Meeting held at Committee Room 5 - Civic Centre

	Committee Members Present: Councillors Nick Denys (Chairman), Philip Corthorne (Vice-Chairman), Adam Bennett, Tony Burles, Reeta Chamdal and June Nelson **LBH Officers Present**: Suzi Gladish (Head of Safeguarding Arrangements), Bukky Junaid (Assistant Director, Access to Support Services), Sandra Taylor (Corporate Director of Adult Services and Health) and Nikki O'Halloran (Democratic, Civic and Ceremonial Manager)
22.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence had been received from Councillor Sital Punja (Councillor Robin Sansarpuri was present as her substitute).
23.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* There were no declarations of interest in matters coming before this meeting.
24.	**MINUTES OF THE MEETING HELD ON 13 SEPTEMBER 2023** *(Agenda Item 3)* It was agreed that the reference to "42 GPs" should be amended to "42 GP practices". **RESOLVED: That the minutes, as amended, be agreed as a correct record.**
25.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 4)* **RESOLVED: That all items of business be considered in public.**
26.	**HILLINGDON SAFEGUARDING PARTNERSHIP ANNUAL REPORT 2022-2023** *(Agenda Item 5)* The Chairman welcomed those present to the meeting. Ms Suzy Gladish, Head of Safeguarding Arrangements, advised that the report covered the work of the Safeguarding Partnership during 2022/2023 and detailed a vision of all rights being protected. Although the focus at this meeting would be on safeguarding adults, it was noted that there were mirrored arrangements for safeguarding children. Partners such as the local authority, Metropolitan Police Service (MPS) and NHS bodies had equal responsibility for safeguarding in the Borough and, as such, made up a shared Executive Leadership Board. It was recognised that there was a crossover between safeguarding children and safeguarding adults as children existed in families with adults and vice versa. A

summary of both areas of work had been included in the report.

Ms Gladish advised that an external review had been undertaken which had focussed on the adult MASH (Multi Agency Safeguarding Hub) function which intended to identify whether or not the needs of specific individuals had been met. The review found that Hillingdon had a strong partnership which was open to being scrutinised and strove to improve practice. The partnership had strong leadership with all partners having equal responsibility and provided an environment of high support / high challenge, where difficult conversations were encouraged.

Concern was expressed in relation to the possibility that information could get lost in the system. Ms Sandra Taylor, the Council's Director of Adult Social Care and Health, advised that all contact came through the Council's Contact Centre and was screened and reviewed by the team. All cases were dealt with within 48 hours but those that were urgent would be dealt with immediately. The MASH was a safety net and records were maintained, should further enquiries arise in relation to the cases of specific individuals. This was particularly useful with regard to cases of neglect and self neglect. Ms Taylor was confident that issues were addressed and dealt with as quickly as possible to ensure that the individuals were safe from potential harm. Whether or not a case was subsequently closed would depend on the nature of the situation as, for example, there might be an ongoing police investigation. The families also needed to be involved and informed.

Ms Bukky Junaid, the Council's Assistant Director Access to Support Services, advised that the MASH was made up of social workers who had daily meetings to discuss high risk cases with Housing, MPS, CNWL, THH, Children's Services, NWL Integrated Care Board, etc. Calls about issues that had not been on partners' mental health radar could come into the Contact Centre and a referral made direct to the relevant team who would identify the risk level and put an action plan in place. Checks would be made to see if the individual had been previously known to partners and, if they were, the allocated social worker would be notified. However, the team would still go through the screening and triage process even if the individual was not already known to partners.

Members queried why there had been significant improvements in relation to the total number of referrals that progressed to a Section 42 Adult Safeguarding enquiry (a 50% reduction). Ms Junaid noted that protection plans were being put in place which had reduced this figure. Ms Taylor advised that the team had been able to reduce the time taken to close cases through a restructure and a review of how cases were dealt with. This had been a positive process for staff and gave professionals space and time to gather enough information to identify the support needed to be able to close cases. Immediate triage at the front door had also really helped to close cases much quicker and manage the demand more effectively.

There had been an increase in the number of Safeguarding Adult referrals reported during 2022/23 (a 13% increase). Ms Taylor noted that the police had been making lots of reports every day so officers had been working with the MPS / Safer Neighbourhood Team to reduce unnecessary contacts. Should the number of reports made by the police continue to increase, additional resources would be needed to strengthen the team, consideration would need to be given to why the police were making so many reports and partners would need to be asked to provide some help. Efficiencies had been developed recently so that the service was safer, quicker and more responsive. Intensive support and early intervention had helped to manage demand.

Ms Gladish advised that the Mental Health and Safeguarding Sub Group had identified and shared local and national practice and sought to reduce neglect. The Sub Group had developed links with health-led strategic forum and had attempted to have shared priorities and pull things together so that it was less confusing. Local quality assurance practices were being scrutinised.

The Voice of the Person used lived experience to develop a questionnaire and the findings had been presented to the Safeguarding Adults and Children's Boards. The information gathered had provided insights to help inform how improvements were made.

Members were advised that the Safeguarding Adults Board had set up Sub Groups to work on a range of task and finish priority areas such as self-neglect, domestic abuse and neglect. Each Sub Group had used a framework of prevention, identification and response to gain an insight to then be able to make improvements. The Domestic Abuse Sub Group had focussed on the Domestic Homicide Review and how to disseminate learning from the review and put appropriate training in place. The breadth of topics was huge. A Sub Group would set its own terms of reference. The Domestic Abuse Sub Group had completed its action plan and had therefore been shut down. The Practice Development Sub Group covered adults and children and pulled together the work of all of the Sub Groups as well as other issues, so domestic abuse remained high on the agenda even if the specific Sub Group for that issue had ended.

Although the partners had equal responsibility when it came to safeguarding duties, concern was expressed that this did not always appear to be true and Members queried whether there were any gaps that needed to be filled. Ms Gladish advised that the Sub Groups were chaired by partners wherever possible and that attendance at these meetings had been good across the Partnership but that action was being taken to get partners more involved. An escalation process had been put in place regarding non-attendance by partners. The Safeguarding Partnership team was small, largely independent of the Council and chaired some of the Sub Groups.

A key area of work had been in relation to hoarding behaviours that might pose a risk and awareness raising activities had been undertaken in relation to suicide prevention, mental health awareness and safe internet usage. Support had also been given by wearing red to show racism the red card.

Learning from Practice Frameworks had been put in place to promote continuous improvement of safeguarding practice by learning from serious incidents. A safeguarding learning event had also taken place to disseminate learning with themes about lived experience and challenges in identifying and responding to coercive and controlling behaviour and the role of diagnostic overshadowing for adults with mental health difficulties and physical health needs.

The Quality Assurance Framework had been introduced in the previous year and had included the Voice of the Person view and the function of the Community MARAC (multi-agency risk assessment conferences) in safeguarding adults who self neglect through hoarding. The Safeguarding Adults IT audit tool had been released and feedback provided as it had not been fit for purpose.

A broad range of training had been offered across the formal and informal partnerships, particularly in relation to female genital mutilation. A webinar programme had been

introduced with each session lasting approximately 90-120 minutes (available online). A late cancellation policy had also been introduced for training sessions and the impact of this was currently being assessed. A webinar and practice briefings had been produced in relation to safeguarding adults with mental health concerns.

Insofar as training was concerned, each partner had its own safeguarding lead who was responsible for disseminating information to colleagues about what training was available and what was compulsory each year. The training offer was done through strategic leads in each agency who drove demand and supervision to identify training needs. When issues were identified within reviews, consideration was given to what training was available and the offer was adapted accordingly by providing webinars, etc.

Ms Gladish advised that a new newsletter was being produced approximately every six weeks to provide practitioners with an overview of key practice developments as well as information about any changes to legislation.

The local authority had seen a substantial increase in the number of Safeguarding Adult referrals (up by 13% on the previous year). Measures had been put in place to stop some escalations and ensure Care Act compliance - neglect was one of the biggest issues that needed to be addressed.

The MPS had been challenged by the increase in reports of domestic abuse, with the West Area having the highest rates in London and the Child Abuse Investigation Team having the fourth highest volume in London.

The North West London Integrated Care Partnership (NWL ICP) had been driving the uptake of health checks for adults with learning disabilities and safeguarding forms had been supplied to GP practice managers.

Central and North West London NHS Foundation Trust (CNWL) had reviewed its referral forms to include mental capacity. Over 600 people had attended CNWL's annual domestic abuse conference including a growing network of people with lived experience.

The Hillingdon Hospitals NHS Foundation Trust had focussed on training and making adult safeguarding training a mandatory course. It had also been possible to collocate the HIDVA (Hillingdon Independent Domestic Violence Adviser) at Hillingdon Hospital and work had been undertaken in relation to ensuring safe discharge.

The Safeguarding Adults Board priorities for 2023-24 would be in relation to neglect and learning from practice. The Voice of the Person would weave through all work undertaken.

Members queried how individuals knew who specific issues needed to be reported to and how they received feedback. Ms Gladish advised that awareness raising was important to ensure that people knew where to go with issues of concern. A Safeguarding Adults Week was held each year when posters were displayed about various forms of neglect that an adult might experience. Ms Junaid advised that safeguarding was everyone's business but that the Council screened and triaged the calls and emails that came in. What action was then taken would depend on the nature of the report. Action would be taken to ensure that the person was safe before then making enquiries as to what other action needed to be taken.

	Ms Taylor advised that the Safeguarding Partnership shared information and would distribute awareness-raising posters. There had been a huge campaign a few years previously and this needed to be revisited and reinvigorated to prompt people to at least think about reporting issues of concern. Concern was expressed that harder to reach communities might have more safeguarding issues than those communities that were easier to engage. Ms Gladish advised that the professional network had to reach out to these communities and had engaged with faith groups and others via webinars to deliver training and resources. Information was also shared with the Stronger Communities Team but it was difficult to measure how successful this action had been. Members asked about the Strategic High Risk Panel (SHRP) which related to children's safeguarding and whether this helped to mitigate the issue of children from minority groups being treated as being older than they were. Ms Gladish advised that this Panel was led by colleagues in Childrens' Services but that Listen Up provided training on 'adultification' and that consideration needed to be given to the language that was used (for example, saying 'children' instead of 'youths'). Work had also been undertaken with community health in relation to the need to protect children as they were children first and foremost. The SHRP worked at a high level to unstick any blockages and deal with adultification and racism. **RESOLVED: That the Health and Social Care Select Committee:** **1. be reassured that the partnership continues to provide leadership and scrutiny of the safeguarding arrangements for Hillingdon residents.** **2. be updated regarding the way in which the partnership has responded to the challenges posed by changing local, national and international contexts.** **3. be informed of the strategic priorities for safeguarding for 2022-23.**
27.	**UPDATE ON THE IMPLEMENTATION OF RECOMMENDATIONS FROM PAST REVIEWS - GP PRESSURES** *(Agenda Item 6)* Consideration was given to the report. Members were aware that the review had been undertaken before the pandemic and that, subsequently, some of the recommendations were slightly out of date. Notwithstanding this, the Committee acknowledged that there were still significant pressures on GPs and, whilst they were happy for any future updates to be included in general health update meetings, it would be useful for reference to be made to the review recommendations where appropriate. With regard to GP appointments, Members asked that further information be provided on the number that were offered in person versus by telephone or virtual. They also requested that they receive an update on the new appointment system that had been introduced and information on who patients could complain to if they were not happy. Other GP-related issues raised at the meeting included: 1. how many complaints received had been in relation to appointments and how quickly these issues were resolved; 2. how many patients did not attend; and 3. how many patients were able to see the same doctor each time they attended the practice. It was agreed that these GP related issues be picked up in a single meeting review on

	21 February 2024. Members were aware that Section 106 (s106) money from planning applications was often used to improve local services. It was agreed that officers be asked to provide a report on the use of s106 money on health-related services in the Borough and accounted for tangibly. **RESOLVED: That:** **1. reference be made to the recommendations from the GP Pressures when providing health updates, where appropriate;** **2. a single meeting review be undertaken on 21 February 2024 in relation to GP-related issues;** **3. Ms Nicola Wyatt be asked to provide a report on the use of s106 money on health-related services in the Borough; and** **4. the report be noted.**
28.	**CAMHS REFERRAL PATHWAY - DRAFT REVIEW RECOMMENDATIONS** *(Agenda Item 7)* Consideration was given to the draft recommendations for the review of the CAMHS referral pathway. It was agreed that the draft recommendations be circulated to the witnesses that had attended the witness sessions to get their views. **RESOLVED: That the draft recommendations be circulated to the witnesses for their views.**
29.	**CABINET FORWARD PLAN MONTHLY MONITORING** *(Agenda Item 8)* **RESOLVED: That the Cabinet Forward Plan be noted.**
30.	**WORK PROGRAMME** *(Agenda Item 9)* Consideration was given to the Committee's Work Programme and the impact of assistive living technologies. **RESOLVED: That the Work Programme be noted.**
	The meeting, which commenced at 6.30 pm, closed at 7.50 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on nohalloran@hillingdon.gov.uk. Circulation of these minutes is to Councillors, officers, the press and members of the public.

CARERS STRATEGY DELIVERY UPDATE

Committee name	Health and Social Care Select Committee
Officer reporting	Gary Collier – Adult Social Care and Health
Papers with report	Appendix 1: Case Studies Appendix 2: Draft 2023 – 2028 Joint Carers Strategy and Delivery Plan.
Ward	All

HEADLINES

1. The contribution of carers to the health and wellbeing of those they care for is significant and the purpose of a carers' strategy is to demonstrate what the Council and its partners are doing to support carers in the Borough. In Hillingdon, the importance of supporting carers is recognised by all health and care partners as being critical to the sustainability of the local health and care system.

2. This report precedes the annual update to Cabinet on the delivery of the Carers' Strategy Delivery Plan that will be considered in December 2023. The report is intended to give the Committee the opportunity to consider the update before Cabinet so that any comments it may have can be reflected in that report. Cabinet requested an annual update in 2015 and this practice has continued. The Committee agreed to align carers strategy delivery updates to the annual Cabinet reporting cycle.

3. A new strategy covering the 2023 to 2028 period is currently under consultation, which is addressed in more detail later in this report.

4. Pending the completion of the new strategy, a delivery plan was developed for 2022/23 that was considered by the Committee at its June 2022 meeting. A draft delivery plan for the period 2023 to 2028 has been completed and is subject to the outcome of consultation on the draft strategy. This report updates the Committee on the delivery of the 2022/23 plan as well as providing progress on the delivery of the plan for 2023/24. It also gives the Committee the opportunity to comment on the draft strategy. The work of the Council and partners in supporting carers is illustrated with case studies that can be found in **Appendix 1** to this report.

Who can be a carer?

5. There are three statutory definitions of who is a carer, and these are as follows:

- *Parent carer:* The Children Act, 1989 defines this term as a person aged 18 or over who provides or intends to provide care for a disabled child for whom the person has parental responsibility.
- *Young carer:* The Children Act, 1989 defines this term as being someone under 18 who helps to look after another person but not under a contract or scheduled voluntary work.
- *Adult carer:* The Care Act, 2014 defines this as an adult, i.e., a person aged 18 or over, who is providing care and/or support for another adult for free but not under a contract or scheduled voluntary work.

6. The Children Act places a duty on the Council to undertake an assessment where it appears that a young carer may have support needs. The Council is required to consider how needs identified from an assessment should be met. There is a similar obligation under the Children Act where a parent carer appears to have support needs or requests an assessment.

7. The Care Act creates a statutory right for adult carers to a carer's assessment and the Council may have an obligation to assist them even if the person they are caring for does not satisfy the national eligibility criteria. This would be subject to them satisfying the national eligibility criteria for carers. Where the cared for person is eligible for social care assistance from the Council, then the support needs of the carer would generally be considered as part of an overall package of care to address their collective needs.

8. The Committee can access more information about the Council's offer to support carers of all ages by visiting the following link on the Council's website:
https://www.hillingdon.gov.uk/socialcare

9. References to the '*review period'* in this report means the period from 1 April 2022 to 31 March 2023 unless otherwise stated.

10. The report is structured as follows:
A. Strategic Context
B. 2022/23 Delivery Plan Update Highlights
C. 2023 – 2028 Joint Carers' Strategy Update.
D. 2023/24 Carers Strategy Delivery Plan Progress Update

RECOMMENDATIONS

That the Committee:
1. **notes progress against the Carers Strategy delivery plan activity for 2022/23 and against the delivery plan for 2023/24.**
2. **comments and questions officers and partners on any aspects of the report.**
3. **identifies any comments it wishes to include in the annual delivery plan update report to Cabinet.**

SUPPORTING INFORMATION

A. Strategic Context

11. Carers say that supporting someone to live an independent life at home, in the community they know, can be very rewarding. However, the cost to carers in terms of their own health, financial situation, employment position and independence can be considerable. In Hillingdon we want to enable our residents to recognise and identify their role as a carer, so they know where to access the right support.

12. There are three main sources of information about the numbers of carers in Hillingdon and these are:
- *The 2021 census:* This is the main source of data about carers in Hillingdon. It showed that there were 22,465 people who identified themselves as carers in March 2021 when the census took place. This was an unexpected drop from 25,905 identified from the 2011 census and reflects the national picture. The Office of National Statistics (ONS) has

identified that the co-occurrence of coronavirus lock-down arrangements as well as changes to the questions asked may have influenced how people perceived and managed their provision of unpaid care, and therefore may have affected how people chose to respond. The tables below provide an age-breakdown and comparison with the 2011 census. A more detailed breakdown of census information is available in **Appendix 2**.

Age Breakdown of Carers in Hillingdon 2011 and 2021 Censuses Compared		
Carer Age Group	**2011 Census**	**2021 Census**
0 - 24	2,569	1,875
25 - 64	18,676	16,625
65 +	4,660	3,965
TOTAL	**25,905**	**22,465**

Age Breakdown of Carers in Hillingdon 2021 Census Young and Young Adult Age Breakdown	
Carer Age Group	**Number**
5 - 18	660
19 - 24	1,215
25 - 64	16,625
65 +	3,965
TOTAL	**22,465**

- *The Carer Register:* The Carer Register was established by Carers' Trust Hillingdon and is maintained by them. Registration by carers is entirely voluntary but is a key route by which information can be targeted by Carers' Trust. As of 30 September 2023, there were 1,287 young carers and 4,962 adult carers registered, which compares with 1,187 young carers and 4,790 adult carers registered on 31 March 2023, which is positive in that it both enables relevant information to be targeted to carers but also enables partners to obtain a greater understanding about the needs of carers in the Borough.
- *Short and long-term (SALT) return:* This is the annual return that the Council is required by law to provide to NHS Digital about people supported (including carers) under its Care Act responsibilities. The return for 2021/22 (the most recent date for which comparative data is available) shows that on 31 March 2022 1,534 people being supported by the Council had support from people identified as their '*main carer*'. These carers were not identified as receiving a service directly themselves or as benefitting from a service being provided to the cared for person.
- *Carers Allowance recipients*: This is benefit available to people providing 35 hours of unpaid care a week or more to a severely disabled person. Data published by the Department for Work and Pensions showed that in May 2023 (the most recent period for which data is available) there were 3,975 people entitled to receive Carers Allowance (CA). People providing this level of care are most vulnerable to experiencing a deterioration in their own health and wellbeing without support. However, the 2021 identified 9,105 carers delivering 35 hours of care or more a week. This demonstrates that there are many people providing significant hours of unpaid care who do not qualify for this additional benefit, therefore limiting its use as a measure of this population.

13. Data from the National Carers' Survey commissioned jointly by the Department of Health and Social Care (DHSC) and Care Quality Commission (CQC) undertaken in November 2021 provides some qualitative information about adult carers already known to the Council who completed the survey. This survey was commissioned by the Department of Health and Social Care and the Care Quality Commission (CQC) and the data sample, which is the carers receiving a carer's assessment in the previous twelve month period, and collection methodology are determined nationally. 677 of Hillingdon's adult carers were sent a survey questionnaire and 34% (233) were returned 233 (34%), which was considered to be statistically valid by DHSC

and CQC.

14. The survey results showed that Hillingdon had the highest proportion of adult carers who found it easy to find information about support out of all the North West London (NWL) boroughs, i.e., Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea, and Westminster. It also showed that Hillingdon received the highest quality of life scoring out of the NWL boroughs. The main actions identified from the survey results and reflected in the strategy delivery plan are summarised below:

- To embed the use of the '*Are you a carer?*' leaflet across health and care partners as standard practice.
- To explore expansion of Personal Budgets for carers, including as Direct Payments.
- To work with care home providers to develop flexible short-break options for carers.
- To continue to develop the range of social opportunities for carers, including peer support groups.

15. The Committee may wish to note that a repeat of the National Carers Survey is currently in progress as part of the two-year cycle as directed by DHSC and CQC.

16. The Committee is reminded that the main offer of support to young and adult carers in the Borough comes through the Carer Support Service contract between the Council and Carers Trust Hillingdon (CTH), which is the lead organisation for the Hillingdon Carers' Partnership. The latter is a consortium of local third sector organisations that has been created to support carers in the Borough. In addition to Carers' Trust, the consortium includes the Alzheimer's Society, Harlington Hospice (including their homecare arm called Harlington Care) and Hillingdon Mind. The Committee may be interested to note that the funding for this service, i.e., £690k, is included in the Better Care Fund (BCF).

17. The multi-agency Carers' Strategy Group (CSG), which is chaired by the Council, has responsibility for overseeing the development and delivery of the Joint Carers Strategy. The diagram below summarises the partners involved in supporting carers.

18. Annex 3 of **Appendix 2** shows how the Carers' Strategy Group fits in to the governance arrangements for Hillingdon's health and care system.

B. 2022-23 Delivery Plan Update Highlights: Challenges and Achievements

2022/23 Challenges

19. This part of the report highlights for the Committee some of the key challenges in 2022/23 and progress against the 2023/24 delivery plan. Challenges in 2022/23 included:

- The mental health legacy of caring for people during the pandemic, especially where caring responsibilities had arisen unexpectedly resulting in increased numbers seeking support. This has continued into 2023/24, which has seen an increase of nearly 47% from 164 in 2022/23 to 241 during the first six months of 2023/24.
- Financial implications of being a carer, e.g., loss of employment income, being exacerbated by the cost of living crisis.
- Impact on physical health of carers not taking a break (or not being able to take a break) from their caring responsibilities during the pandemic. This may be a contributing factor to an increase in permanent admissions to care homes being seen in 2023/24.

- Convergence of pressures on mental health of carers from caring role, anxiety about financial concerns and impact on physical health.

2022/23 Delivery Plan Updates

20. The agreed actions for 2022/23 shown below are aligned to the outcomes in the draft strategy that was under development during 2022/23. Where actions have been rolled forward into 2023/24, an update is provided where available. The Committee is asked to note that there were no specific actions identified against outcome 3: *The financial impact of being a carer is minimised*, in 2022/23.

Outcome 1: Carers are identified, recognised and able to make a positive contribution.

21. **Re-establish carer leads in six GP Primary Care Networks (PCNs).** *Slippage (Amber).* By the end of 2022/23, 39 of the 44 practices in Hillingdon had established carer leads. ***2023/24 update***: This has reduced to 33 as people have moved on or taken on other responsibilities and joint work between The GP Confederation and Carers Trust continue to move towards 100% coverage, which remains the goal but is unlikely to be achieved in 2023/24.

Carer Leads in GP Surgeries: The Role Explained

Key tasks include:

- Proactively identifying and supporting carers, many of whom do not see themselves as carers;
- Ensuring that a surgery Carer Register is maintained and updated regularly;
- Ensuring the practice provides active signposting to the Hillingdon Carers' Partnership;
- Ensuring that standardised packs of information for carers are available within the waiting room;
- Feeding into The Confederation and its partners, e.g., Hillingdon Carers Partnership and the ICB, any gaps in provision or requirements to help practices to support carers further;
- Working with colleagues in the practice to provide enhanced access and flexibility of appointments for carers;
- Considering how else the practice might facilitate improved carer-health – monthly carer health checks for example;
- Attending any training/information sessions that relate to the support of carers within General Practice.

22. **Subject to permission to share information, undertake comparison of carers on GP registers with those on carers' register developed by the Carer Support Service to identify gaps in support.** *Slippage(Amber).* Liaison with practices regarding the ability to cross reference carers registers started in 2022/23. ***2023/24 update***: It has become apparent that this action cannot be taken forward as Care Trust Hillingdon does not record NHS numbers and it is not practical to expect carers would have this information available when being added to the Carer Register.

23. **Finalise the '*Are you a carer?*' information leaflet.** *Completed (Green).* This co-produced leaflet was distributed to all health and care partners. ***2023/24 update***: The leaflet has been updated and a new supply has been distributed to partners. Hard copies of the leaflet will be made available at the Committee's November meeting.

24. **Establish auto-generated reporting of carers with multiple caring responsibilities**.

Completed (Green). This work was instigated by Councillor Haggar when she was the Carers Champion and means that it is now possible to identify carers at risk of escalating needs as a result of multiple caring responsibilities. These risks are addressed through the process of review care needs. This work is now part of business as usual.

25. **Review the role of the Carer Fora**. *Slippage(Amber).* ***2023/24 update***: Following discussion at the Carers Strategy Group, it has been agreed to retain the current two meetings a year. These take place at the Civic Centre in March and October.

26. **Refresh the Hospital's visiting rules, introduce carer passports and promote '*John's campaign'* to ensure that carers are involved in care and are able to support patients during a stay.** *Completed (Green).* The Hillingdon Hospitals' visiting rules have been updated and are stated on their website along with the commitment to '*John's campaign'* statement.

About John's Campaign

This is a nationally recognised campaign to support carers to remain with the people they care for whilst they are in hospital. A carer should be facilitated to stay with the person they care for and to contribute to their care. This applies in any settings such as hospitals, GP surgeries and care homes.

27. **Hillingdon Hospital: Ensure that the Cerner electronic patient record (EPR) system is developed so that asking if a patient has a carer or is a carer is a mandatory aspect of assessment and triggers appropriate care planning (if possible and where appropriate).** *Slippage (Amber).* ***2023/24 update***: This is part of a large digital technology project and the aim is that this action will be completed by the end of 2023/24. It is becoming operational across three wards from November 2023.

Outcome 2: The physical and mental health and wellbeing of carers is supported.

28. **Refresh the Memorandum of Understanding on an integrated approach to identifying and assessing carer need in Hillingdon**. *Slippage (Amber).* **2023/24 update:** The Memorandum of Understanding (MoU) is a shared commitment of the Council and partners to the vision, mission, supporting principles and intended outcomes for carers set out in the draft Joint Carers Strategy. Development of the MoU is dependent on the conclusion of the strategy and will be deferred until 2024/25 pending the conclusion of the consultation on the strategy. The action would renew the MoU entered into by partners in December 2017.

29. **Develop the range of bereavement cafés and post-bereavement support available to carers**. *Completed (Green).* CTH working with Hillingdon Mind established support groups for bereaved carers and a bespoke bereavement counselling service for carers was established.

Outcome 4: Carers have a life alongside caring.

30. **Explore re-launch of the guidance for employers of carers in employment**. *Slippage (Amber).* Guidance for supporting employers of people who are carers was produced by the Council with Carers Trust Hillingdon in 2019 and it has been agreed with partners that a refresh of this guide be deferred to 2024/25.

Outcome 5: Carers have access to quality information and advice at any point in their caring journey and know where to find this.

31. **Include information about support for carers on GP practice web pages.** *On track (Green):* 60% of GP practices had information on their websites regarding support for carers. ***2023/24 update:*** A target of 100% was set for 2023/24. The position is currently nearly 82%.

32. **Hillingdon Hospitals: Ensure that the Patient Advisory and Liaison Service (PALS) has the necessary information and resources to signpost carers and patients with carers to access support.** *Completed (Green):* Joint working with Carers Trust ensured that relevant information was available and displayed in 2022/23. ***2023/24 update:*** A task for 2023/24 is to establish a means for ensuring that PALS information is kept up to date.

33. **Hillingdon Hospitals: Develop process to ensure that carers have access to information, advice and support about the hospital discharge process and what to expect after discharge.** *Completed (Green):* Discharge checklists now include involvement of carers and the carer information booklets are provided to show how carers can get support.

Outcome 6: Carers have the skills for safe caring.

34. **Develop end of life training for carers**. *Completed (Green):* Three rounds of three sessions were offered to carers in 2022/23. ***2023/24 update:*** The 2023/24 offer has increased to three rounds of four sessions. The training has been delivered jointly by Harlington Hospice and Carers Trust.

Outcome 7: Young carers (YCs) are supported from inappropriate caring and provided with the support they need to learn, develop and thrive and enjoy being a young person.

35. **To work alongside a group of schools to:**

- **Raise awareness and reissue newly designed Schools packs.** *Completed (Green):* A targeted approach to sharing the new information packs developed by Carers Trust Hillingdon with the schools they were already working with was taken to ensure that the information was embedded and to assist in the creation of pupil, parents and staff noticeboards. This approach was also intended to manage capacity and reduce waste as it ensured that packs were received and utilised.
- **Encourage them to complete the national Young Carers in Schools (YCiS) award:** *Completed (Green):* 4 schools have achieved their YCiS bronze award. A further 6 schools submitted their bronze accreditation paperwork by March 2023.
- **Develop their own young carer support provision:** Oakwood School have initiated their own YC peer mentoring programme where sixth form pupils provide support for young carers in younger years. All 12 schools supported by CTH has worked with now offer a lunchtime drop-in session with their Young Carers Operational Lead staff member.
- **Provide support sessions in school for the most disadvantaged YCs, usually those caring for a parent with mental ill health and/or substance misuse:** *Completed (Green):* There were 1,203 attendances by 192 individual young carers at school support sessions during 2022/23.
- **Recruit a pool of volunteer mentors to support them to catch up in maths and English:** 9 volunteer mentors were recruited and started 1:1 support for young carers in schools in September 2023.

Achievements

36. Partner achievements during the review period that are in addition to the specific actions within the 2022/23 delivery plan are highlighted below for the Committee's consideration.

Council Achievements

37. ***Carers Assessments (Adults):*** There were 851 carers' assessments undertaken in 2022/23, which includes 286 triage assessments completed by Carers' Trust. This compares to 810 assessments in 2021/22 and 211 triage assessments undertaken by Carers' Trust. Triage assessments are much shorter than the full assessment and are used by Carers' Trust to help a carer identify whether they are likely to receive support from the Council, which would only be obtainable following a full assessment. In 2022/23, Carers' Trust referred 142 carers to the Council for a full assessment.

38. The Committee is reminded that adult carers of adults are routinely identified by Adult Social Care through the assessment of need process under the Care Act and a carer assessment offered. As reported to the Committee in the June 2022 update, our experience is that many carers decline the offer. For example, in 2022/23, 3,960 carers assessments were offered to 2,733 people and nearly 76% (or 3,003) were refused. In 2021/22, 81% of assessments offered were refused. The experience during the first six months of 2023/24 mirrors the 2022/23 position. The Committee is reminded that the reasons given for declining an assessment include people who consider that the assessed care package for the person they are caring for sufficiently addresses their needs; people not wanting to identify themselves as carers, and those who feel that the services available through the Hillingdon Carers Partnership meets their needs. Feedback through the Carers Forum suggests that some carers fear that assumptions will be made about the level of caring that they are prepared to undertake if they are identified as a carer.

39. It is important that the Committee is aware that carers who do not wish to go through the carer assessment process may still access the universal services provided under the Carer Support Service contract previously mentioned. This is also the case with carers assessed as not meeting the national eligibility criteria for carers.

40. ***Respite and other carer-related service provision*****:** During 2022/23, 3,970 carers were provided with respite or another carer service at a cost of £2,004k. This compares to 3,338 carers being supported at a cost of £2,059k during 2021/22. This includes bed-based respite and home-based replacement care funding arranged via the Council as well as support provided through the Carer Support Service contract and other voluntary sector provided services. It also includes directly purchased services via Direct Payments. The cost of services to meet needs identified as a result of a Care Act assessment of the cared for person that benefit the carer are not included as it is not possible to apportion the costs on the Council's case management IT system.

41. The Committee may also wish to note that 2021/22 saw an increase in the number of carers receiving Direct Payments in their own right from 103 to 133. There was no change to the actual numbers of carers receiving Direct Payments to meet all or part of their assessed needs in 2022/23.

More About Direct Payments

With Direct Payments the Council's financial contribution to meeting assessed social care needs is paid directly to the eligible person either in the form of a pre-paid card or directly into a bank account. This gives the eligible person more flexibility and control to directly employ their own care workers or a personal assistant who will, for example:

- Be the same person and be available when required.
- Speak the same language.
- Understand cultural and/or religious needs.

Hillingdon Carers' Partnership Achievements

42. The section of the report summarises some of the achievements of the Hillingdon Carers Partnership (HCP) in 2022/23 and during the first six months of 2023/24.

43. ***New carers registered:*** 1,000 new adult carers joined the carers register during 2022/23 against a target of 750 and 429 left. 460 new adult carers joined during the first six months of 2023/24 and 242 left. 317 new young carers joined the register in 2022/23 against a target of 50, and 25 left.

44.***New carer representatives:*** Two new carer representatives to join the Carers Strategy Group as experts by experience were found, one of them being a parent carer.

45. ***Additional income for carers raised:*** £837,153 was secured in carer-related benefits in 2022-23

46. ***Replacement care*****:** 9,500 hours of replacement care received by adult carers.

47. ***Short breaks (adult carers):*** 2,644 breaks from caring were provided through carer cafés, trips (e.g., visits to arts, crafts, and cultural activities), social groups and workshops.

48. **Short breaks (young and young adult carers):** In 2022/23, there were 2,586 individual breaks from caring including:

- 4 residential weekends away for 63 young people.
- 34 different activity sessions as part of CTH school holiday programme.
- 71 Young Carer Club sessions.
- 7 whole family trips attended by 193 family members.

49. **Psychotherapeutic and family support**: Via Hillingdon Mind, 91 carers in 2022/23 received psychotherapeutic support and 83 households received family support.

50. **Outreach events**: 29 outreach events were held in 2022/23 that resulted in 152 new carers being identified. 76 of these were from a series of roadshows run by H4All and 39 from the annual Carers Fair held at The Pavilions.

51. **Dementia café:** A new dementia café was established at the Gurdwara Temple in Hayes in 2022/23 as a collaboration between the Alzheimer's Society and CTH and this has attracted attendance from people of other faiths and under-served communities.

52. **External funding attracted to support carers:** In 2022/23, £108.4k additional funding was

secured from external funders, i.e., not local statutory organisations, and this included £90k from the British and Foreign School Society, which has increased CTH staff capacity to meet demand for their Schools Support Programme. During the first half of 2023/24, HCP has secured an additional £652.2k in external funding and this includes £530k over five years to continue the Carer Mental Health Programme led by Hillingdon Mind and £65.2k over three years from the Masonic Charitable Foundation to fund a part-time school outreach development manager post employed by CTH.

CNWL Community Adult Mental Health Service Achievements

53. **Introduction of DIALOG+ approach across community mental health services:** CNWL started the roll out of the DIALOGUE + approach in 2022/23. The idea behind this approach is that all patients within adult community mental health services should have a named worker and a co-produced care plan so there is consistency and improved quality of care across the population. The care plan tool seeks to identify carers and address their needs.

54. **Triangle of Care roll out across community mental health teams**: £40k has been provided by CNWL to fund a post with Hillingdon Mind to support the roll out of the Triangle of Care model (see below) and facilitate CNWL accreditation by Carers Trust UK.

Triangle of Care Expanded

There are six standards to the Triangle of Care, and these are:

1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
2. Staff are '*carer aware'* and trained in carer engagement strategies.
3. Policy and practice protocols re: confidentiality and sharing information, are in place.
4. Defined post(s) responsible for carers are in place, e.g., Carers' leads or champions.
5. A carer introduction to the service and staff is available, with a relevant range of information across the care pathway, e.g., an introductory letter from the team or ward explaining the nature of the service provided and who to contact.
6. A range of carer support services is available.

C. 2023 – 2028 Joint Carers' Strategy

55. The Committee was asked to consider the proposed vision, mission, supporting principles and outcomes at its meeting in June 2022 and these were broadly accepted. **Appendix 2** sets out the final draft strategy and delivery plan to deliver the intended outcomes for carers for the period up to 2028. The Committee is reminded that some of the key challenges that the strategy seeks to address include:

- Identification of young carers.
- Identification of '*hidden*' adult carers.
- Identification of carers from under-
- Offering carer assessments in a way that works for all carers.
- Provision of short-break options for

represented communities, e.g., male carers.
- Ensuring that parent carers are recognised and supported.
- Identification and support for carers through primary care.

carers.
- Involving a range of carers at a strategic level to shape what services look like in the future.
- Managing impact of cost of living crisis on carers.
- How technology can be used more to help carers carry out their role.

56. Consultation on the draft strategy is now in progress and is expected to conclude in Q4. The Carers Forum has been consulted in the development of the strategy and the intention is to also consult with the following groups:

- Hillingdon Health and Care Partners
- CNWL Service User/Carer Forums
- GP Practice Patient Participation Groups
- Faith Network Groups
- Young Adult Carer Consultation Group

57. The questions being asked as part of the consultation are:

- Are the identified outcomes for carers the right ones?
- Are there any other actions that health and care partners could take that would make a major difference to the health and wellbeing of carers?
- Have we identified the right success measures?

58. As reported to the Committee in June 2022, the challenge is how to measure the impact of support provision for carers without necessitating the creation of a resource intensive bureaucracy that detracts from service delivery.

D. 2023/24 Delivery Plan

59. This section of the report provides the Committee with progress updates on 2023/24 delivery plan actions where information is available. Progress against actions rolled over from 2022/23 has been addressed in part B of this report.

60. ***Relaunch the Carer Support Service Carer Register***: There will be an article in Hillingdon People in the spring that will seek to encourage people who might be carers to contact Carers Trust and register.

61. ***Refresh the Memorandum of Understanding between health and care partners on an integrated approach to identifying and assessing carer need in Hillingdon***: This is related to the Joint Carers Strategy being agreed and is being deferred to 2024/25.

62. ***Retender the Carer Support Service contract***: A direct award is being made to CTH on behalf of the HCP until 31 March 2025 and a competitive tender will be undertaken during 2024/25. It is proposed that a contract of up to eight years be offered to secure provider stability and support service planning.

63. ***Explore options for increasing the percentage of adult carers supported by the Council having needs met via Direct Payments***: The Direct Payment process is under review and ways of simplifying it being explored. The target is for the review to be completed by 31 March 2024 and the outcomes implemented during 2024/25.

64. ***Develop a programme to ensure that information and advice is accessible to Hillingdon's diverse communities:*** The CTH advice team staff speak multiple community languages and have established relationships with Hillingdon's diverse communities over many years. The team has actively supported the H4All Community Roadshow programmes delivered in partnership with The Confederation, including hosting stalls at community and bespoke events. The monthly support group at the Gudwara Temple in Hayes hosted by the Alzheimer's Society has been mentioned previously in this report but contributes to the delivery of this action.

65. ***In consultation with carers, keep under review their training need and develop an annual training programme with health and care partners***: Two new services have been established by CTH and these are:

- **Finding your Way – an introduction to caring.** This is support with finding the right help and an opportunity to meet others new to caring for newly registered carers at CTH's regular coffee and chat sessions.
- **Caring day-to-day.** These are training and information sessions as requested by carers of any age. Sessions cover topics such as: '*Care Homes Explained'*, '*Finding your way round Social Care*' and '*Legal Planning'*.

66. ***Review the young carers assessment process***: Children's Service are working with CTH to simplify the assessment form, which will then be tested with young carers.

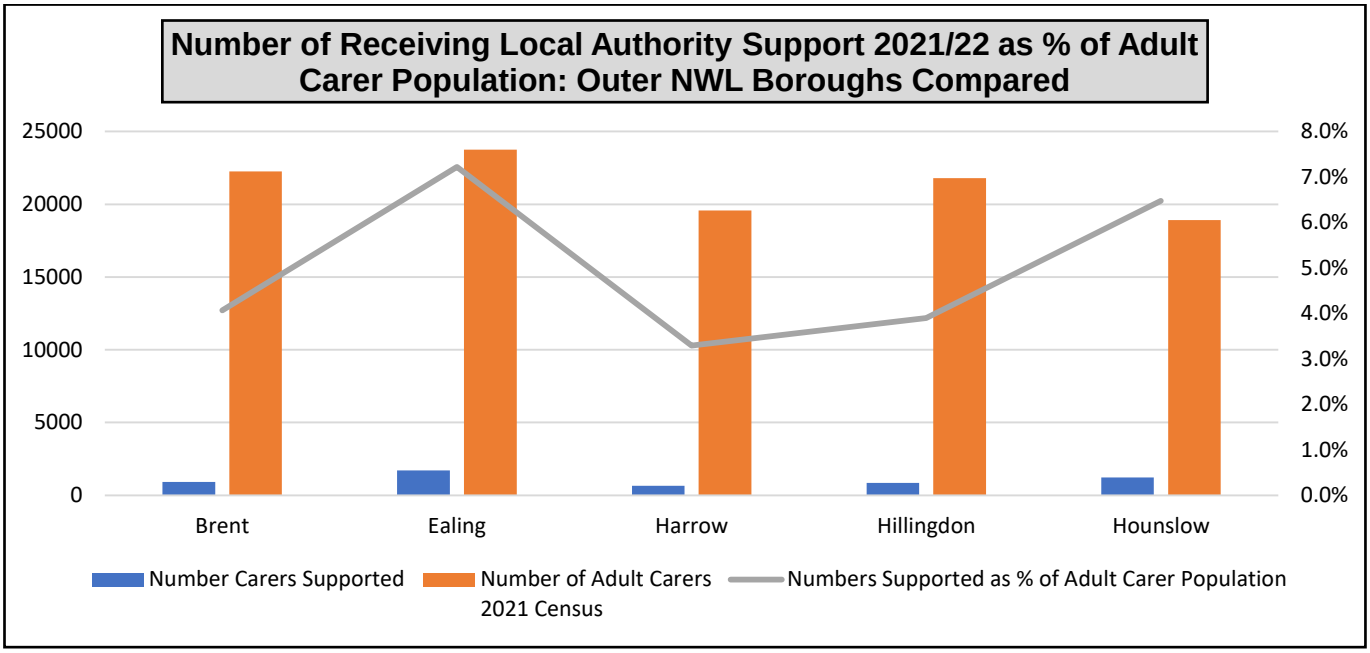
67. ***Increase the number of schools participating in the young carer recognition programme:*** There are currently 15 schools in the programme and a further 15 waiting. This includes a combination of primary and secondary schools.

PERFORMANCE DATA

Current Performance Information

68. There are two key sources of comparative data in respect of adult carers and these the carer quality of life measures within the Adult Social Care Outcomes Framework (ASCOF). These are tested via the National Carer Survey referred to earlier in this report. The second source is the national short and long-term (SALT) services return that all local authorities with adult social services responsibilities is required to complete annually. There is always a long time lag between submission of data and the publication of national reports to allow for benchmarking.

69. Consequently, the most recent comparative data is for 2021/22 and this is summarised in the chart below. This shows that the percentage of the carer population supported by the Council in 2021/22 (2.8%) was broadly comparable with Brent and Harrow but significantly below that of Ealing and Hounslow. The difference with Ealing and Hounslow may be attributable to interpretation of SALT return requirements. In addition, there is the high number of carers who decline a carers assessment addressed in paragraph 38 and there is no comparative data on this as it is not collected nationally.



Source: NHS Digital (Jan 2023)

70. The metrics in the new strategy (please see section 8: *Better outcomes for carers* of **Appendix 2**) have been devised to reflect national measures as well as to demonstrate the success of the strategy whilst considering the caveats about ease and cost of data collection and analysis. The Carer Support Service is critical to Hillingdon's performance against these metrics.

71. The Committee may wish to note that there are no national metrics in respect of young carers at this time. This means that it is not possible to make a direct comparison of outcomes for young carers with other local authorities.

RESIDENT BENEFIT

72. The report identifies how carers have been supported by the Council and partners in 2022/23 and 2023/24 as well as plans for continued support to 2028.

FINANCIAL IMPLICATIONS

73. There are no direct financial implications arising from this report.

LEGAL IMPLICATIONS

74. There are no direct legal implications arising from this report.

BACKGROUND PAPERS

2022 – 2025 Joint Health and Wellbeing Strategy

Appendix 1 – Case Studies

Case Study A: Carer of Person with Dementia

Mr A came to Hillingdon Carers Partnership as a result of him attending a Carers Trust Hillingdon *Introduction to Caring* course (see refer to paragraph 65) and raised concerns about his wife. Mrs A has a diagnosis of dementia that affects her speech and her ability to understand complex sentences and needs instructions in no more than five words. Mr A has not been able to grasp the changes for a number of reasons:

- Their roles had reversed and as he has his own mental health issues and previously Mrs S supported him.

- He finds it difficult to retain information which makes it difficult for change to take place.

- He had only a rudimentary understanding of his wife's condition.

Mr A used to run various businesses and was reliant on people he trusted to do things on his instruction. His support since retirement has come from his wife as there are no relatives available nearby to offer support. Mrs A was a hairdresser prior to her retirement and used to be a very sociable person but has now become very withdrawn and this has contributed to the shrinkage of their social network.

Actions:

- Power of Attorney for finance and property was secured for Mr A on behalf of his wife.

- The Alzheimer's Society educated Mr A to help him to better understand the condition and discussed practical strategies to help him to cope.

- Mr A was referred to the *Caring with Confidence* course run by Hillingdon Carers Partnership.

- A referral was also made to Occupational Therapy and the Continence Service in respect of Mrs A.

- Mr A struggled with providing personal care for his wife so he possibility of a referral to Adult Social Care was discussed with him and he eventually agreed.

- We referred Mr A to his GP for possible counselling and medication as he was feeling very low.

- We addressed the issue of stimulation for his wife and offered a range of possible activities.

Outcomes:

- As a result of the Occupational Therapy assessment grab rails and a ramp have been installed. The Continence Service is now send pads on a regular basis.

- A care agency is now involved for personal care for Mrs A, but they have also supported Mr A in practical terms, helping him to manage his wife in terms of physical support. Mr A was inadvertently being quite heavy handed with his wife which caused bruising, and this could

cause concern and be misinterpreted as a safeguarding issue.

- He attended a *Caring with Confidence* course and feels better equipped to understand and deal with his wife's condition.

- Mr A accessed the Talking Therapies Service for counselling and was prescribed anti-depressants and his mood has improved.

- The stimulation aspect is on-going as Mr A has to facilitate access to this for his wife and he sometimes remains overwhelmed at the situation but this is being worked on gradually.

Case Study B: Carer of Person with Dementia

Mrs B is caring for her husband. His dementia started affecting him in such a way that he was no longer able to do the things he used to do. Mrs B was frustrated because she had to take on new roles and could not cope with the changes in her husband. She was uncertain for the future and wanted guidance and information. A home visit was carried out.

Actions:

- It was identified that Mrs B needed to apply for benefits such as Attendance Allowance and Council Tax reduction.

- Coping strategies were discussed with Mrs B was finding it hard to manage, particularly because she did not fully understand dementia and what to expect.

- Mrs B felt she was becoming isolated because she was unable to leave her husband and apart from going to religious activities, she did not have other interests. Mrs B felt her husband was also losing interest in other things and was sleeping a lot.

Outcomes:

- Information given about support from the Hillingdon Carers Partnership.

- Mrs B was assisted to apply for the Attendance Allowance and Council tax reduction.

- The Dementia Café was recommended and information was given about other local activities.

- Mrs B was referred to the *Caring with Confidence* dementia training programme.

- Mrs B and her husband are now accessing other services and are engaging with other people.

Case Study C: Young Carer of Mother with Disabilities

Ms C is a 10-year-old young carer for her mother who is a single parent and has physical disabilities and mental health issues. Ms C has a club foot and has undergone a number of operations to improve her mobility. When Carers Trust first began supporting the family, they were sleeping on the floor in Ms C's grandmother's flat, having been evicted from temporary housing in another London borough.

Ms C's mum was struggling to cope with day-to-day life and was facing a potential custodial sentence due to not attending community service. Ms C's school attendance was also 25%.

The family had a social worker but Mum was very mistrusting of professionals and was reluctant to work with Carers Trust or Social Services.

Actions:

- Carers Trust Family Support Team undertook a home visit and gradually built a relationship with Mum and Ms C.

- A legal aid solicitor to work with mum was sourced to resolve their long-standing housing issue, which ultimately resulted in the Council agreeing to accept responsibility to house the family. Mum was helped to view potential properties and the provision of hardship grants helped her to furnish the accommodation.

- The Family Support Team liaised with the Probation Service to arrange for mum to complete her hours during school hours so that she was still available for GL when needed. As a direct result, mum has been offered a voluntary role with the possibility of progression to a paid permanent position, she is absolutely delighted as she has been out of work since GL was born.

- Ms C has recently undergone another foot surgery which further affected his attendance and mum's ability to safely get him to and from school. We worked with the school to ensure he had work sent home weekly and to ensure there was regular, effective communication between school and Mum. We also organised a wheelchair so that GL could return as soon as possible.

Case Study D: Parent Carer

D is 12 and has a diagnosis of Autism and severe learning difficulties and lives with his mother and two younger siblings in a two bedroom Council property. He has complex needs that necessitate constant supervision from an adult. The complex needs include erratic sleep patterns leading to him waking several times a time and not wanting to go back to sleep. He can display aggressive and dangerous behaviours such as pulling the hair of other children, throwing, and smashing objects around him or running into a busy road. He can also eat inappropriate things. D finds his behaviours amusing and often laughs, which adds to the stress experienced by his mother. D has an Education Health and Care Plan in place and attends a local school.

D’s mother is a single parent and his siblings are aged 7 and 9. The 9 year old is showing signs of special needs i.e., ADHD. Mother is physically, mentally, and emotionally exhausted. She has no family support and no reliable network of friends. There is a history of domestic violence from the children’s father who currently is not involved with the children.

Mother has been struggling with finances and the family’s housing situation. The house appears to need repairs i.e., fence in the garden is broken, there are no internal doors to the bedrooms, there are bare floor boards in the kitchen and in also D’s room, where the carpet was pulled up because he was smearing. The house is very untidy- there are toys and objects scattered around the house and in the garden.

Mother struggles with organisation. She has made an application for rehousing as she needs bigger property so children can have their own rooms. OT is involved to look at housing needs

as well as making it safe for the interim including exploring need for a safe space bed.

Mother was referred to Carers Trust and the family has been supported by their Family Support Team from October 2022 until September 2023.

Actions:

Carers Trust assisted with the following:

- Liaising with Housing to request a more appropriate property as well as remedial works.
- Supported mum to reapply for Disability Living Allowance.
- Advocating on family's behalf with Children's Services to change care agency and increase care hours funded.
- Arranged for changes in school transport arrangements as D was collected last which impacted on his siblings getting to school on time.
- Arrangements were made for the garden to be cleared.
- Liaised with the school attended by D's siblings regarding further Child Development Centre assessments.
- Attended Child in Need (CIN) visits and meetings to support mum. Mum has even been brought to the CIN meetings by the Carers Trust worker.
- Lending mum an old phone when D broke hers and later passing on messages from professionals to mum when the phone was broken again.
- Providing family trips to give mum a break.

Current Position
Mum has ceased contact with Carers Trust, but the family is having regular contact with the allocated social worker, and review meetings are being undertaken involving all the relevant professionals.

Case Study E: Adult Carer of Adult with Autism and Learning Disabilities

Mrs E is the carer for her son, M, who is 20 and has complex needs. He needs a lot of prompts and instruction to complete daily living activities safely, e.g., personal care, and the time involved can range from 2 to 3 hours to complete the simplest task. This has impacted on both Mr and Mrs E but particularly on Mrs E who her son's main carer and has had to leave her job to look after him full-time. Mr E also had to take a lot of time off work as M was unable to go out of the house safely without 1:1 support. This was because he was likely to abscond and could be a danger to himself.

M had an autism diagnosis but not for one for a learning disability, which his behaviours suggested that he may have. This impacted on access to some health services, i.e., psychology, specialist learning disability nursing and key worker support. M did have an active

Education, Health, and Care Plan (EHCP) and was attending a school for people with additional needs in the borough.

The family were referred to the Preparation for Adulthood (PfA) Team within Adult Social Care by the Police following an incident where M had been violent towards Mrs E and caused damage to the home. This incident was a culmination of a period of aggressive and violent behaviour that Mr and Mrs E were finding it increasingly difficult to manage.

About the Preparation for Adulthood Team

This team sits in Adult Social Care and is responsible for managing the transition of young people with Special Educational Needs and Disabilities from Children's Services to Adults.

The PfA Team undertook an assessment of M's needs under the 2014 Care Act and also assessed Mrs E's needs in her role as a carer. This resulted in her receiving a Direct Payment that enable her to access private therapy to help her deal with the impact of supporting her son on her mental health and wellbeing.

The PfA Team also worked with the Learning Disability Health Team to secure an urgent learning disability diagnosis assessment. This confirmed that M had a learning disability and enabled M to access specialist health services. Assistance with managing M's challenging behaviour was also available from the Council's Positive Behaviour Support Team. A place in a college more able to support a person with M's needs was also secured through joint work between the PfA and SEND Teams.

Current Position

The family situation is now more stable as M's needs are being more effectively managed. Mrs E has also provided feedback that the therapy sessions funded via the Direct Payment have been very helpful in addressing her anxiety and supporting her confidence.

Hillingdon Joint Carers' Strategy

2023 – 2028

March 2023

Hillingdon Joint Carers' Strategy 2023 - 2028
Table of Contents

Hillingdon Joint Carers' Strategy 2023 - 2026

1. Introduction

Hillingdon's Joint Carers' Strategy, 2023-2028, details how the Council, the NHS and the voluntary sector will work together to improve support for all unpaid carers who live – or provide care for someone who lives – in the London Borough of Hillingdon.

A glossary of terms used in this document can be found in Annex 1.

Who can be a carer?

There are three statutory definitions of who is a carer, and these are:

- *Parent carer:* The Children Act, 1989 defines this term as a person aged 18 or over who provides or intends to provide care for a disabled child for whom the person has parental responsibility.

- *Young carer:* The Children Act, 1989 defines this term as being someone under 18 who helps to look after another person but not under a contract or scheduled voluntary work.

- *Adult carer:* The Care Act, 2014 defines this as an adult, i.e., a person aged 18 or over, who is providing care and/or support for another adult for free but not under a contract or scheduled voluntary work.

2. Our Vision for Carers

Working together, and with carers, we will improve the health and wellbeing of carers of all ages in Hillingdon and deliver a positive experience of care and support services.

3. Mission Statements

Our mission is that by 2028 most unpaid carers can say:

- *I am supported to provide care to the extent that I wish and do so in a way that accommodates my own education, employment and health and wellbeing needs.*

- *I have received effective advice and support that minimises the financial impact of caring on our household.*

- *I have a voice: I am recognised both as an 'expert' partner in care planning for the person I care for and my experiences and opinions are valued and used to inform the improvement of support for carers.*

- *I have access to appropriate support that suits my needs, including breaks from being a carer and a social life outside of caring.*

- *I know where to go for information and advice and this meets my needs.*

- *I have received the right training and support to deliver my caring role effectively and in a way that ensures my personal safety and the safety of the person I care for.*

- *The children and young people in my family who have caring responsibilities are given support to mitigate the negative effects of caring.*

4. Supporting Principles

Our approach to delivering the vision will be governed by the following principles:

- **Thinking carer:** We will take a carer focused approach to everything we do so that the potential impact on carers is considered.

- **Identification and recognition**: We will work together support the identification and recognition of carers.

- **Listening and respect:** We will listen to and respect carers as expert care partners and they will be actively involved in planning the care and support that the cared for person receives.

- **Choice and control:** We will support carers to have choice and control over how their needs are met, including working with the independent sector to develop more personalised options.

- **Engagement:** We will engage with carers to hear from them about how their needs are changing and to invite their views about priorities.

- **Innovative approaches:** We will be open to new approaches to meeting the needs of carers that have not been tried before or have not been tried before locally.

5. National and Local Policy Influences

National

The Children Act, 1989 (as amended), places a duty on the Council to assess the needs of a parent carer where it appears that they may have needs or where they request an assessment. This will mainly apply to parents of people with Special Education Needs and Disabilities (SEND) who have or would be entitled to have Education, Health and Care Plans (EHCPs).

The Children Act also places a duty on the Council to undertake an assessment where a young carer may have support needs. The Council is required to consider how needs identified from an assessment should be met.

The Care Act, 2014, creates a statutory right to a carer's assessment for an adult carer and the Council may have an obligation to assist them even if the person they are caring for does not satisfy the national eligibility criteria. This would be subject to them satisfying the national eligibility criteria for carers. Where the cared for person is eligible for social care assistance from the Council then the support needs of the carer would usually be considered as part of an overall package of care to address their collective needs.

National policy demonstrating a continuing commitment to supporting carers is set out in the Government's white papers *People at the Heart of Care: adult social care reform* (Dec 2021) and *Health and social care integration: joining up care for people, places and populations* (Feb 2022).

National good practice guidelines for supporting adult carers are set out in national guidance 150: *Supporting adult carers*, produced by the National Institute for Health and Care Excellence (Jan 2020).

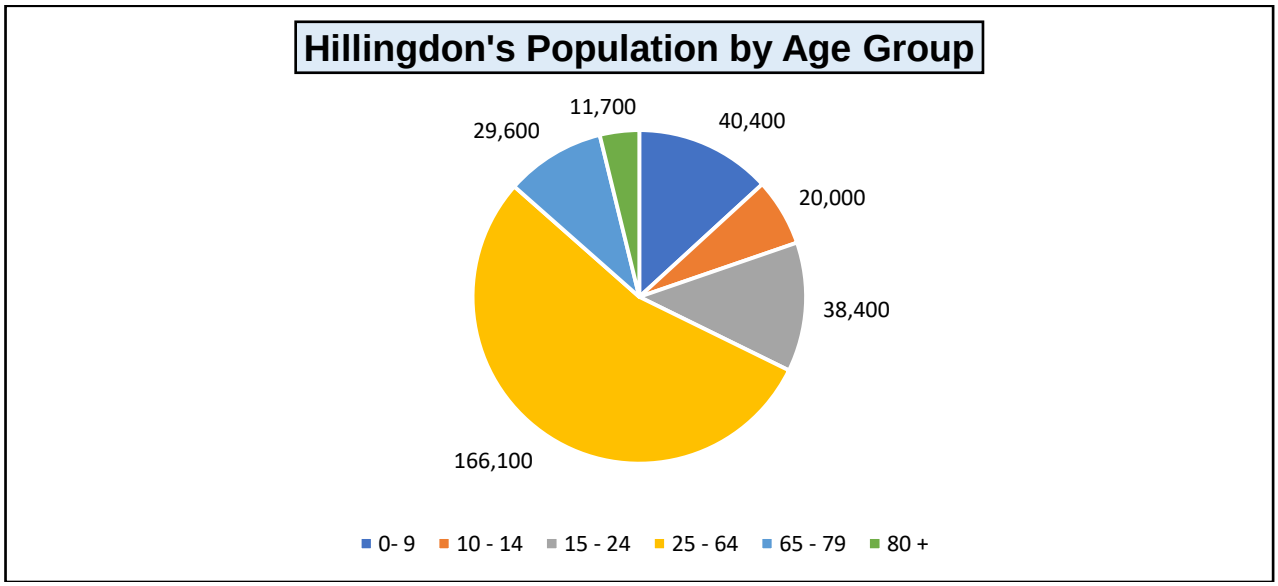
A commitment to supporting greater recognition and support for carers, particularly those from vulnerable communities, was reflected in the NHS Long-term Plan published in 2019. However, the Covid-19 pandemic has impacted on delivery.

Local
The development of the Joint Carers' Strategy links into priority 2 of the statutory Joint Health and Wellbeing Strategy, 2022 – 2025, which is *Tackling unfair and avoidable inequalities in health and in access to and experiences of services.* This includes a commitment to *'increase the opportunities for people undertaking an unpaid caring role to be identified and ensure access to the support that will enable them to continue caring for as long as they are willing and able to do so'.* The Joint Carers' Strategy explains how this commitment will be delivered in the period to 2028. The Joint Health and Wellbeing Strategy can be accessed by using the following link Social care and wellbeing - Hillingdon Council

The new strategy will also contribute to the delivery of the *Thriving, Healthy Households* commitment within the 2022 – 2026 Council Strategy, i.e., that '*children, young people, their families and vulnerable adults and older people live health, active and independent lives'*. The Council Strategy can be accessed by using the following link Council strategy 2022-2026 - Hillingdon Council

6. Carers in Hillingdon: Needs and Challenges

About Hillingdon's Population
The 2021 census shows that Hillingdon has a population of 305,900 with an age breakdown as shown in the chart below.



Source: 2021 census (Office of National Statistics)

Carer Profile: Census 2021

How many people are there providing unpaid care to Hillingdon residents within the definitions described in the introduction? It is important to identify how many people should have access to support to ensure the maintenance of their own health and wellbeing and to enable them to continue in their caring role for as long as they are willing and able to do so.

The 2021 census is a key source of data to answer this question. The table below provides a comparative breakdown of the age of carers as identified by the 2011 and 2021 censuses.

Age Breakdown of Carers in Hillingdon 2011 and 2021 Censuses Compared		
Carer Age Group	**2011 Census**	**2021 Census**
0 - 24	2,569	1,875
25 - 64	18,676	16,625
65 +	4,660	3,965
TOTAL	**25,905**	**22,465**

Age Breakdown of Carers in Hillingdon 2021 Census Young and Young Adult Age Breakdown	
Carer Age Group	**Number**
5 - 18	660
19 - 24	1,215
25 - 64	16,625
65 +	3,965
TOTAL	**22,465**

Hillingdon and England Compared

Key messages include:

- **Number of carers in Hillingdon:** The number of people in Hillingdon identifying as a carer reduced from 25,905 in 2011 to 22,465 in 2021. This reflects a national trend.

- **Carers providing at least 20 hours of unpaid care per week:** 4.3% of the population were providing at least 20 hours care per week. This was lower than the national figure for England of 4.5%.

- **Carers providing between 35 and 49 hours unpaid care per week:** The significance of 35 hours a week is that it is regarded by the Department of Work and Pensions (DWP) as equivalent to a full-time job. 09.% of Hillingdon's population were providing this amount of unpaid care a week. This was marginally lower than the national figure of England of 1%.

- **Carers providing at least 50 hours unpaid care per week:** 2.5% of Hillingdon's population were providing this level of unpaid care, which was lower than the figure for England of 2.7%

The table below shows the percentage of Hillingdon's population providing different levels of unpaid carer identified in the censuses of 2021 and 2011 compared with London and England.

Hours per week of unpaid care provision of usual residents (aged five years and over) Hillingdon - London - England (2011 to 2021)						
Classification	**Hillingdon (2011) %**	**Hillingdon (2021) %**	**London (2011) %**	**London (2021) %**	**England (2011) %**	**England (2021) %**
Does not provide weekly unpaid care	88.8	91.6	89.7	92.2	88.7	91.1

Up to 19 hours of unpaid care	7	4.1	6.4	3.8	7.2	4.4
20 to 49 hours of unpaid care	1.6	1.8	1.5	1.7	1.5	1.8
50 or more hours of unpaid care	2.5	2.5	2.4	2.3	2.7	2.7

Source: ONS 2021 census

Hillingdon and North West London

The North West London (NWL) sector includes the eight London boroughs of Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster. In March 2021 nearly 41% of carers in Hillingdon were providing 35 hours of unpaid care per week in March 2021. In the context of the other eight boroughs in NWL, this meant that Hillingdon had the second highest percentage after Brent and Hounslow (joint first). Hillingdon also had the second highest percentage of carers (at 28.8%) providing 50 hours of care or more. Hounslow had the highest proportion.

Census Data Explained

The Office of National Statistics (ONS) has identified that the co-occurrence of coronavirus lock-down arrangements as well as changes to the questions asked may have influenced how people perceived and managed their provision of unpaid care, and therefore may have affected how people chose to respond.

The wording of the questions asked in 2011 and 2021 were different. For example, the question about unpaid care in the 2011 census specified "*look after, or give any help or support to family members, friends, neighbours or others*". The 2021 census question used the phrase "*look after or give any help or support to anyone*".

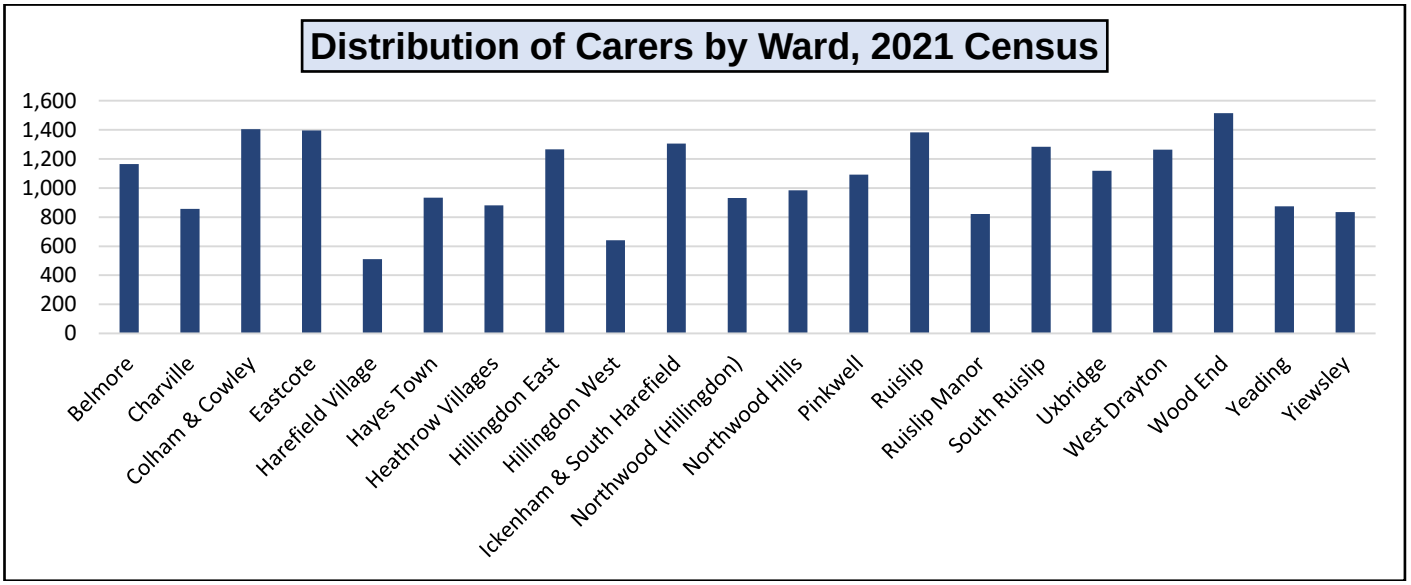
Broader demographic changes in Hillingdon suggest that it is highly unlikely that the number of carers has reduced over the decade since the last census. For example, the census also shows that the 25 to 64 age group (the age group of the majority of carers in 2011) increased by 13.1% in ten years and those aged 65 and above (the second largest age group of carers in 2011 and largest group of cared for people) by 14.8% in the same period. It is probable that the 2021 census results are to do with perception rather than a decline in numbers. In short, there is a significant '*hidden carer'* issue, i.e., people undertaking a caring role but who do not see themselves as carers and therefore miss out on access to support.

Gender of Carers

The 2021 census showed that 58.9% (13,235) of people who identified as carers were female and 41.1% (9,235) were male. This gender split is similar to the London average (60%) and the NWL average of 58.2%.

Where Carers in Hillingdon Live

The chart below shows that the wards with the largest population of carers in the borough according to the 2021 census are Wood End, Colham and Cowley, Eastcote and Ruislip.



Source: ONS

2021 Census and Carers' Allowance

According to the 2021 census just under 41% of people identifying themselves as carers were providing 35 or more hours care a week. This is significant because the provision of this level of care helps to determine access to Carer's Allowance (CA), a major source of income for carers. The census suggested that in March 2021 there were at least 9,105 carers delivering 35 hours of care or more a week. Data published by the Department for Work and Pensions shows that in May 2023 (the most recent period for which data is available) there were 3,975 people entitled to receive CA. People providing this level of care are most vulnerable to experiencing a deterioration in their own health and wellbeing without support. This suggests that there is a large group of people providing a high level of care who do not qualify for the additional income.

About Carers Allowance

Carer's Allowance (CA) is a non-contributory benefit for people aged 16 or over:

- who look after a severely disabled person for at least 35 hours a week.
- who are not gainfully employed, i.e., not earning more than £95 per week after certain deductions) and
- who are not in full-time education.

The severely disabled person must be getting either the highest or middle rate of Disability Living Allowance care component, any rate of Personal Independence Payment, or Attendance Allowance, or a Constant Attendance Allowance at the maximum rate under the War Pensions or Industrial Injuries Scheme.

Parent Carers

It will not be possible to identify from the 2021 census how many people identify as parent carers as questions at this level of detail were not asked. However, data from the Council's Early Help Module database shows that in March 2023 there were 3,251 children and young

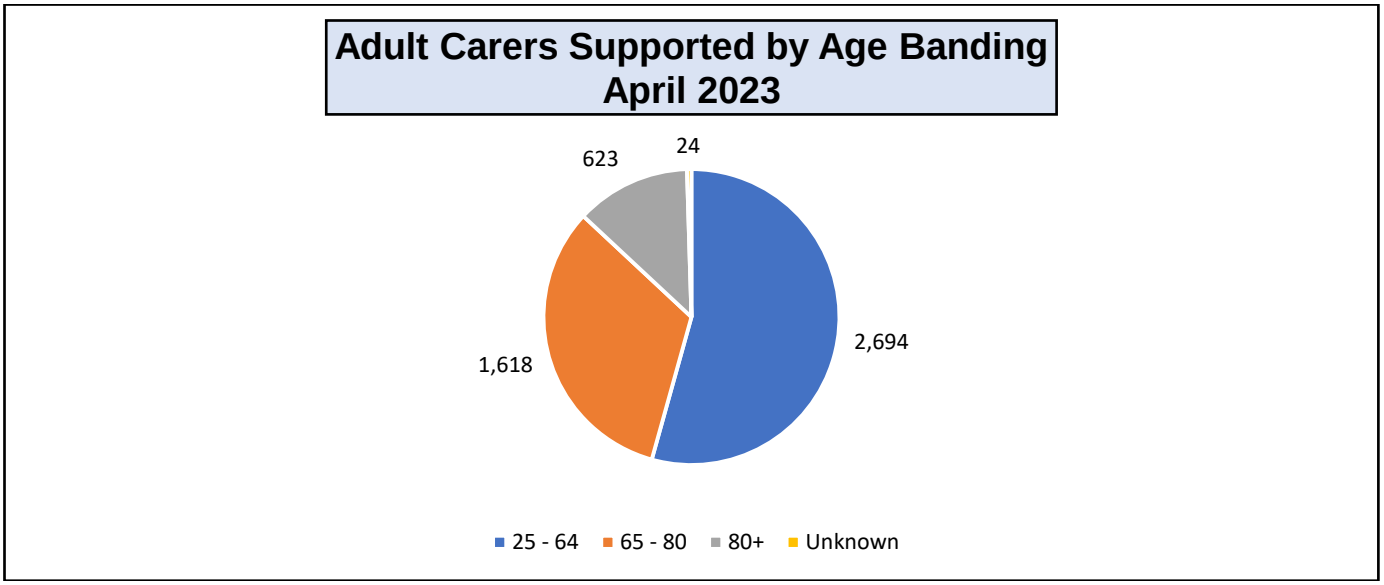
people with Education, Health, and Care Plans (EHCPs). This suggests at least an equivalent number of parent carers, although not all would require additional assistance.

Profile of Carers Supported

Carer Support Service

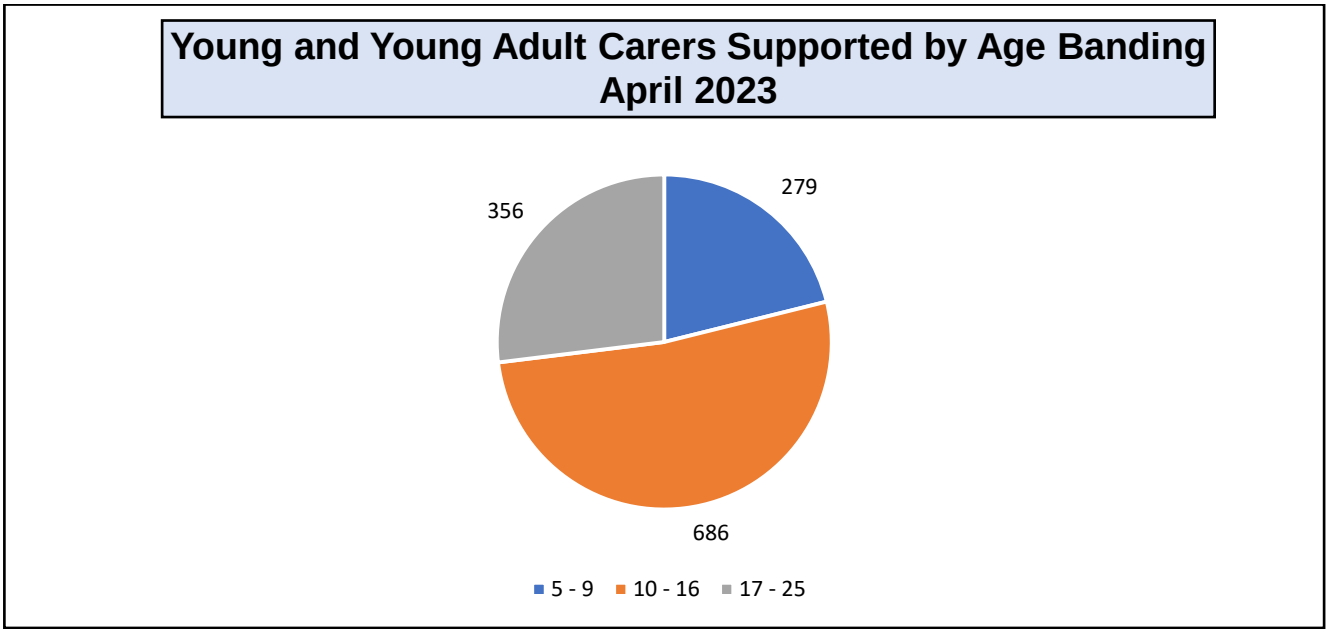
The Carer Support Service is a one-stop shop of support for carers of all ages in Hillingdon and is currently delivered by the Hillingdon Carers' Partnership. For the purposes of the Carer Support Service adults refers to carers aged 25 and above. Young or young adult carers means people refers to carers aged under 25.

As of 1st April 2023, the Partnership supported 4,959 carers aged 25 and above and 1,156 young carers. The chart below shows that the majority of carers (2,694 or 54%) were aged between 25 and 64.



Source: Carers' Trust Hillingdon (April 2023)

The chart below shows that of the young carers registered with Carers Trust on 1st April 2023 nearly 52% (686 out of 1,321) were aged between 10 and 16.



Source: Carers' Trust Hillingdon (April 2023)

Analysis shows that carers being supported live in all areas of the borough. The highest percentage of adult carers at nearly 17% (787) live in the Hayes and Harlington postcode area (UB3) and nearly 15% (784) in the Ruislip post code (HA4). The lowest percentage at nearly 4% (185) of adult carers live in the Northwood and Pinner postcode (HA5). Approximately 4% (192) of adult carers supported live outside of the borough but care for someone living in the borough.

For young carers nearly 23% (294) of those supported live in the Hayes and Harlington postcode. Just over 19% (249) live in the Sipson, West Drayton and Harmondsworth postcode area (UB7). Lower numbers of young carers can be found in the Northwood and Pinner (HA5), Northwood and Northwood Hills (HA6) and Harefield, Ruislip and Ickenham (UB9) postcode areas. Just over 1% (18) of young carers supported lived outside of the borough but were caring for someone resident in the borough.

Ethnicity of Carers Supported by the Carer Support Service

April 2023

Ethnic Group	Adult Total	% Adult Carers	Young Carers	% Young Carers	TOTAL	%
White British	2,526	50.9%	676	51.2%	**3,202**	51%
Black African	201	4.1%	88	6.7%	**289**	4.6%
Mixed Race	154	3.1%	55	4.2%	**209**	3.3%
Black British	168	3.4%	35	2.6%	**203**	3.2%
Asian British	285	5.7%	86	6.5%	**371**	5.9%
Indian	596	12%	101	7.6%	**697**	11.1%
Pakistani	145	2.9%	31	2.3%	**176**	2.8%
Bangladeshi	67	1.4%	6	0.5%	**73**	1.2%
Other Asian	252	5.1%	76	5.8%	**328**	5.2%
Arabic	20	0.4%	9	0.7%	**29**	0.5%
Caribbean	63	1.3%	27	2.0%	**90**	1.4%

Traveller	6	0.1%	0	0%	**6**	0.1%
White other	355	7.2%	131	9.9%	**486**	7.7%
Not stated	121	2.4%	0	0%	**121**	1.9%
TOTAL	**4,959**	**100%**	**1,321**	**100%**	**6,280**	**100%**

Source: Carers Trust Hillingdon (April 2023)

The 2021 census showed that 48.5% of Hillingdon's population described themselves as being from White British communities. Hillingdon Carers Partnership data shows that 51% of all carers using services registered with the partnership on 1st April 2023 were from White British communities, which suggests an under-representation of other population groups that requires further analysis.

In line with 2021 census data, the majority of the adult carers supported by the Hillingdon Carers Partnership are female and this is illustrated in the table below. This does suggest that there is an issue with '*hidden'* male carers.

Gender Adult Carers					
Gender	**Carers Trust**	**Mind**	**Alzheimer's Society**	**TOTAL**	**%**
F	2,847	160	155	3,162	63.8%
M	1,675	43	79	1,797	36.2%
TOTAL	**4,522**	**203**	**234**	**4,959**	100%

***Source*:** Carers Trust Hillingdon (April 2023)

The table below shows the majority of young carers supported are also female, although the difference between the genders is much closer than for adult carers.

Carer Support Service: Young Carer Gender Breakdown April 2023		
Gender	**Number**	**%**
Male	617	46.7
Female	700	53
Non-binary	4	0.3
TOTALS	**1,321**	**100**

***Source*:** Carers Trust Hillingdon (April 2023)

The main conditions of the people being supported by carers aged under 65 include children with additional needs (47%), people with physical and/or sensory disabilities (19%), people with mental health needs (15%) and people with learning disabilities.

Adult Social Care

Local authorities have a legal obligation to provide financial support for adult carers where they satisfy the National Eligibility Criteria for Carers set out in regulations linked to the Care Act,

2014.

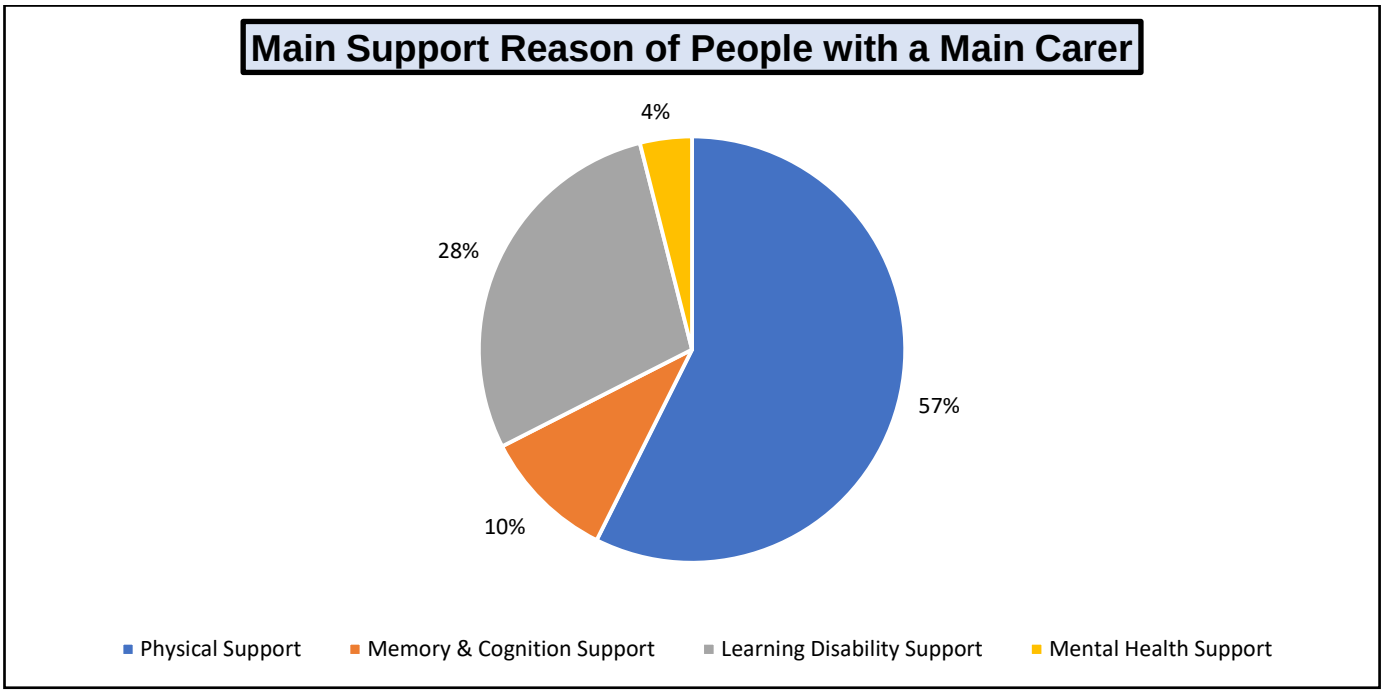
About the National Eligibility Criteria for Adult Carers of Adults

The national criteria states that a carer will have eligible needs if:

- Their needs have arisen as a consequence of providing necessary care for an adult.
- The effect of the carer's needs is that:
  - the carer's physical or mental health is, or is at risk of, deteriorating and/or
  - the carer is unable to achieve any of a range of outcomes set out in the Act, e.g., carrying out any caring responsibilities the carer has for a child; providing care to otl persons for whom the carer provides care; maintaining a habitable home environme in the carer's home; managing and maintaining nutrition, etc.
- As a consequence, there is, or there is likely to be, a significant impact on the carer's wellbeing.

The level of financial support provided is subject to a financial assessment.

The Council is required by law to provide data to NHS Digital about people supported (including carers) under its Care Act responsibilities in the annual Short and Long-term (SALT) return. The return for 2021/22 (the most recent date for which comparative data is available) shows that on the 31st March 2022 1,534 people being supported by the Council had support from people identified as their '*main carer'*. These carers were not identified as receiving a service directly themselves or as benefitting from a service being provided to the cared for person. The chart below shows that the main support need (known as '*primary support reason'*) of people with a '*main carer'* was physical support (57%).



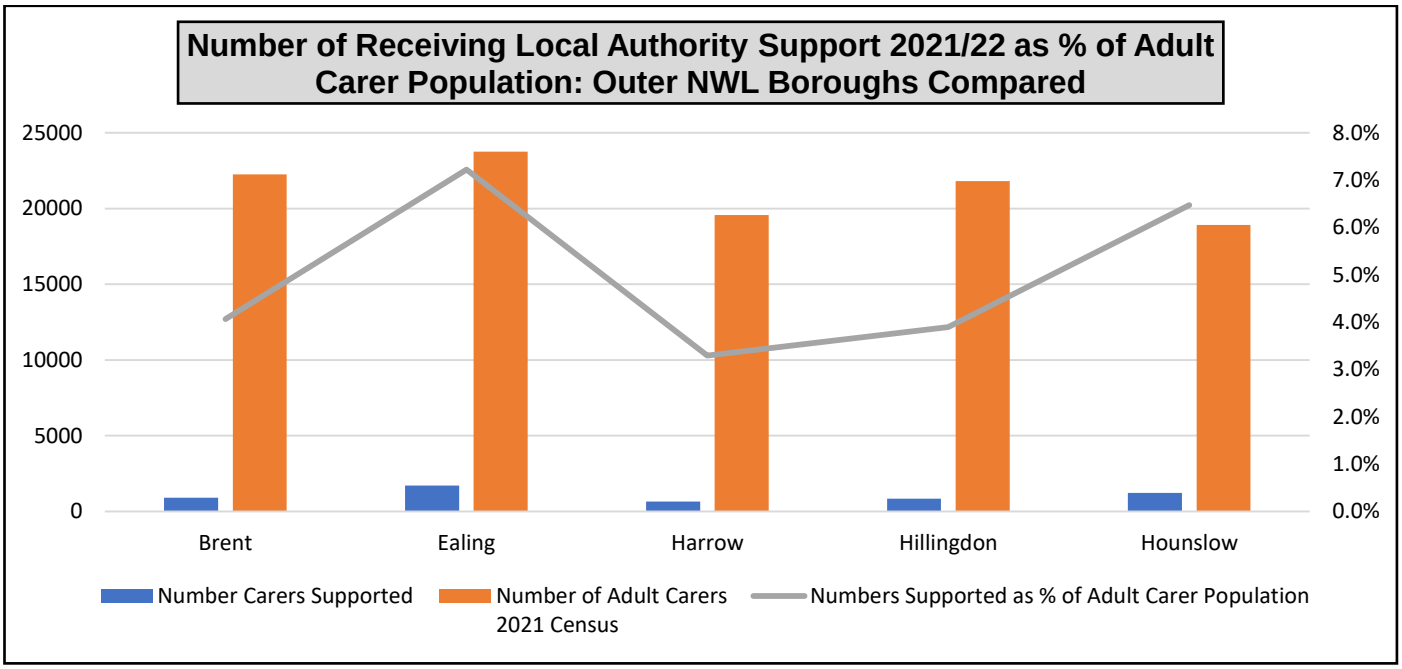
NHS Digital data shows that on the 31st March 2022 the Council was supporting 630 adult carers who were receiving direct support following a carer's assessment in their own right or jointly with the person they were caring for. An additional 220 adult carers were identified as benefitting from respite or other forms of carer support delivered to the cared-for person in 2021/22.

About Carers Assessments

A carer's assessment is for carers over 18 years old who are looking after another adult over 18 years old who is disabled, ill or elderly. It is an opportunity to record the impact caring has on their life and what support or services they need. The assessment will look at, for example, physical, mental and emotional needs, and whether they are able or willing to carry on caring.

Carers' assessments are completed either by the Council or on the Council's behalf under the Carer Support Service contract by Carers Trust Hillingdon.

When comparing Hillingdon's position with near neighbours it is possible to see from the chart below that the percentage of the carer population supported by the Council in 2021/22 (2.8%) was broadly comparable with Brent and Harrow but significantly below that of Ealing and Hounslow. The difference with Ealing and Hounslow may be attributable to interpretation of SALT return requirements.



Source: NHS Digital (Jan 2023)

Factors that are not reflected in these figures are the number of carers in Hillingdon who decline a carer's assessment. For example, in 2021/22 81% (3,299) of the 4,655 people offered a carer's assessment declined. This trend has continued into 2022/23 with 77% (2,429) of assessments offered during the period April to December 2022 refused. Anecdotally the reasons for refusal include:

- The services offered through the Carer Support Services contract met their need.

- Carers do not feel that the service offer available from an assessment justifies the time taken to complete it.

The percentage of carers directly supported by the Council whose needs were met wholly or in part by Direct Payments in 2021/22 was 21.4%, which was significantly below the NWL borough average of 47.9%. This is an area for further development.

Carers and Covid-19

2020/21 and 2021/22 were dominated by the Covid-19 pandemic, which has had a significant impact on carers. Some of the challenges that this presented include:

- People having to undertake caring responsibilities unexpectedly but not recognising themselves as carers.

- The reluctance of carers to take up short break opportunities over infection prevention and control concerns.

- Limited availability of some short break options during covid-related restrictions.

- Mental health implications of caring during covid-related restrictions, i.e., coping with the pressures of being a carer.

- Managing the financial implications of being a carer.

The legacy of the pandemic on the health and wellbeing of carers will continue to be monitored. A key issue identified by the census is, however, that it would seem that many of the people who undertook caring responsibilities during the pandemic did not identify themselves as carers and may continue not to do so where this is a continuing responsibility.

Listening to Carers: National Carers' Survey

The National Carers' Survey is commissioned by the Department of Health and Social Care (DHSC) and the Care Quality Commission (CQC) and takes place every two years. This was most recently undertaken in November 2021 as the survey scheduled for 2020/21 was postponed due to the pandemic.

The survey data sample and collection methodology were determined nationally, and 677 survey forms were issued to adult carers who had received a carer's service, assessment, or review during 2021/22. 233 (34%) completed forms were returned, which is considered to be statistically valid by DHSC and CQC.

The main conditions that carers were supporting the people they were caring for with were physical disability (nearly 50%); learning disability (42%) and dementia (33%). The main tasks being undertaken by carers were keeping an eye on the cared for person to make sure that they were OK (95%); other practical assistance (95%); and help with paperwork and other financial matters.

Some key facts from the survey include:

- **78% of carers who responded live with the person they care for**. This is a small reduction, i.e., 4%, on the results from the 2018/19 survey but it is difficult to say whether this can be attributed to the Covid-19 pandemic.

- **45% of carers spend over 100 hours a week caring**. This is a 6% reduction on the 2018/19 survey and may be attributable to the Covid-19 pandemic leading to more people taking on caring roles.

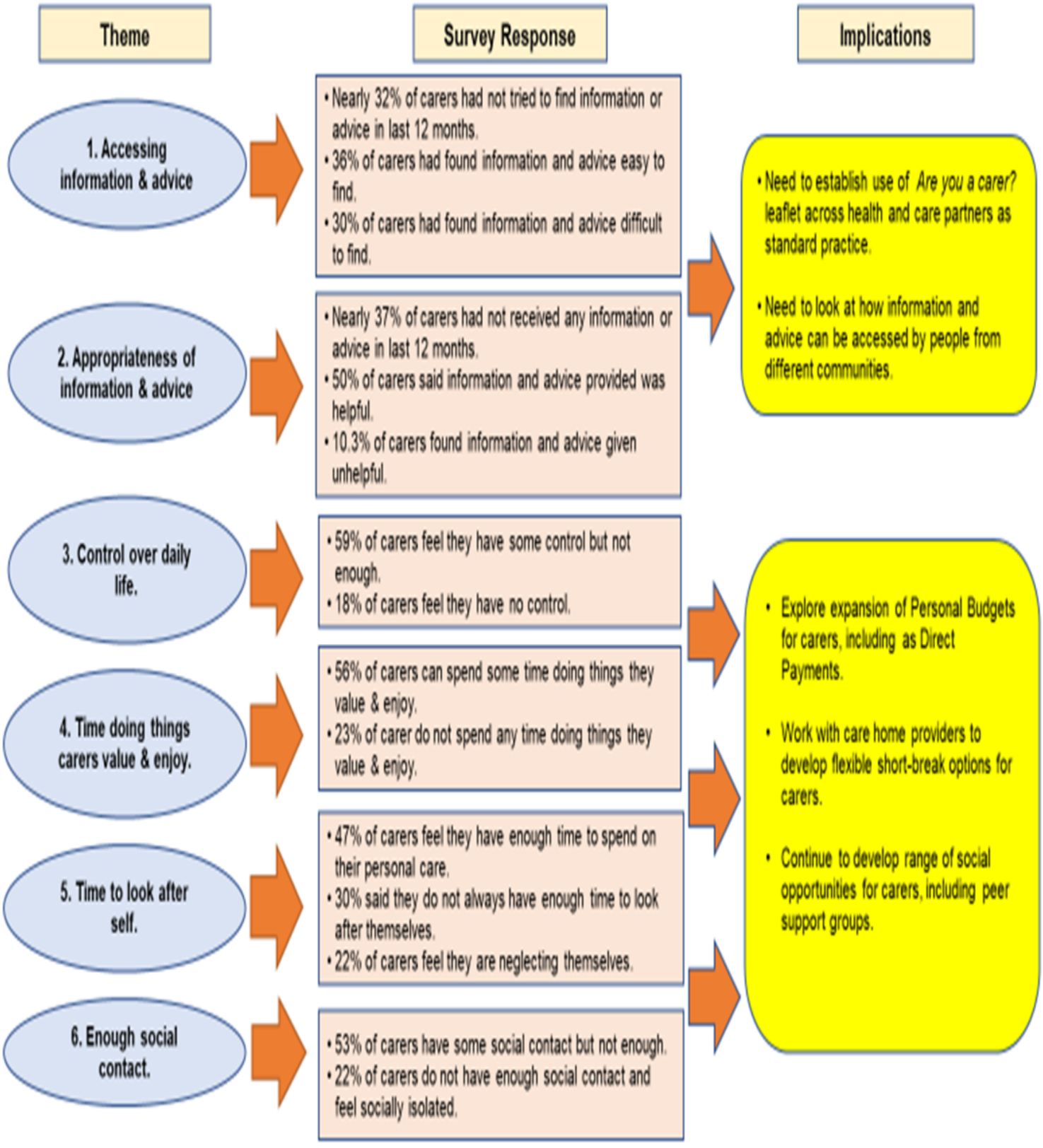
- **43% of carers have been performing caring duties for over 20 years**. This is nearly 7% higher than in 2018/19 and it is expected that the percentage will increase as the numbers of carers in the 25 to 64 age group get older.

- **49% of carers are aged 65 and over**. This represents no change on the 2018/19 survey results. The 2021 census shows that 18% of carers are within this age group.

- **25% of people looked after by carers are aged 85 and above.** The census shows that 2% of carers are within this age group.

- **64% of carers are satisfied with the support and care services they receive for themselves and the person they care for.** This represents no change on the 2018/19 survey results and was the third highest out of the eight boroughs in North West London, with the highest score being 71%.

The main results of the survey and their implications are shown below.


Theme
Survey Response
Implications
1. Accessing information & advice
• Nearly 32% of carers had not tried to find information or advice in last 12 months.
• 36% of carers had found information and advice easy to find.
• 30% of carers had found information and advice difficult to find.
2. Appropriateness of information & advice
• Nearly 37% of carers had not received any information or advice in last 12 months.
• 50% of carers said information and advice provided was helpful.
• 10.3% of carers found information and advice given unhelpful.
• Need to establish use of Are you a carer? leaflet across health and care partners as standard practice.
• Need to look at how information and advice can be accessed by people from different communities.
3. Control over daily life.
• 59% of carers feel they have some control but not enough.
• 18% of carers feel they have no control.
4. Time doing things carers value & enjoy.
• 56% of carers can spend some time doing things they value & enjoy.
• 23% of carer do not spend any time doing things they value & enjoy.
5. Time to look after self.
• 47% of carers feel they have enough time to spend on their personal care.
• 30% said they do not always have enough time to look after themselves.
• 22% of carers feel they are neglecting themselves.
6. Enough social contact.
• 53% of carers have some social contact but not enough.
• 22% of carers do not have enough social contact and feel socially isolated.
• Explore expansion of Personal Budgets for carers, including as Direct Payments.
• Work with care home providers to develop flexible short-break options for carers.
• Continue to develop range of social opportunities for carers, including peer support groups.

Listening to carers: How carer views are collected

Current partners supporting carers obtain feedback from carers in many different ways and this is illustrated below. Some of the feedback that we have had from carers is shown in section 8: Better Outcomes for Carers.

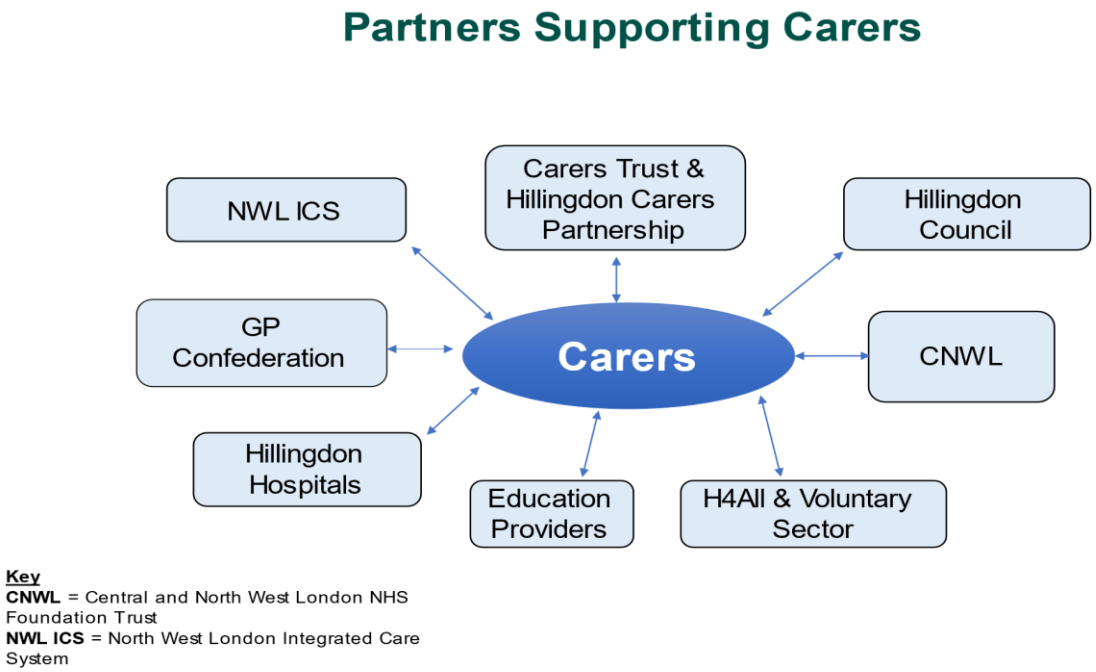
Council	Hillingdon Carers' Partnership	Other Partners
Parent carers • Day to day social care contact. • Through the Parent Carer Forum. **Young & Adult Carers** • Day to day social care contact. **Adult Carers** • Carer forums held twice a year. • Biennial National Carers' Survey.	**Adult Carers** • Carers' forums held twice a year. • Rolling annual '*We care'* Survey. • Post activity questionnaires for one-off events. • Pre- and post-training evaluations. • '*Big Listen'* events using interactive feedback methods. • Carer Cafés. • Impact and evaluation framework – baseline assessment as part of Carers Assessment and review after 6 months. • Website **Young/Young Adult Carers** • Questionnaires – hard copy & Survey Monkey annually: - Parental Survey - Young carers (5-9 years) - Young carers - (10-15 years) • '*Chicken and Chat*' and '*Pizza and Planning'* events. • Guided discussion workshops.	**CNWL Mental Health** • Hillingdon service user and carer involvement group that meets every two months and has a carer as co-chair. • Co-production activities which include transformation of services. • Head of service and senior manager team regular visits to local carer support group. • Carer involvement in clinical meetings. **CNWL Community** • Centrally run carers' forum chaired by a carer. • Central patient and carer involvement team. https://www.cnwl.nhs.uk/patients-and-carers/patient-and-carer-involvement • Check in and chat service for carers. • Dedicated websites. https://www.cnwl.nhs.uk/patients-and-carers • Carer involvement in quality improvement and research. • Carer involvement in serious incident investigations. **THH** • Day to day via discussions regarding patient care. • Via contact with PALS. • Patient engagement forum and Patient engagement review group development to include carer input. • Coproduction within the Clinical Modelling Programme from April 2022 – March 2024 to review and improve service delivery.

The views of carers collected through the channels shown above feed into the multi-agency Carers Strategy Group (CSG) to help shape priorities in the delivery plan intended to implement the vision and outcomes for carers within this strategy. People who are carers or former carers

are members of the CSG as experts by experience and are supported in this role by the Carer Support Service provider.

7. Partners Supporting Carers: Our story so far …

The diagram below shows current partners involved in supporting carers in Hillingdon.



Partner Achievements

Achievements arising from the 2018 – 2021 Joint Carers' Strategy include:

- One stop shop support service for carers delivered by the Hillingdon Carers' Partnership embedded.
- A rise in the number of carers identified and referred to the Carer Support Service for support by partner organisations across Hillingdon. Of 583 new carers registered in the 12 months from 1.10.21-30.9.22, 223 were referred by partner organisations from outside HCP. By far the greatest rise was from H4All, and the majority of others were from Social Services.
- 27 GP practices with identified carer leads: This increased to all 45 practices in Hillingdon until the Covid-19 pandemic, which resulted in the number reducing to 27.
- Since the pandemic emergency planning is offered to all newly registering carers and following a carers assessment.
- Co-production and distribution across partners of the *'Are you a carer?'* information booklet.
- A professionally designed information pack for schools has been developed to that has gone to all schools to raise awareness of young carers so that teachers and staff are better placed to support them. This is supported by a schools outreach programme delivered by HCP.

- £1.7m in additional external funding has been secured by the Hillingdon Carers' Partnership to fund additional services for carers.

- £4,413,856 in additional carer-related benefits has been secured by the Hillingdon Carers' Partnership between April 2018 and September 2022 to enable carers to manage the financial implications of caring.

- Roll out of the Triangle of Care (see glossary in Annex 1) within secondary mental health services.

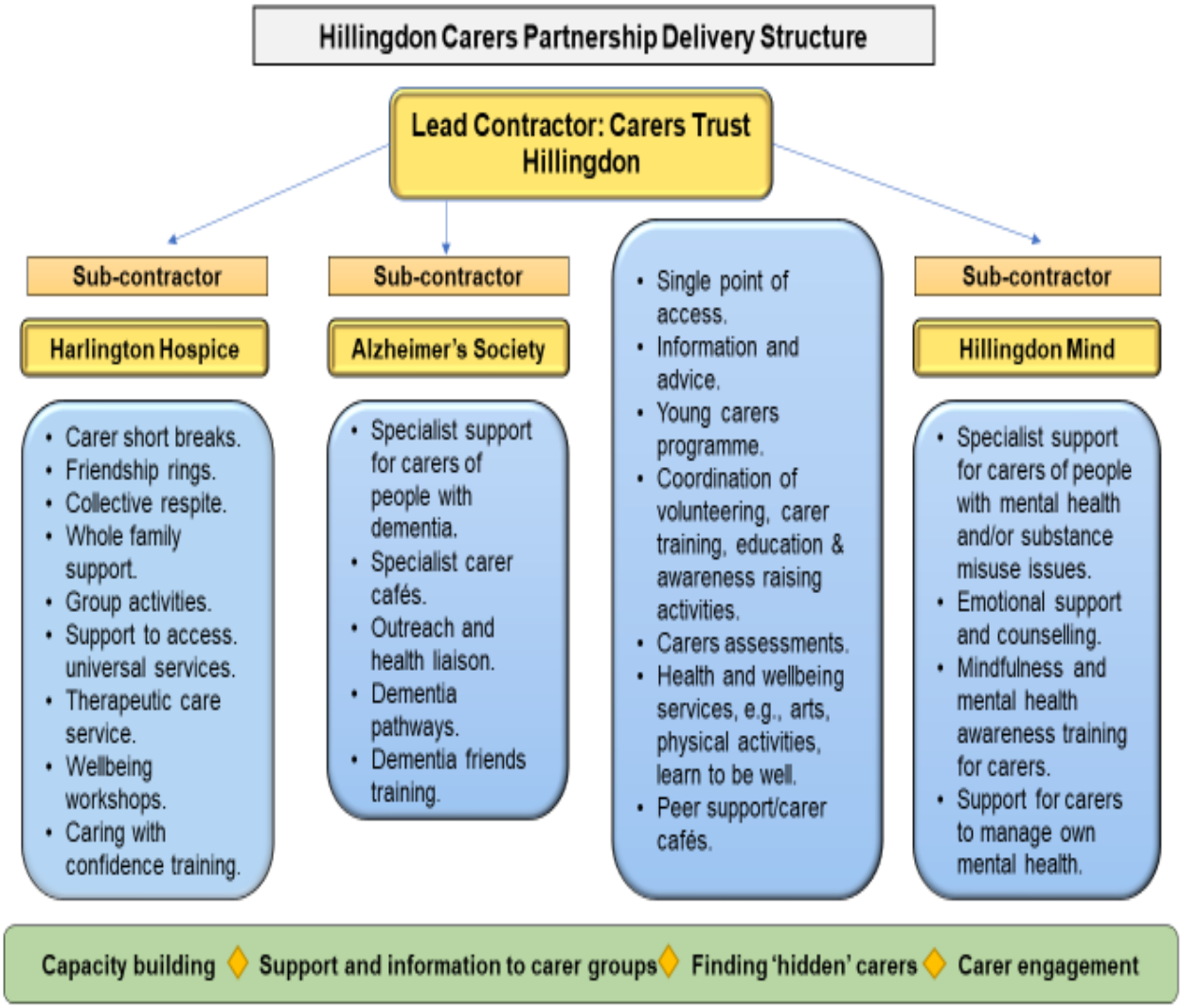
- People with multiple caring responsibilities: Systematic identification of people with multiple caring responsibilities established in Adult Social Care to inform social care reviews.

- Improved systems and processes that assist in joining up support and decision making between the Carers' Support Service, the Council's Adult and Children's Services and local health services are in place.

- Development and implementation of the Carer Recognition Scheme.

Support For Young and Adult Carers

The main offer of support to young, young adult and adult carers in Hillingdon is through the Carer Support Service, which is currently being delivered by the Hillingdon Carers Partnership. The diagram below shows how the service is being delivered.



Support for Parent Carers

The support needs of parent carers are considered as part of a child and family assessment. The support available prior to and/or following an assessment is reflected within the Council's published local offer for people with Special Educational Needs and Disabilities (SEND), which can be accessed via this link SEND local offer - Hillingdon Council. A child and family assessment could conclude that a short break is required to give the parent carer and the child or young person some space from one another, which would lead to a short break assessment being undertaken as part of EHCP. The specialist short breaks provider is currently Community Connex Limited.

Challenges for the 2023 – 2028 Strategy

Some of the key challenges that this strategy will seek to address include:

- Ensuring carers receive recognition and respect in the care of their loved one (s).
- Involving a range of carers at a strategic level to comment on the quality of services and shape what services look like in the future.

- Identification of young carers.
- Identification of '*hidden*' adult carers.
- Identification of carers from under-represented communities, e.g., male carers.
- Ensuring services work together to support the whole family.
- Ensuring that parent carers are recognised and supported.
- Provision of a variety of short break options for carers.
- Identification and support for carers through primary care.
- Offering carer assessments in a way that works for all carers.
- Ensuring carer registers are established and maintained in primary care.
- Managing the impact of the cost of living crisis on carers.
- Exploring how technology can be used more to help carers carry out their role.

8. Better Outcomes for Carers

This section describes the outcomes for carers that the strategy is seeking to achieve. It also summarises the work that will be undertaken to achieve the outcomes and deliver the vision for carers by 2028.

Outcome 1: Carers are identified, recognised and able to make a positive contribution.

What carers have told us	**What we will do 2023 – 2028**
'Help carers to identify themselves as carers if they wish to'. *'Health services should recognise when we're a carer and help us to recognise this too, especially at the point of diagnosis of the person we're caring for'.* *'Carer needs sometimes ignored by the Hospital'.* '*Parent carers often aren't recognised. You're just seen as a parent rather than a carer and your needs aren't seen.'*	• The Carer Support Service provider will develop and maintain a Hillingdon Carer Register for all carers supporting residents of Hillingdon to register themselves. This will enable information that may be of assistance to carers to be targeted to them more easily. • Linked to the Hillingdon Carer Register, we will promote the Hillingdon Carer Card to enable carers to identify themselves as carers if required, for example, to health and care professionals. • We will work with Hillingdon's communities (including the business community) to increase to value to carers of having the
Measuring Delivery	

• % of adult carer population on the Carer Register for Hillingdon. • % adult carers of adults receiving a carer's assessment. • Number of identified carer champions in GP surgeries/PCNs • A minimum of 2 Carer Forum meetings taking place each year. • An annual carer fair held to raise awareness.	Hillingdon Carer Card. • Options for improving access to needs assessments for parent carers will be explored. • The feasibility of establishing a measure for the percentage of parent carers receiving a triage assessment will be explored. • The Carer Support Service provider and health and care partners will work in partnership to ensure the development and maintenance of an understanding by health and care professionals about the role of unpaid carers. • Carer champions will be identified in all GP practices. • Carer registers will be established in GP practices. • In GP practices people with long-term conditions will be proactively asked to identify if they have a carer and who this is. • Carer passports will be introduced in the Hillingdon Hospitals and '*John's Campaign*' will be promoted to ensure that carers are involved and able to support patients during a hospital stay. • We will ensure that the Cerner electronic patient record (EPR) system is developed so that asking if a patient at Hillingdon Hospitals has a carer or is a carer is a mandatory aspect of assessment and triggers appropriate care planning (where possible and appropriate). • A mechanism will be established at The Hillingdon Hospitals to ensure that, where appropriate, carers are involved in shared decision making alongside patients. • The Triangle of Care will be embedded in CNWL mental health services and rolled

	out across community health services. • We will explore ways to obtain the views of carers from under-represented communities. • Borough-wide publications such as *Hillingdon People* will be used to raise awareness of support options available to carers. • Views of carers will be fed to the multi-agency Carers Strategy Group to shape priorities.

Outcome 2: The physical and mental health and wellbeing of carers is supported.

What carers have told us	What we will do 2023 – 2028
'Ability of carers to cope with caring varies from carer to carer – everyone has a different breaking point'. *'I am always on alert and feel exhausted, there is no recognition of how caring impacts our health through constant worry about loved ones'.* *'Making relationships is hard for carers as I can't easily leave the house'.* *'Too many assumptions are made about your willingness to care and the types of support available'.*	• Using 2021 census data we will compare the profiles of carers supported under the Carer Support Service contract with the profile of carers on GP registers to identify gaps in support that may require targeted interventions. • We will renew the memorandum of understanding between statutory health and care to agree an integrated approach to identifying and assessing carer need in Hillingdon. • We will ensure the continuation of a one stop support service for carers through the retendering of the Carer Support Service contract. • Carers will be screened in primary care for depression and other health problems. • Carers will continue to have access to CNWL Recovery and Wellbeing courses. • We will use new digital technologies to support carers where this is appropriate and will be of assistance, e.g., telecare and telemedicine.
Measuring Delivery Carer quality of life metrics, i.e., % of adult carers to say: • *I'm able to spend my time as I want, doing things I value or enjoy.* • *I have as much control over my daily life as I want.* • *I look after myself.* • *I have no worries about my personal safety.*	

• *I have as much social contact as I want with the people I like.* • *I feel I have encouragement and support.*	• To prevent loneliness and isolation we will continue to develop a range of opportunities for carers to meet with other people, including other carers. This will be delivered through the Carer Support Service contract, the promotion of Direct Payments for carers who meet the National Eligibility Criteria for carers and social prescribing. Social prescribing will also assist carers who do not meet eligibility criteria. • We will facilitate access to education for adult carers who wish to continue or restart structured learning. • Partners will liaise with the Council's Safeguarding Adults Team to ensure that safeguarding issues identified are responded to appropriately. This may, where necessary and appropriate, include liaison with the Metropolitan Police Service.

Outcome 3: The financial impact of being a carer is minimised.

What carers have told us	**What we will do 2023 – 2028**
'When I became a carer, I had no idea how I was going to manage financially'. *'I took a part time job to try and fit in with my caring role but was often unable to pick up the shifts due to the priority of caring'.*	• Access to information, advice and support about allowances and benefit entitlements will continue to be delivered through the Carer Support Services contract. • We will ensure that information and guidance to employers about the rights of people with caring responsibilities is available. • We will relaunch guidance for employers on how to support working carers.
Measuring Delivery	
• Value of benefits/allowances secured for carers.	

Outcome 4: Carers have a life alongside caring.

What carers have told us	**What we will do 2023 – 2028**
'Ability of carers to cope with caring varies	

from carer to carer – everyone has a different breaking point'. *'I am always on alert and feel exhausted, there is no recognition of how caring impacts our health through constant worry about loved ones'.*	• We will promote the use of Direct Payments to secure more personalised options for addressing the social care needs of carers. • We will also explore options for Personal Health Budgets in the form of Direct Payments to meet assessed health needs as well integrated budgets to meet health and social care needs.
Measuring Delivery • Number of adult carers in receipt of short break opportunities. • Number of short break opportunities available. • % of carers supported by Adult Social Care receiving support in full or in part via Direct Payments. • Number of carers having health needs met through Personal Health Budgets.	• We will work with care home providers to develop more flexible respite options to respond to the needs of carers. • We will continue to develop flexible short break options as the needs of carers change over the lifetime of the strategy. • We will review the short break options available to parent carers. • The Carer Support Service Provider will work with the Council and Neighbourhoods to support carers to develop emergency replacement care plans. • We explore options to support carers and former carers into employment. Examples of support included would be help with job-searching, applications & CVs, and interview techniques; wellbeing support; IT skills; and access to training. • Through the Carer Support Service, we will support carers to access volunteering opportunities in or near their communities. • People who are carers or former carers will be supported to be members of the Carers Strategy Group as experts by experience.

Outcome 5: Carers have access to quality information and advice at any point in their caring journey and know where to find this.

What carers have told us	What we will do 2023 – 2028

'Provide us with someone to talk to who knows the relevant system/processes inside-out and can make this easier for us to ask the right questions'. *'What happens when you don't know your way around social care? Or if you do, you don't know what to say'.* *'Understand that Black, Asian and minority ethnic carers may not be familiar with the support offered by services or may not be able to access them'.* *'Allowances need to be made carers who aren't confident using a computer'.*	• Good quality information and advice will continue to be provided through the Carer Support Service contract. • Through the Carer Support Service contract, we will continue to keep health and care professionals updated about sources of help and onward referral. • We will explore different approaches to the delivery of information and advice to ensure access from Hillingdon's diverse communities. • We will ensure that carers have access to information, advice and support about the hospital discharge process and what to expect after discharge. • We will ensure that the Patient Advisory and Liaison Service (PALS) at The Hillingdon Hospitals has the necessary information and resources to sign-post carers and patients with carers to access support.
Measuring Delivery • % of adult carers who have found it easy to access information and/or advice. • % of adult carers who are satisfied with the information and/or advice they have received.	

Outcome 6: Carers have the skills they need for safe caring.

What carers have told us	**What we will do 2023 – 2028**
'When you become a carer for a loved one, assumptions are often made that you know what to do and how to do it and this isn't always true'.	• We will listen to what carers have to say about the skills they need to undertake their caring role. • We will inform carers through a Carer Register developed under the Carer Support Service contract about new skills that they may need, e.g., infection prevention and control measures, manual handling, etc. • The Carer Support Service provider will work with the Council and health and care partners to develop training opportunities for carers so that they have the skills to continue in their caring role safely.
Measuring Delivery • Number, range and utilisation of training opportunities for young, adult and parent carers.	

Outcome 7: Young carers are supported from inappropriate caring and provided with the support they need to learn, develop and thrive and enjoy being a young person.

What young carers have told us	What we will do 2023 – 2028
'Our role as young carers should be acknowledged when we are supporting a member of our family'. *'It should be recognised that I am a carer and still young'.* *'I need people to talk to me about being a carer in a way that I will understand'.*	• We will continue to work with schools to ensure that young carers are identified and can access appropriate support. • Working with young carers we will keep the young carers' assessment process under review to ensure that it is fit for purpose. • We will continue to develop the range of age-appropriate short break opportunities for young carers. This will mainly be delivered through the Carer Support Services contract and partnership working with the voluntary and community sector. • To guard against young carers providing inappropriate levels of caring or otherwise experiencing abuse or neglect, we will ensure that there is an awareness among stakeholders of the signs to look out for and action to take if they spot, such as a referral to the Stronger Families Hub.
Measuring Delivery • % of young carer population on Carer Register for Hillingdon. • Number of young carers in receipt of short break opportunities. • Number of short break opportunities available.	

9. Delivering Better Outcomes for Carers: Monitoring Delivery

The Delivery Plan

The delivery plan that summarises the actions that will be undertaken during the lifetime of the strategy can be seen in Annex 2. This shows the actions that will be delivered in the short-term (2023/24), medium-term (2024/26) and the longer-term (2026/28). The expectation is that the delivery plan will be a living document and priorities may change over the lifetime of the strategy in response to evolving need.

The multi-agency Carers Strategy Group has responsibility for monitoring implementation of the actions within the delivery plan, the content of which will be reviewed on an annual basis to ensure that it is responsiveness to the changing needs of carers in Hillingdon. An annual update on the implementation of the delivery plan as well as emerging challenges for carers will be reported to the Council's Cabinet and the Delivery Board for Hillingdon's borough-based partnership. Annex 3 shows how delivery of carers strategy fits into the management of

Hillingdon's health and care system.

Measuring Delivery
The metrics that will be used to test the success of the strategy in supporting carers in Hillingdon are shown above in section 8: *Better Outcomes for Carers*. It is expected that metrics will evolve during the lifetime of the strategy.

Annex 1 – Glossary of Terms Used in Strategy Document

This annex is intended to explain terms used in this strategy document that have not been explained elsewhere.

Term	Explanation
Carer passports	A carer passport in a hospital is a simple tool which identifies someone as being in a caring role for one of the hospital's patients, involving them more fully in the patient's care, and connecting them with further support.
Carer Recognition Scheme	This was a scheme introduced by the Council in 2018 that enabled people to nominate carers for a recognition certificate awarded by the Mayor of Hillingdon.
Education, Health and Care Plan (EHCP)	An EHCP is for children and young people aged up to 25 who need more support than is available through special educational needs support. EHCPs identify educational, health and social needs and set out the additional support to meet those needs.
H4All	This is a consortium of local voluntary and community sector organisations that includes Age UK, Carers Trust Hillingdon, the Disablement Association Hillingdon (DASH), Harlington Hospice and Hillingdon Mind.
John's Campaign	John's Campaign is a campaign for extended visiting rights for family carers of patients with dementia in hospitals in the United Kingdom. It applies to all hospital settings (acute, community, mental health).
NHS Digital	NHS Digital is the trading name of the Health and Social Care Information Centre, which is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care in England, particularly those involved with the National Health Service of England
Neighbourhood Teams	Local areas of often 30,000-50,000 people supported by primary care, other health partners and the Council to improve the health and wellbeing of the community and tackle health inequalities.
Primary Care	Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice (GPs), community pharmacy, dental, and optometry (eye health) services.

Primary Support Reason	Means one or more of the following categories of need set out in the guidance for the statutory annual Short and Long Term (SALT) return to the NHS Digital: • Physical Support: Access & mobility only • Physical Support: Personal care support • Sensory Support: Support for visual impairment • Sensory Support: Support for hearing impairment • Sensory Support: Support for dual impairment • Support with Memory & Cognition • Learning Disability Support • Mental Health Support • Social Support: Substance misuse support • Social Support: Asylum seeker support • Social Support: Support for Social Isolation/Other
Social Prescribing	In Hillingdon this is where H4All Wellbeing Officers working with Neighbourhood Teams link up residents with community groups and activities to provide practical and emotional support to address their needs.
Triangle of Care	The Triangle of Care guide was launched in July 2010 by The Princess Royal Trust for Carers (now Carers Trust) and the National Mental Health Development Unit. There are six standards to the Triangle of Care, and these are: 7. Carers and the essential role they play are identified at first contact or as soon as possible thereafter. 8. Staff are '*carer aware'* and trained in carer engagement strategies. 9. Policy and practice protocols re: confidentiality and sharing information, are in place. 10. Defined post(s) responsible for carers are in place, e.g., Carers' leads or champions. 11. A carer introduction to the service and staff is available, with a relevant range of information across the care pathway, e.g., an introductory letter from the team or ward explaining the nature of the service provided and who to contact. 12. A range of carer support services is available.

Annex 2 – Joint Carers' Strategy 2023 – 2028 Delivery Plan

Outcome 1: Carers are identified, recognised and able to make a positive contribution.					
	Activity	**2023/24**	**2024/26**	**2026/28**	**Lead Organisation**
1.1	Relaunch the Carer Support Service Carer Register to encourage carers to register.	√			LBH/Carer Support Service Provider
1.2	Develop the Hillingdon Carer Card to improve its attractiveness to carers.	√	√		Carer Support Service Provider
1.3	Re-establish carer leads in 100% of GP practices that are members of The [GP] Confederation.	√	√		The [GP] Confederation
1.4	Explore options for improving access to needs assessments for Parent Carers.	√			LBH
1.5	Introduce Carer passports at Hillingdon Hospitals.	√	√		Hillingdon Hospitals
1.6	Ensure that the Cerner electronic patient record (EPR) system is developed so that asking if a patient has a carer or is a carer is a mandatory aspect of assessment and triggers appropriate care planning (if possible and where appropriate).	√	√		Hillingdon Hospitals
1.7	Establish a '*colleague as a carer'* support group as part of Hillingdon Hospitals' staff wellbeing workstream.	√			Hillingdon Hospitals
1.8	Roll out the Triangle of Care across community health services.	√	√	√	CNWL
1.9	Review the role of the carer forums.	√		√	LBH
1.10	Explore ways of obtaining the views of '*hidden*' carers across Hillingdon's diverse communities.	√	√	√	Carer Support Service Provider

1.11	Explore options for re-establishing a Carer Recognition Scheme.		√		LBH

Outcome 2: The physical and mental health and wellbeing of carers is supported.					
	Activity	**2023/24**	**2024/26**	**2026/28**	**Lead Organisation**
2.1	Subject to availability of suitable permissions, complete comparison of carers on GP registers with those on the Carer Register developed by the Carer Support Service provider to identify gaps in support.	√	√	√	Carer Support Service Provider/The Confederation
2.2	Refresh the Memorandum of Understanding between health and care partners on an integrated approach to identifying and assessing carer need in Hillingdon.	√			LBH
2.3	Complete development of a baseline profile of carers currently supported, i.e., age, gender, ethnicity and location in the borough to map against the health and wellbeing needs of Hillingdon's population identified from the 2021 census.	√			LBH
2.4	Retender the Carer Support Service contract to comply with procurement regulations and secure service stability for up to eight years.	√			Carer Support Service Provider
2.5	Implement the *Carers and Hospital Discharge: Toolkit for London Hospitals and Community Providers* across Hillingdon Hospitals.	√	√		Hillingdon Hospitals
2.6	Roll out screening of carers for depression and other health problems in GP practices.	√	√	√	The Confederation
2.7	Complete pilot of bespoke bereavement counselling service for carers supported through caring at end of life.	√			Carer Support Service Provider

Outcome 3: The financial impact of being a carer is minimised.					
	Activity	**2023/24**	**2024/26**	**2026/28**	**Lead Organisation**
3.1	Develop web-based information for employers about the rights of people with caring responsibilities.		√		Carer Support Service Provider
3.2	Explore re-launch of the guidance for employers of carers in employment.		√		LBH

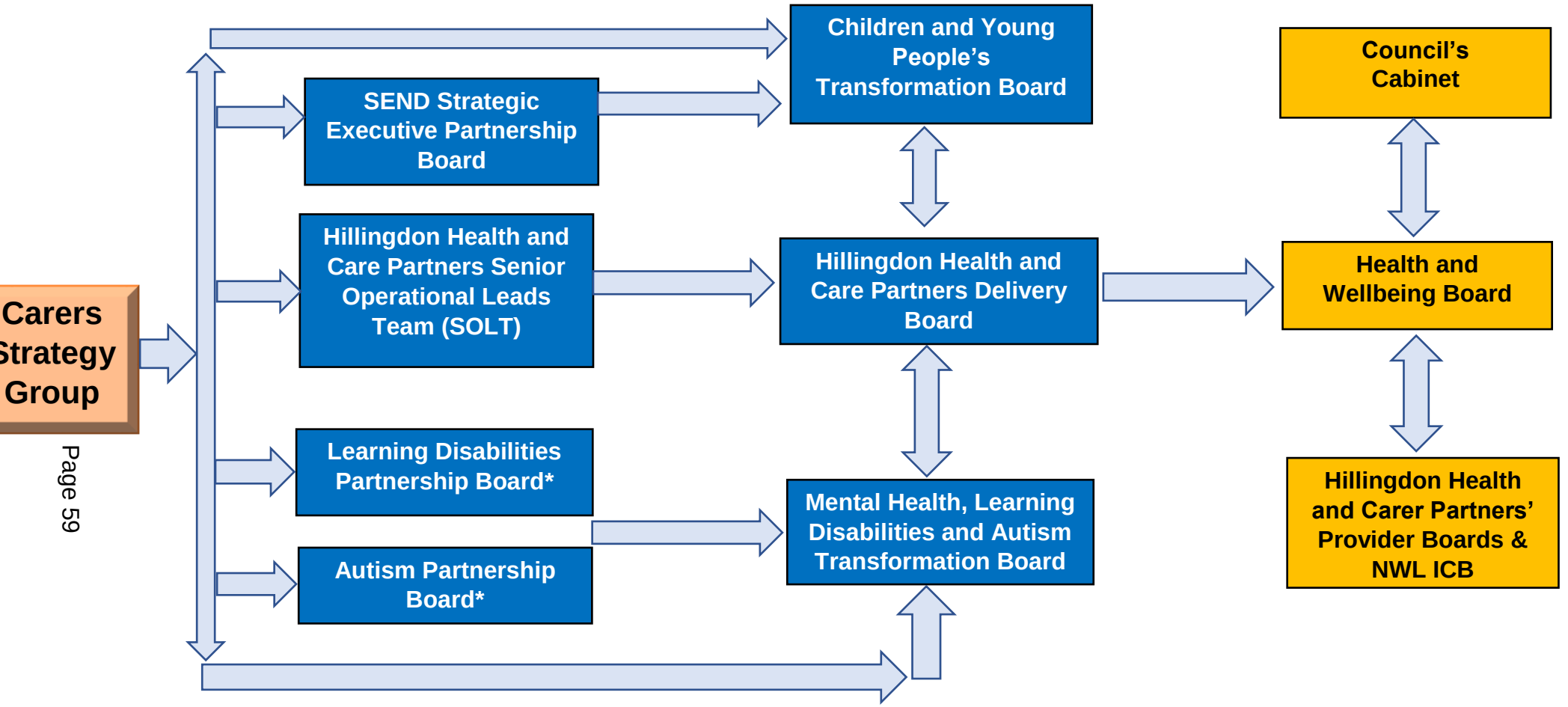
Outcome 4: Carers have a life alongside caring.					
	Activity	**2023/24**	**2024/26**	**2026/28**	**Lead Organisation**
4.1	Explore options for increasing the percentage of adult carers supported by the Council having needs met via Direct Payments.	√	√		LBH
4.2	Explore scope for health needs of carers being addressed through Personal Health Budgets taken as Direct Payments and Integrated Budgets.		√		NWL ICB

Outcome 5: Carers have access to quality information and advice at any point in their caring journey and know where to find this.					
	Activity	**2023/24**	**2024/26**	**2026/28**	**Lead Organisation**
5.1	Include information about support for carers on web pages of 100% GP practice.	√	√		The Confederation
5.2	Establish a means of ensuring that the information held by the Patient Advisory and Liaison Service (PALS) at Hillingdon Hospitals is kept up to date.	√			Hillingdon Hospitals
5.3	Develop a programme to ensure that information and advice is accessible to Hillingdon's diverse communities.	√	√	√	Carer Support Service Provider

Outcome 6: Carers have the skills they need for safe caring.					
	Activity	**2023/24**	**2024/26**	**2026/28**	**Lead Organisation**
6.1	In consultation with carers, keep under review their training needs and develop an annual training programme with health and care partners.	√	√	√	Carer Support Service Provider
6.2	Develop an end of life training programme for carers that is reviewed annually.	√	√	√	Carer Support Service Provider

Outcome 7: Young carers are supported from inappropriate caring and provided with the support they need to learn, develop and thrive and enjoy being a young person.					
	Activity	**2023/24**	**2024/26**	**2026/28**	**Lead Organisation**
7.1	Working with young carers, review the young carer assessment process to ensure that it is fit for purpose.	√			LBH
7.2	Increase the number of schools participating in a young carer recognition programme.	√	√	√	Carer Support Service Provider
7.3	Support schools to develop their own support provision for young carers.	√			Carer Support Service Provider
7.4	Develop and deliver support sessions in school for the most disadvantaged young carers, e.g., those caring for a parent with mental ill health and/or substance misuse.	√	√	√	Carer Support Service Provider

Annex 3 – Carers Strategy Delivery Governance Arrangements



Key

	Statutory Bodies
	Governance Group
	Reporting line
*	Boards also reporting to the SEND Strategic Partnership Board

This page is intentionally left blank

2023/24 BETTER CARE FUND SECTION 75 AGREEMENT

Committee name	Health and Social Care Select Committee
Officer reporting	Gary Collier – Adult Services and Health Richard Ellis – NHS North West London
Papers with report	**Appendix 1:** Section 75 Agreement
Ward	All

HEADLINES

This report is being brought to the Committee's attention as it is included within its work programme for 2023/24. The Committee received a report about the 2022/23 Better Care Fund (BCF) and the agreement under Section 75 (s75) of the National Health Service Act, 2006 (NHS Act, 2006) at its November 2022 meeting and this report is intended as an update to Members, including new national requirements, how the BCF is being applied in Hillingdon in 2023/24 and the significance of the s75 agreement.

RECOMMENDATION

That the Committee question officers and partners on the content of the report.

SUPPORTING INFORMATION

About the Better Care Fund

1. The Committee is reminded that the Better Care Fund (BCF) is a national initiative intended to support people to live healthy, independent and dignified lives through joining up health, social care and housing services seamlessly around the person. This is underpinned by the following national objectives:

- ***National BCF Objective 1:*** Enable people to stay well, safe, and independent at home for longer.
- ***National BCF Objective 2:*** Provide the right care in the right place at the right time.

2. The BCF is a collaboration between the Department of Health and Social Care (DHSC), the Department of Levelling Up, Housing and Communities (DLUHC), NHS England and the Local Government Association and has been a conduit for closer working relationships between health and social care partners in Hillingdon. It seeks to address the fragmentation of service provision that can arise from the separate legal frameworks that exist for health and social care, which can have implications for the experience of care faced by residents.

3. The first BCF plan was for 2015/16 and the latest iteration covers the two-year period from April 2023 to March 2025. The requirements for 2023/25 plan are contained within the *Better Care Fund Planning Requirements, 2023/25* published by the Department of Health and Social Care (DHSC) and NHS England on 4 April 2023.

4. Access to some funding within the BCF is dependent on compliance with national BCF conditions. In 2023/24, this means **£22,869k** NHS funding and **£12,578k** paid directly to the

Council by the DLUHC to support the local health and care system is conditional on compliance with national requirements. The NHS funding comes to Hillingdon through the North West London Integrated Care Board (the *'ICB'*).

5. The documents that formed part of Hillingdon's BCF submission can be accessed via the Council's website using the following link: https://www.hillingdon.gov.uk/bcf. In addition to the detailed financial breakdown, the relevant documents include:

- **Narrative plan:** This is intended to demonstrate how the BCF national conditions are being met. It is also intended to address key lines of enquiry set out in the planning guidance.
- **Completed template:** This details the financial arrangements and the local targets for the national metrics and supporting rationale.
- **Intermediate care demand and capacity template:** First introduced in 2022/23, this is intended to develop a single picture of intermediate care needs and resources across the health and care system. Although there was a requirement to submit the template, it will not be included as part of the plan assurance process.

Intermediate Care Services Explained

Intermediate care services are a range of short-term services provided to people free of charge to enable them to return home more quickly after a hospital stay or avoid going into hospital unnecessarily. The range of services include: reablement, crisis response, home-based rehabilitation, and bed-based services.

6. Table 1 below shows the alignment between BCF schemes and place-based transformation workstreams.

Table 1: Alignment of BCF Schemes and Transformation Workstreams

BCF Scheme	Transformation Workstream
Scheme 1: Neighbourhood development.	**Workstream 1:** Neighbourhood Based Proactive Care.
Scheme 2: Supporting carers.	Enabler
Scheme 3: Reactive care	**Workstream 2:** Reactive Care
Scheme 4: Improved market management and development.	Enabler
Scheme 5: Integrated support for people with learning disabilities and/or autistic people.	**Workstream 4:** Care and support for adults with mental health challenges and/or people with learning disabilities and/or autism.

7. The priorities for each can be found in Schedule 1 of the s75 agreement attached as **Appendix 1.**

BCF Changes 2023/25

8. *Adults focus:* The planning requirements for the 2023/25 BCF plan places much greater emphasis on supporting adults and, for this reason, the scheme concerning integrated care and support for children and young people has been removed from the plan. This results in a reduction of £4,860k (£2,537k for the Council and £2,323k for the ICB) in the value of the BCF compared to 2022/23. However, the Committee is asked to note that this makes no material

difference as partnership and financial arrangements will continue.

9. *BCF review:* For 2023/24, the ICB has sought to achieve some consistency in approach across the eight boroughs within the North West London sub-region whilst recognising local circumstances. This has resulted in some schemes funded from the additional NHS contribution funding stream being removed pending the outcome of a review of out-of-hospital services and BCF schemes that will take place in the autumn. There is a resultant £23,878k reduction in ICB voluntary contribution for 2023/24 compared to 2022/23 (including the £2,323k in respect of children and young people's services). This has no significant effect in 2023/24 as there is a commitment to continue all schemes pending the outcome of the review and the expectation is that no changes will be made during this financial year without agreement.

10. The Council has increased its voluntary contribution to the 2023/25 BCF plan from £45,454k in 2022/23 to £53,250k in 2023/24, which reflects the ambition to move towards a place-based health and care budget within the BCF legal framework referred to above and as discussed at Health and Wellbeing Board (HWB) meetings over the last two years. This is funding in existing placement and homecare budgets and does not represent an additional financial pressure on the Council.

11. The intention of local health and care partners is to conclude our own place-based review to inform that being undertaken by ICB with the aim of securing mutual agreement on the final content of the 2024/25 plan, if possible, by the end of 2023. Any reference to 2024/25 financial arrangements within this report is therefore identified as provisional, subject to the outcome of this review.

12. *Mental health discharges*: Funding from the Discharge Fund and additional ICB contribution is facilitating additional social work capacity to support the discharge from hospital of adults with mental health needs. These cases tend to be complex, which can lead to increased length of stay in hospital. The additional social care capacity is intended to contribute to a reduction in length of stay. Support for some people with mental health needs leaving hospital will also be provided by a new hospital discharge floating support service funded via the ICB additional contribution.

2023/25 BCF National Conditions

13. There are four national conditions and Hillingdon received written confirmation from NHS England on 5 October 2023 that all conditions had been met.

14. ***National Condition 1:*** **A jointly agreed plan** - A plan that has been agreed by the HWB. This must demonstrate that:

- Funding is placed in one or more pooled budgets in an agreement under section 75 (s75) of the NHS Act, 2006.
- NHS trusts, social care providers, voluntary community and social enterprise (VCSE) and housing must be involved in development of the plan.

15. ***National Condition 2:*** **Demonstrating delivery of BCF national objective 1 -** ***Enabling people to stay well, safe and independent at home for longer*****.** This includes demonstration of:

- How personalised care and asset-based approaches are embedded.
- Implementation of joined up approaches to population health management and proactive care.
- Multi-disciplinary teams at place or neighbourhood level.
- Additional support to unpaid carers and availability of adaptations for people at risk of reduced

independence.

16. ***National Condition 3*: Demonstrating delivery of BCF national objective 2 - *Providing the right care in the right place at the right time***. This must show how the ICB and social care commissioners will continue to:

- Support safe and timely discharge from hospital to usual place of residence.
- Implement ministerial priority to tackle delayed discharges.

17. It also requires identification of:

- How additional discharge funding will be used for 2023/24 and outline plans for 2024/25.
- How discharge funding will impact on discharge-related metrics.
- Summarise progress against 2022/23 high impact change model for discharge self-assessment.

18. ***National Condition 4:*** **Maintaining the NHS's contribution to adult social care and investment in NHS commissioned out of hospital services.** The minimum contributions are as follows:

- ***Minimum contribution to adult social care:*** This is £8,339k for 2023/24 and will rise to £8,811k in 2024/25.
- ***Minimum contribution to out of hospital services:*** The minimum amount in 2023/24 is £6,498k and in 2024/25 will be £6,866k. Most of this funding is locked into a community health contract between the ICB and CNWL.

BCF Section 75 (s75) Agreement

19. The Committee is reminded an agreement under s75 of the NHS Act, 2006, enables councils and NHS Bodies, e.g., integrated care boards, to contribute to a common fund called a pooled budget, which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care through delegation of functions. It enables joint commissioning of integrated services. Having a pooled budget has been a BCF requirement since its inception and the Council has continued to be the host for it. The s75 also provides a mechanism for the transfer of funds between the NHS and the Council.

20. Although there was a national requirement to complete a two-year BCF plan, there is only a requirement to enter into a one-year agreement to cover 2023/24. The approach in Hillingdon has been to seek approval for one-year with the option to extend for a further year, with authority to approve the extension delegated to the Leader of the Council and Cabinet Member for Health and Social Care.

<u>Delegation of Functions Examples</u>

21. Table 2 below provides examples of delegation of functions that are given legal sanction by the s75 agreement.

Table 2: Examples of Delegation of Functions Between NHS and Social Care		
Function	**Example**	**Description**
Lead commissioning	Bridging Care Service	This supports the discharge of people from hospital who require care back to their own homes for up to five days

Table 2: Examples of Delegation of Functions Between NHS and Social Care		
Function	**Example**	**Description**
		pending an assessment of long-term care needs or referral to the Reablement Service.
	Step-down nursing beds	These beds support the discharge of people who do not need to be in hospital but need to be in a nursing home setting pending an assessment of ongoing care needs. The length of stay would usually be up to six weeks.
	Community equipment	This service provides aids of daily living ranging from bath board to four section electric beds and hoists with the aim of enabling residents to remain in their own home.
	Carers Support Service	This contract brings together Council and NHS funding to support both young and adult carers.
Assessment and case management	Case management for people with learning disabilities	The Council case manages people with learning disabilities in receipt of Continuing Healthcare funding on behalf of the ICB, as well as jointly funded cases.
	Community equipment	Both the Council and ICB delegate responsibility to suitably qualified staff employed by or on behalf of either partner to undertake assessments and prescribe equipment to meet either social care or health needs as relevant.
	Personal Health Budgets (PHBs)	The Council manages PHBs taken as direct payments on behalf of the ICB.

Transfer of Funds Examples

22. The examples given in Table 2 entail a transfer of funds between the NHS and the Council but there is also a transfer of funds in respect of the funding or joint funding of posts. Examples include social work support for hospital discharge, and additional capacity within the Council's Brokerage Service.

BCF Section 75 Agreement Key Features

23. The s75 agreement is largely a roll forward from 2022/23 agreement that the Committee considered in November 2022. However, the main features can be summarised as follows:

- ***Parties to the Agreement***: The s75 agreement will be between the Council and the ICB.
- ***Agreement duration***: The term of the 2023/24 agreement is 3 April 2023 until 31 March 2024 but, as stated above, with the option to extend for a further year to 31 March 2025.
- ***Hosting***: The practice since the inception of the BCF has been for the Council to host the pooled budget, which is the equivalent of a joint bank account.
- ***Hospital discharge arrangements***: Schedule 1D of the s75 agreement in **Appendix 1** sets out financial arrangements supporting hospital discharge. This includes funding for short-term bed-based block contracts as well as financial arrangements for out-of-hospital services that are not bed-based. It sets out services funded from the Discharge Fund as well as other funding streams within the BCF. The agreement allows for funding arrangements for some services within the Schedule 1D to continue to continue beyond 31 March 2024, subject to termination arrangements within the schedule, or an extension of the current agreement, or a new s75 agreement being established.
- The agreement also identifies usage of underspend from 2022/23 winter pressures funding that is not included within the Pooled Budget and will not continue beyond 2023/24.
- ***Delegations***: These have been amended to permit the Council to act as lead commissioner on behalf of the ICB in respect of the Carer Support Service.
- ***Risk share***: It is established practice that both partners manage their own risks and this is extended to the 2023/24 plan.
- ***Dispute resolution***: The dispute provisions of the agreement have been rolled over from the agreement supporting the 2022/23 BCF plan.
- ***Governance****:* The delivery of the successive iterations of Hillingdon's plans has been overseen by the Core Officer Group comprising of the ICB's Joint Borough Directors for Hillingdon, the Council's Corporate Director for Adult Social Care and Health, HHCP's Managing Director and the BCF Programme Manager. The governance schedule (Schedule 3) within the s75 agreement demonstrates the interrelationship between the Core Officer Group, HHCP's Delivery Board and the HWB.

PERFORMANCE DATA

National Metrics

24. The 2023/25 metrics are aligned to the two national conditions concerned with the implementation of the national BCF objectives. The approach taken by partners in agreeing targets has been, as in previous years, that they should be realistic and achievable. The detail of all targets and the supporting rationale can be found using the link in paragraph 5.

25. The national metrics linked to the *Enabling people to stay well, safe and independent at home for longer* objective in 2023/24 are:

- **Unplanned admissions for ambulatory sensitive chronic conditions**. The conditions within the scope include acute bronchitis, angina, heart disease, heart failure, dementia, emphysema, epilepsy, high blood pressure, diabetes, chronic obstructive pulmonary disease (COPD) and fluid on the lungs (pulmonary oedema). The 2022/23 target for this metric was also achieved and the 2023/24 target was set by taking the 2022/23 actual number of admissions and reducing this by 1%.

Commentary

Quarter 2 Position: *On track (Green)* - Concentration of community resources on discharge impacts on admission avoidance capacity. This is being addressed with transition to a new operating model reflected within BCF plan and previously discussed by the Committee.

- **Permanent admissions to care homes by people aged 65 and over**. The 2022/23 target was achieved and that for 2023/24 takes into consideration the increase in the older people population, increased levels of acuity as a legacy of the pandemic and the fact that some short-term placements are unavoidable and appropriate to meet need, including needs of unpaid carers.

Commentary

Quarter 2 Position: *Not on track (Amber)* - Increasing numbers of older people with increased acuity being seen, which may be attributed to Covid legacy. 75% of 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.

- **The proportion of older people who were still at home 91 days after discharge from hospital into reablement or rehabilitation services**. 2023/24 will be the final year of this metric. Hillingdon's 2022/23 target was achieved. The denominator for this metric is the number of older people discharged to Reablement from hospital in Q3 and the numerator is those who were still at home in Q4.

Commentary

Quarter 2 Position: *Data not available* - The severity of the winter will impact on the deliverability of the target, as will the increased acuity of people being discharged into the service generally; readmissions related to the original cause of admission; and readmissions for different reasons.

- **Emergency hospital admissions due to falls in people aged 65 and over**. The 2023/24 target was set by reducing the 2022/23 actual outturn by 1%. The target was set on advisement from NWL and reflects a common approach across all eight boroughs in the sector.

Commentary

Quarter 2 Position: *On track (Green)* - The 2022/23 falls prevention programme has been expanded in 2023/24 to include a 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.

26. The national metric linked to the *Provide people with the right care, at the right place, at the*

right time objective in 2023/24 are:

- **Discharge to usual places of residence.** The target for this metric was narrowly missed in 2022/23. The 2023/24 target was set by reducing the 2022/23 outturn by 1%. This target was also set on advisement from NWL and reflects a common approach across all eight boroughs in the sector.

Commentary

Quarter 2 Position: *Not On track (Amber)* - Increasing levels of frailty are necessitating step-down in bed-based provision that does not count as normal place of residence.

27. It was intended that a new metric to measure the period between the '*discharge ready date'*, i.e., the date when it is expected that a person will be ready for discharge and when they are actually discharged was going to be introduced for winter 2023/24 but this has been deferred.

Monitoring Arrangements

28. Reporting on the delivery of the national metrics, the priorities and other measures shown in Schedule 1 of **Appendix 1** takes the form of the integrated performance report that is considered by the HWB on a quarterly basis.

29. The Committee may wish to note that the volume of scrutiny of the BCF has increased considerably over the last two years and now includes:

- Quarterly performance templates submitted to NHS England.
- Monthly reports to NHS England on Hospital Discharge Fund spend and activity. This reporting requirement has changed from being fortnightly from November.
- Fortnightly reports to the ICB on Discharge Fund activity.

RESIDENT BENEFIT

30. The BCF provides a framework for integration between health and social care that supports better health and wellbeing outcomes for residents. This is aided by access to £22,869k NHS funding and £12,578k from the DLUHC that is contingent on compliance with national BCF requirements.

FINANCIAL IMPLICATIONS

BCF Value 2023/25

31. The value of the BCF for 2023/24 as shown in Table 3 below is **£96,535k** and the provisional value for 2024/25 is **£98,520k**. A detailed financial breakdown of the contributions to the 2022/23 plan can be found by following the link shown in paragraph 5.

Table 3: 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**

32. Table 4 below provides a breakdown of the mandated funding streams for the BCF and also the additional voluntary contributions. Funding identified with an asterisk (*) is provisional pending the outcome of the review of out of hospital services and BCF schemes referred to earlier in this report.

Table 4: 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**

33. Table 5 provides a breakdown of the minimum BCF financial contributions.

Table 5: BCF MINIMUM CONTRIBUTIONS SUMMARY 2023/25		
Funding Breakdown	**2023/24 (£)**	**2024/25 (£)**
NHS MINIMUM CONTRIBUTION BREAKDOWN	**22,869,590**	**24,164,009**
• Protecting Social Care	8,339,569	8,811,589
• Out of Hospital	6,489,889	6,866,726
• Other minimum spend	8,040,132	8,485,694
•		
LBH MINIMUM CONTRIBUTION BREAKDOWN	**12,578,861**	**12,578,861**
• Disabled Facilities Grant (DFG)	5,111,058	5,111,058
• Improved Better Care Fund (iBCF)	7,467,803	7,467,803
•		
MINIMUM BCF VALUE	**35,448,451**	**36,742,870**

34. Table 6 below summarises the LBH and NHS contributions for the period of the 2023 to 2025 plan by scheme.

Table 6: ICB and LBH Financial Contribution by Scheme Summary							
Scheme		**2023/24**			**2024/25**		
		LBH (£,000)	**NHS (£,000)**	**TOTAL (£,000)**	**LBH (£,000)**	**NHS (£,000)**	**TOTAL (£,000)**
1.	Neighbourhood development	3,052	3,025	**6,077**	3,052	3,084	**6,136**
2.	Supporting carers	690	471	**1,161**	690	475	**1,165**

Table 6: ICB and LBH Financial Contribution by Scheme Summary							
Scheme		2023/24			2024/25		
		LBH (£,000)	NHS (£,000)	TOTAL (£,000)	LBH (£,000)	NHS (£,000)	TOTAL (£,000)
3.	Reactive care	5,489	19,990	**25,479**	6,180	20,964	**27,144**
4.	Improving care market management and development	26,232	5,083	**31,315**	26,272	5,287	**31,559**
5.	Integrated care and support for people with learning disabilities and/or autistic people	31,412	993	**32,405**	31,372	1,044	**32,416**
Programme Management		0	97	**97**	0	100	**100**
TOTAL		**66,875**	**29,659**	**96,534**	**67,566**	**30,954**	**98,520**

Summary of Financial Changes

35. For ease of reference, the main financial changes from the 2022/23 plan are:

- ***Additional LBH contribution*:**
  - Scheme 4: Long-term residential care home budget 65 + (£5,193k).
  - Scheme 4: Long-term nursing care home budget 65 + (£7,468k).
  - Scheme 4: Long-term homecare budget 65 + (£5,962k).

- ***Minimum NHS contribution***
  - Scheme 1: Safeguarding children hub (£63.6k).
  - Scheme 1: Ageing Well Ambulant Clinic (£207.5k).
  - Scheme 3: Ageing Well Integrated Discharge Team (£141.5k).

- **Additional NHS contribution to Social Care**:
  - Scheme 3: Hospital discharge Approved Mental Health Professional (AMHP) (£67k).
  - Scheme 3: Mental Health Discharge Social Worker post (£50k).
  - Scheme 3: Mental Discharge Floating Support Service pilot (£50.9k).
  - Scheme 3: Short-term nursing care home bed block contract (£491k).

36. In addition to the services within the former integrated care and support for children and young people scheme mentioned earlier in this report that have been removed from the 2023/25 BCF, £905k core funding for voluntary and community organisations such as Age UK, Carers Trust Hillingdon, the Disablement Association Hillingdon (DASH) and Hillingdon Mind has also been removed from the BCF Pooled Budget. This reflects the move away from grants to commissioned services under longer-term contracts and 2023/24 is a transition year during which current provision will be reviewed to determine the future service model. This work is aligned to the review of out of hospital services and BCF schemes outlined earlier in this report.

<u>Hospital Discharge Funding Arrangements</u>

37. *Discharge Fund:* This includes a component that is paid directly to the Council as a Section 31 grant by the DLUHC and an allocation by the ICB. The values are shown in Table 3 above. Members may wish to note that the ICB allocation for 2024/25 is provisional and dependent on the outcome of the review of out of hospital services and BCF schemes previously mentioned. The total allocation to the ICB for 2024/25 by the DHSC is £20m, which is double the 2023/24

allocation. The Discharge Fund spending plan can be found using the link provided in paragraph 5 of this report.

38. *Improved Better Care Fund (iBCF):* The iBCF funding is paid directly to the Council from Department of Levelling-up, Housing and Communities (DLUHC) under Section 31 of the Local Government Act 2003, with specific grant conditions, including a requirement that the funding is pooled in the BCF. The grant conditions for 2023/25 are the same as for the last three years, namely that the funding is used for:

- Meeting adult social care needs;
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and/or
- Ensuring that the local social care provider market is supported.

39. Table 6 above shows that the Hillingdon allocation for both 2023/24 and 2024/25 will be maintained at £7,467k and the practice of using the £220k uplift to the iBCF that the Council received in its 2022/23 iBCF allocation to contribute to the costs of short-term placements to support hospital discharge is being rolled forward into 2023/24 and 2024/25.

40. As for the last three years, the remainder of the funding is being used to support the local care market, i.e., long-term placements. This will fund the annualised effect of the fee uplifts as well as additional fee increases to reflect the financial pressures faced by regulated care providers due to higher staff, energy, and supply costs.

BACKGROUND PAPERS

2022 – 2025 Joint Health and Wellbeing Strategy (March 2022)
Better Care Fund Planning Requirements, 2023/25 (NHS England/DHSC April 2023: PR00315)

Appendix 1

Dated: day of November 2023

London Borough of Hillingdon

and

North West London Integrated Care Board

2023/24

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES UNDER THE BETTER CARE FUND UNDER SECTION 75 NATIONAL HEATH SERVICE ACT, 2006

CONTENTS

Acknowledgement: This agreement is based on a template developed by Bevan Brittan LLP
Fleet Place House | 2 Fleet Place | Holborn Viaduct | London EC4M 7RF
T 0870 194 1000 F 0870 194 7800

THIS AGREEMENT is made on day of November 2023.

PARTIES

(1) **London Borough of Hillingdon** of Civic Centre, High Street, Uxbridge UB8 1UW (the **"*Council*"**)

(2) **North West London Integrated Care Board** (the "***ICB***") of 15 Marylebone Rd, London NW1 5JD

BACKGROUND

A. The Council is a Local Authority established under the London Government Act 1963 (as amended) and by virtue of Part 1 of the Care Act 2014 the Council is responsible for ensuring access to, commissioning and/or providing social care services on behalf of the adult population of the London borough of Hillingdon.

B. The ICB is established under Chapter A3 of Part 2 of the National Health Service Act, 2006. The ICB shall be responsible for commissioning services to meet the health needs of persons who are patients of the providers of primary medical services in the London borough of Hillingdon as described in the 2006 Act.

C. Collectively the Council and the ICB shall be known as the '*Partners'*.

D. The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the ICB and the Council establish a pooled fund for this purpose.

E. Section 75 of the 2006 Act gives powers to local authorities and integrated care boards to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

F. The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services. It is also provides the means through which the Partners can pool funds and align budgets as agreed between the Partners.

G. The aims and benefits of the Partners in entering into this Agreement are to:
   a. improve the quality and efficiency of the Services;
   b. progress towards closer integration between health and social care where this is demonstrably the most effective mechanism for delivering better outcomes for Service Users and the Partners.
   c. meet the National Conditions and Local Objectives;
   d. make more effective use of resources through the establishment and maintenance of a pooled fund for revenue and capital expenditure on the Services;
   e. ensure that by 2025/26 improvement in the health and wellbeing of all residents can be demonstrated as well as a reduction in disparities in health and care across Hillingdon's communities.

H. The Partners have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements.

I. The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 65Z7 or in compliance with section 65Z7 of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

J. as applicable, to the extent that exercise of these powers is required for this Agreement.

K. The Council and the ICB have approved the terms and conditions of this Agreement.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1983 Act means the Mental Health Act, 1983.

2004 Regulations means the Environmental Information Regulations 2004.
2006 Act means the National Health Service Act, 2006.
2014 Act means the Care Act, 2014 unless otherwise stated.
2018 Act means the Data Protection Act, 2018.
Affected Partner means, in the context of Clause 23, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event
Agreement means this agreement including its Schedules, Annexes and Appendices.
Approved Expenditure means any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price and Performance Payments.
Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.
Better Care Fund (BCF) means the Better Care Fund as described in NHS England Publications Approval Ref. No. PR00315.
Better Care Fund Plan means for 2023/25 the schemes described in **Schedule 1**.
Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement.
Commencement Date means 00:01 hrs on the 3rd April 2023.
Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;
(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or
(c) which is a trade secret.

Contract Price means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability or Performance Payment.
Core Officer Group has the same meaning as Partnership Board defined below.
Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract) to be payable by any Partner(s) to the Provider as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under the relevant Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract, liable to the Provider.
Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.
Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.
Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;
(b) acts of terrorism;
(c) acts of God;
(d) fire or flood;
(e) industrial action;
(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;
(g) any form of contamination or virus outbreak; and

(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming

relief

Functions means the NHS Functions and the Health-related Functions set out in **Schedule 2**.

Health Related Functions means those of the health-related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services that are set out in **Schedule 1**.

Host Partner means the Partner that will host the Pooled Fund.

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act, 2012.

ICB Statutory Duties means the duties of the ICB pursuant to Chapter A3 of Part 2 of the 2006 Act.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Description in **Schedule 1** of this Agreement.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an individual Scheme on behalf of each other is exercise of both the NHS and Council Functions through integrated structures.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(c) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Service under a Scheme Description and Specification.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the NHS England Better Care Fund Planning Guidance as are amended or replaced from time to time.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the ICB as are relevant to the commissioning of the Services and further described in **Schedule 2**.

NHS NWL means the North West London Integrated Care Board.

Non-Pooled Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification.

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 8.4.
Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.
Partner means either the ICB or the Council, and references to "**Partners**" shall be construed accordingly.
Partnership Board means the *'joint committee'* established in accordance with paragraph 10 (2) of the Regulations, which will be responsible for the review of performance and oversight of this Agreement as set out in the governance arrangements in **Schedule 3**, where it is described as the *'Core Officer Group'*.
Patients means the same as **Service Users**.
Performance Payment Arrangement means any arrangement agreed with a Provider and one of more Partners in relation to the cost of providing Services on such terms as agreed in writing by all Partners.
Performance Payments means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement.
Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.
Permitted Expenditure has the meaning given in Clause 7.3.
Personal Data means Personal Data as defined by the 2018 Act.
Personal Health Budgets means an amount of money to support a person's identified health and wellbeing needs the application of which is planned and agreed between the individual, their representative, or, in the case of children, their families or Carers and the local NHS Continuing Healthcare Team.
Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations.
Pooled Fund Manager means the Section 151 (Local Government Act, 1972) officer of the Council, who is the Corporate Director of Finance or the Accountable Officer of the ICB or their authorised representative, dependent on context.
Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.
Quarter means each of the following periods in a Financial Year:

- *Quarter 1*: 1 April to 30 June
- *Quarter 2*: 1 July to 30 September
- *Quarter 3*: 1 October to 31 December
- *Quarter 4*: 1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.
Regulations mean the *NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617* (as amended).
Residents mean people who live within the geographical boundaries of the London Borough of Hillingdon.
Scheme Description means the description of an Individual Scheme agreed by the Partners to be commissioned under this Agreement as described in **Schedule 1**.
Section 117 (s117) refers to the duties on local authorities and ICBs to provide aftercare to people previously detained under section 3 of the 1983 Act.
Sensitive Personal Data means Sensitive Personal Data as defined in the 2018 Act.
Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Description and Specification.
Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Users means those individuals for whom the Partners have a responsibility to commission the Services.

SoSHSC means the Secretary of State for Health and Social Care.

Term refers to the period of the Agreement as described in clause 2 of this Agreement.

Third Party Costs means all such third-party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Partnership Board.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "*including*" or "*includes*", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "*person*" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "*staff*" and "*employees*" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 Subject to compliance with the terms and conditions of this Agreement, this Agreement shall remain in force with respect to each party and their obligations until 31st March 2024 unless terminated in accordance with the relevant clauses, provisions, or sections of the Agreement.

2.3 This Agreement may be extended for a further twelve month period to 31st March 2025.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open and transparent with information about the performance and financial status of each scheme set out in Schedule 1; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme Description.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish a single pooled budget.

4.2 The Council delegates to the ICB and the ICB agrees to exercise, on the Council's behalf, the Health-related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions as described in **Schedule 2**.

4.3 The ICB delegates to the Council and the Council agrees to exercise on the ICB's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health-related Functions as described in **Schedule 2**.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement will include such functions as will be agreed from time to time by the Partners.

5.3 Where the Partners add a new Individual Scheme to this Agreement a Scheme Description and Specification for each Individual Scheme shall be in the form set out in **Schedule 1** and shall be completed and agreed between the Partners.

5.4 The Partners will not enter into a Scheme Description in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.5 The introduction of any Individual Scheme will be subject to approval in accordance with the governance process set out in **Schedule 3**.

5.6 For the purposes of implementing the Schemes in **Schedule 1**, the ICB delegates to the Council its functions below:

5.6.1 section 3(1)(b) of the 2006 Act of arranging for the provision of other accommodation for the purpose of any service provided under the 2006 Act;

5.6.2 section 3(1)(e) of the 2006 Act of arranging for the provision of such other services or facilities for the prevention of illness, the care of persons suffering from illness,

and the after-care of persons who have suffered from illness as are appropriate as part of the health service.

5.7 Table 1 below shall describe the form that the delegation provided for in Clause 5.6 above shall take.

Table 1: Summary of Form of Delegated Functions: ICB to Council	
Scheme	**Functions Delegated**
Scheme 1	None
Scheme 2	Delegation by the ICB to the Council to act as lead commissioner on behalf of the ICB for the Carer Support Service.
Scheme 3	a) Delegation by the ICB to the Council to enter into contractual arrangements with homecare providers on behalf of the ICB.
	b) Delegation by the ICB to the Council to procure the provision of beds for use as intermediate care or short-term placements on behalf of the ICB as described in **Schedule** 1**D** of this Agreement.
	c) Delegation by the ICB to the Council authority to act as lead commissioner on behalf of the ICB for the Bridging Care Service described in **Schedule 1D**.
	d) Delegation by the ICB to the Council to undertake the brokerage function for nursing care home placements on behalf of the ICB as described in **Schedule 1D** of this Agreement.
	e) Delegation by the ICB to the Council to act as lead commissioner on behalf of the ICB for the community equipment service as described in **Schedule 1B**.
	f) Delegation by the ICB to the Council authority to undertake assessments and prescriptions for community equipment to meet health needs.
Scheme 4	Delegation by the ICB to the Council to manage the process for people registered with Hillingdon GPs to access Personal Health Budgets as described in **Schedule 1C** of this Agreement.
Scheme 5	a) Delegation to the Council by the ICB the case management function for people with a learning disability and/or autism assessed as being eligible for NHS Continuing Healthcare (CHC) funding as described in **Schedule 1E** of this Agreement. b) Delegation to the Council by the ICB to act as lead commissioner in securing care and support to meet the assessed needs of

	people with a learning disability and/or autism eligible for CHC funding.

5.8 For the purposes of implementing the Schemes as described in **Schedule 1** the Council delegates its functions under section 2 (1) of the Care Act, 2014, to the ICB as follows:

5.8.1 Arrangements for the provision of services, facilities or resources, or take other steps that will:

a) Contribute towards preventing or delaying the development by adults in its area of needs for care and support;

b) Contribute towards preventing or delaying the development by carers in its area of needs for support;

c) Reduce the needs for care and support of adults in its area;

d) Reduce the needs for support of carers in its area.

5.9 Table 2 below shall describe the form that the delegation provided for in Clause 5.8 shall take.

Table 2: Summary of Form of Delegated Functions: Council to ICB

Scheme	Functions Delegated
Scheme 1	None
Scheme 2	None
Scheme 3	Delegation to the ICB by the Council authority to undertake assessment and prescription of community equipment to meet social care needs.

5.10 The Partners agree that the delegation of functions under this Clause 5 will:

5.10.1 Likely lead to an improvement in the way in which these functions are discharged; and

5.10.2 Will improve health and wellbeing.

6 COMMISSIONING ARRANGEMENTS

6.1 For the duration of the Term each Partner shall retain Lead Commissioner responsibility for the Services within the Schemes described in **Schedule 1** for which they had Lead Commissioner responsibility prior to the Commencement Date. This shall include performance management and contract monitoring of all relevant Service Contracts and payment of the Provider of a Services Contract.

6.2 Both Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

6.3 Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Description and Specification are commissioned within each Partners Financial Contribution in respect of that particular Service in each Financial Year.

6.4 Each Partner shall keep the other Partner and the Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in the Pooled Fund.

6.5 The Partnership Board will report back to the Health and Wellbeing Board as required by its Terms of Reference.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain a Pooled Fund for revenue and capital expenditure as set out in **Schedule 1**.

7.2 The Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 It is agreed that the monies held in Pooled Funds may only be expended on the following:

7.3.1 the Contract Price*;*

7.3.2 where the Partners are to be the Providers as shall be described in Schedule 1A, the Permitted Budget;

7.3.3 Third Party Costs*;*

7.3.4 Approved Expenditure

This shall be "*Permitted Expenditure*".

7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue or capital expenditure with the express written agreement of each Partner.

7.5 For the avoidance of doubt, monies held in the Pooled Funds may not be expended on Default Liabilities unless this is agreed by all Partners.

7.6 Pursuant to this Agreement, the Partners agree to appoint the Council as Host for the Pooled Fund as set out in the Scheme Specifications. The Host Partner shall be responsible for:

7.6.1 Managing and accounting for all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

7.6.2 Providing the financial administrative systems for the Pooled Fund; and

7.6.3 Appointing the Pooled Fund Manager;

7.6.4 Ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

8 POOLED FUND MANAGEMENT

8.1 The Partners agree that the Council shall act as host for the purposes of Regulations 7(4) and 7(5) in respect of Pooled Fund 1 and the Council shall appoint an officer to act as the Pooled Fund Manager for the purposes of Regulation 7 (4).

8.2 The Pooled Fund Manager shall have the following duties and responsibilities:

8.2.1 the day to day operation and management of the Pooled Fund;

8.2.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Description and Specification;

8.2.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

8.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

8.2.5 reporting to the Partnership Board as required by the Partnership Board and the relevant Scheme Description and Specification;

8.2.6 preparing and submitting to the Partnership Board Quarterly reports (or more frequent reports if required by the Partnership Board) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Partnership Board to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

8.2.7 preparing and submitting reports to the Health and Wellbeing Board as required by it.

8.3 In carrying out their responsibilities as provided under Clause 8.2 the Pooled Fund Manager shall deliver the recommendations of the Partnership Board and shall be accountable to the Partners through the Partnership Board.

9 FINANCIAL CONTRIBUTIONS

9.1 The Financial Contribution of the ICB and the Council to the Pooled Fund for each Financial Year of operation of each Individual Scheme will be as set out in the **Schedule 1A**.

9.2 With the exception of Clause 12, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Partnership Board minutes and recorded in the budget statement as a separate item.

10 NON-FINANCIAL CONTRIBUTIONS

10.1 The Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of service contracts and the Pooled Fund).

11 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

11.1 The Partners have agreed risk share arrangements as set out in **Schedule 4**.

Overspends in Pooled Fund

11.2 For the Term of the Agreement overspends in the Pooled Fund shall be managed as set out in **Schedule 4**.

Underspends

11.3 For the Term of the Agreement underspends in the Pooled Fund shall be managed as set out in **Schedule 4**.

Benefits

11.4 In the event cash savings are delivered, these will be retained by the partner generating the said saving.

12 CAPITAL EXPENDITURE

12.1 The Pooled Fund shall not be applied towards any one-off expenditure on goods and/or services outside of the remit of Schemes 1 and 4 of **Schedule 1**, specifically the use of Disabled Facilities Grants, without prior approval of the Partnership Board.

13 VAT

13.1 The Partners shall agree the treatment of the Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

14 AUDIT AND RIGHT OF ACCESS

14.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund in accordance with Section 7 of the Local Audit and Accountability Act, 2014.

14.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

15 LIABILITIES AND INSURANCE AND INDEMNITY

15.1 Subject to Clause 15.2, and 15.3, if a Partner (“First Partner”) incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner (“Other Partner”) which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other

Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

15.2 Clause 15.1 will only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Partnership Board.

15.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 15, the Partner that may claim against the other indemnifying Partner will:

15.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

15.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

15.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

15.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

15.5 Each Partner shall always take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

16 STANDARDS OF CONDUCT AND SERVICE

16.1 The Partners will always comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

16.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partner will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

16.3 The ICB is subject to the ICB Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Fund are therefore subject to ensuring compliance with the ICB Statutory Duties and clinical governance obligations.

16.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

17 CONFLICTS OF INTEREST

17.1 The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in **Schedule 6**.

18 GOVERNANCE

18.1 Overall strategic oversight of partnership working between the partners is vested in the Health and Well Being Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

18.2 The Partners have established a Partnership Board to undertake responsibility for

management of the pooled fund.

18.3 The Partnership Board is based on a joint working group structure. Each member of the Partnership Board shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Partnership Board to carry out its objects, roles, duties and functions as set out in this Clause 18 and **Schedule 3**.

18.4 The terms of reference of the Partnership Board will be as set out in **Schedule 3**.

18.5 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

18.6 The Health and Wellbeing Board will be responsible for the overall approval of the Individual Schemes, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund, in accordance with the process set out in **Schedule 3**.

19 REVIEW

19.1 Save where the Partnership Board agree alternative arrangements (including alternative frequencies) the Partners must undertake an annual review ("***Annual Review***") of the operation of this Agreement, any Pooled Fund and the provision of the Services within 3 Months of the end of each Financial Year.

19.2 The Partners shall within 20 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause 19. The annual report shall be subject to approval by the Health and Wellbeing Board.

19.3 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England, the Partners shall co-operate with NHS England to agree a recovery plan.

19.4 Any review undertaken in accordance with this Clause 19 must reflect an intention to deliver the aims and benefits identified in Clause (F) of this Agreement.

20 COMPLAINTS

20.1 During the term of the Agreement, the Partners will explore establishing a joint complaints system. The application of a joint complaints system will be without prejudice to a complainant's right to use either of the Partners' statutory complaints procedures where applicable.

20.2 Prior to the development of a joint complaints system or after the failure or suspension of any such joint complaints system the following will apply:

20.2.1 where a complaint wholly relates to one or more of the Council's Health Related Functions it will be dealt with in accordance with the statutory complaints procedure of the Council;

20.2.2 where a complaint wholly relates to one or more of the ICB's NHS Functions, it will be dealt with in accordance with the statutory complaints procedure of the ICB;

20.2.3 where a complaint relates partly to one or more of the Council's Health Related Functions and partly to one or more of the ICB's NHS Functions then a joint response will be made to the complaint by the Council and the relevant NHS organisation, in line with local joint protocol;

20.2.4 where a complaint cannot be handled in any way described above or relates to the operation of the arrangements made pursuant to this Agreement or the content of this Agreement, then the Partnership Board will set up a complaints subgroup to examine the complaint and recommend remedies. All complaints must be reported to the Partnership Board.

21 TERMINATION & DEFAULT

21.1 The termination and default provisions as set out in Clauses 21.2 to 21.8 of this Agreement will apply.

21.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Description and Specification (where applicable) provided that the

Partners ensure that the Better Care Fund requirements continue to be met.

21.3 If any Partner ("*Relevant Partner*") fails to meet any of its obligations under this Agreement, the other Partner may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 22.

21.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach.

21.5 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users.

21.6 Upon termination of this Agreement (or any part thereof) for any reason whatsoever the following will apply:

21.6.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

21.6.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

21.6.3 the Lead Commissioner will make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Commissioner will not be required to make any payments to the Provider for such amendment or termination unless the Partners will have agreed in advance who shall be responsible for any such payment.

21.6.4 where a Service Contract held by a Lead Commissioner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

21.6.5 the Partnership Board will continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

21.6.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

21.7 In the event of termination in relation to an Individual Scheme the provisions of Clause 21.6 will apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

22 DISPUTE RESOLUTION

22.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

22.2 The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 22.1, at a meeting convened for the purpose of resolving the dispute.

22.3 If the dispute remains after the meeting detailed in Clause 22.2 has taken place, the matter

shall be referred in writing to the ICB Clinical Lead for Hillingdon and the Co-chairmen of the Health and Wellbeing Board. The ICB Clinical Lead for Hillingdon and the Co-chairmen of the Health and Wellbeing Board will meet within fourteen (14) days of the date of the referral for the purpose of resolving the dispute.

22.4 The decision of the ICB Clinical Lead for Hillingdon and the Co-chairmen of the Health and Wellbeing Board as described in Clause 22.3 will be final and binding on both Partners.

22.5 Nothing in the procedure set out in this Clause 22 will in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

23 FORCE MAJEURE

23.1 Neither Partner will be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

23.2 On the occurrence of a Force Majeure Event, the Affected Partner will notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

23.3 As soon as practicable, following notification as detailed in Clause 23.2, the Partners will consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 23.4, facilitate the continued performance of the Agreement.

23.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner will have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation will be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

24 CONFIDENTIALITY

24.1 In respect of any Confidential Information a Partner receives from another Partner (the "***Discloser***") and subject always to the remainder of this Clause 24, each Partner (the "***Recipient***") undertakes to keep secret and strictly confidential and will not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

24.1.1 the Recipient will not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

24.1.2 the provisions of this Clause 24 will not apply to any Confidential Information which:

a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

b) is obtained by a third party who is lawfully authorised to disclose such information.

24.2 Nothing in this Clause 24 will prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

24.3 Each Partner:

24.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

24.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 24.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 24;

24.3.3 will not use Confidential Information other than strictly for the performance of its

obligations under this Agreement.

24.4 Information provided in accordance with the Partners' respective Whistleblowing Policy shall not constitute a breach of this Clause 24.

25 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

25.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Act to respond to a request promptly and within the statutory timescales. This cooperation will include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

25.2 Any and all agreements between the Partners as to confidentiality will be subject to their duties under the 2000 Act and 2004 Act. No Partner will be in breach of Clause 25 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

26 DATA PROTECTION AND INFORMATION SHARING

26.1 The Partners must comply with the provisions of the Data Protection Laws and any other relevant data protection law in force so far as applicable to this Agreement and the Services and must indemnify each other against all actions, costs, expenses, claims, proceedings and demands which may be brought against the other Party for breach of statutory duty under these statutes which arises from the use, disclosure or transfer of Personal Data by the other Party or its servants or agents.

26.2 For the purposes of this Clause 26, the terms "*Data Controller*", "*Data Processor*", "*Data Subject*", "*Data*" and "*Processing*" will have the meaning prescribed under the Data Protection Laws.

27 OMBUDSMEN AND INVESTIGATIONS BY REGULATORY BODIES

27.1 The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both) and any other regulatory body in connection with this Agreement.

28 NOTICES

28.1 Any notice to be given under this Agreement must either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 28.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice must be deemed to have been served if:

28.1.1 personally delivered, at the time of delivery;

28.1.2 sent by facsimile, at the time of transmission;

28.1.3 posted, at the expiration of forty-eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

28.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

28.2 In proving such service, it will be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

28.3 The address for service of notices as referred to in Clause 28.1 shall be as follows unless otherwise notified to the other Partner in writing:

28.3.1 if to the Council, addressed to the **Corporate Director for Adult Social Care and Health**;
Tel: 01895 250506
E.Mail: staylor@hillingdon.gov.uk

and

28.3.2 if to the ICB, addressed to the **Borough Director**;
Tel: 01895 203005
E.Mail: richard.ellis9@nhs.net/sue.jeffers@nhs.net

29 VARIATION

29.1 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

30 CHANGE IN LAW

30.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

30.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

30.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 22 (Dispute Resolution) shall apply.

31 WAIVER

31.1 No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

32 SEVERANCE

32.1 If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

33 ASSIGNMENT AND SUB CONTRACTING

33.1 The Partners shall not sub-contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

34 EXCLUSION OF PARTNERSHIP AND AGENCY

34.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

34.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

34.2.1 act as an agent of the other;

34.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

34.2.3 bind the other in any way.

35 THIRD PARTY RIGHTS

35.1 Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act

1999 or otherwise.

36 ENTIRE AGREEMENT

36.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

36.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

37 COUNTERPARTS

37.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

38 GOVERNING LAW AND JURISDICTION

38.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

38.2 Subject to Clause 22 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

THE CORPORATE SEAL of **THE**)

LONDON BOROUGH COUNCIL OF HILLINGDON)
was hereunto affixed in the presence of:)

Signed for on behalf of **NORTH WEST LONDON INTEGRATED CARE BOARD**

_____

Authorised Signatory

Schedule 1 - Scheme Descriptions

Scheme 1: Neighbourhood Development

a) **Scheme Aim(s)**

To manage demand arising from demographic pressures by reducing the movement of Hillingdon residents/patients from lower tiers of risk into higher tiers of risk through proactive early identification and facilitating access to preventative pathways.

b) **2023/24 Priorities**

The 2023/24 priorities under this scheme include:

- Implementation of leadership and governance arrangements for six Integrated Neighbourhood Teams.
- Integration of community nursing at Neighbourhood level.
- Integration of therapies at Neighbourhood level.
- Implementation of three Same Day Urgent Primary Care Hubs.
- Alignment of Adult Social Care staff to Neighbourhoods.
- Development and implementation of a third sector Neighbourhood offer.
- Delivery of three Same Day Urgent Primary Care Hubs, including community diagnostics.
- Improve dementia diagnosis rates.

c) **Intended Outcomes/Success Measures**

This scheme will contribute to the following key BCF metric:

- ***Unplanned admissions for ambulatory sensitive chronic conditions (admission avoidance metric)***: Reduction in non-elective admissions of people with ambulatory care sensitive conditions. The ceiling for 2023/24 is 879.7 per 100,000 population aged 18 and over.
- ***Permanent admissions to care homes by people aged 65 and over***: Reduction in permanent admissions to care homes per 100,000 65 + population. The ceiling for 2023/24 is 270 admissions.
- **Emergency hospital admissions due to falls in people aged 65 and over:** The ceiling for 2023/24 is 865 admissions.

Scheme 2: Supporting Carers

a) **Scheme Aim(s)**

This scheme seeks to maximise the amount of time that carers are willing and able to undertake a caring role. This will be contributed to by carers being able to say:
• "*I am physically and mentally well and treated with dignity*"
• "*I am not forced into financial hardship by my caring role*"
• "*I enjoy a life outside of caring*"

• "*I am recognised, supported and listened to as an experienced carer*"

b) **2023/24 Priorities**

The 2023/24 priorities under this scheme are:

- Consulting on the draft all-age 2023 – 2025 Joint Carers Strategy.
- Completing restoration of carer leads in GP surgeries.
- Establishing carer registers in 100% of GP practices that are members of The Hillingdon [GP] Confederation.
- Reviewing the carers assessment process for parent carers and young carers.
- Retendering the Carer Support Services contract.
- Explore options for increasing the percentage of adult carers supported by the Council having needs met via Direct Payments.
- Supporting schools to develop their own support provision for young carers.
- Refresh the Memorandum of Understanding between health and care partners on an integrated approach to identifying and assessing carer need in Hillingdon.

c) **Intended Outcomes/Success Measures**

This scheme will contribute to the following BCF national metrics:

- ***Admission avoidance metric*:** Reduction in non-elective admissions of people with ambulatory care sensitive conditions. See scheme 1.
- **Percentage of people who are discharged from acute hospital to their usual place of residence**: The percentage of Hillingdon residents aged 18 and above discharged to their usual home. See scheme 3.
- ***Permanent admissions to care homes metric:*** See scheme 1.
- ***Still at home 91 days after discharge metric:*** see scheme 3.

Scheme 3: Reactive Care

a) **Scheme Aims**

The aims of this scheme are to provide a co-ordinated time limited same day community based response to:

- Unplanned rapid physical and/or mental health deterioration in the health of a patient with complex needs or multiple long term conditions in order to prevent unnecessary hospital admission/ED attendance and/or premature admission to long-term care.
- Promote faster recovery from acute (mental) illness, in order to support timely discharge from hospital and maximise independent living.

b) **2023/24 Priorities**

The 2023/24 priorities for this Scheme include:

- Implementing the new End of Life Coordination Hub Operating Model.
- Implementation of an Integrated Active Recovery Service.
- Implementation of '*Maximising HomeFirst'* programme to reduce length of stay.
- Establishing block contracts for pathway 3 discharges.
- Establishing bed-based step-up arrangements to support admission avoidance.

c) **Intended Outcomes/Success Measures**

This scheme will impact on the following BCF metrics:

- ***Discharge to usual places of residence:*** This is the percentage of people aged 18 and above discharged from hospital to their usual place of residence. The target for 2023/24 is 91.9%.
- ***The proportion of older people who were still at home 91 days after discharge from hospital into reablement:*** The 2023/24 target is 94.9%. 2023/24 is the final year of this metric.
- ***Proportion of people discharged who are still at home after 91 days:*** This new metric is due to replace the above measure from 2024/25.
- **Discharge metric ahead of winter 2023**. This new metric is intended to measure the period between the '*discharge ready date'*, i.e., the date when it is expected that a person will be ready for discharge and when they are actually discharged.

Other success measures include:

- ***Daily bed occupancy rate at Hillingdon Hospital:*** The bed occupancy rate should be at no more than 90%.
- ***Length of stay of seven days or more (Hillingdon Hospital):*** Percentage of people in hospital with a length of stay of seven days or more (known as '*stranded patients'*) should be no more than 30% of the bed base, i.e., 90 based on 315 core beds.
- ***Out of hospital capacity:*** Health and social care capacity at no more than 90% utilisation.

Scheme 4: Improving care market management and development

a) **Scheme Aim(s)**

This enabling scheme supports other schemes within the BCF and aims to achieve:

- A market capable of meeting the health and care needs of the local population within financial constraints; and
- A diverse market of quality providers maximising choice for local people.

b) **2023/24 Priorities**

The 2023/24 priorities under this scheme are:

- Implementing a coordinated approach to supporting the sustainability of the regulated care market.
- Implementing Market Sustainability Plan in respect of care homes for people aged 65 + and providers of homecare for people aged 18 +.
- Establishing care home block contracts to support discharge.

c) **Intended Outcomes/Success Measures**

This scheme will contribute to the following national BCF metrics:

- ***Admission avoidance metric*:** Reduction in non-elective admissions of people with ambulatory care sensitive conditions. See scheme 1.
- **Percentage of people who are discharged from acute hospital to their usual place of residence**: The percentage of Hillingdon residents aged 18 and above discharged to their usual home. See scheme 3.
- ***Permanent admissions to care homes metric:*** See scheme 1.

The following measures will be used to identify whether the scheme is working:

- Number of CQC registered care providers that experience business failure.
- Reduction in inappropriate non-elective admissions from extra care sheltered housing schemes.
- Proportion of people on an end of life pathway on CMC who achieved their preferred place of death.

Scheme 5: Integrated care and support for people with learning disabilities and/or autism

a) **Scheme Aims**

The intended aims of this Scheme are to:

- To improve the quality of care for people with a learning disability and/or autism;
- To improve quality of life for people with a learning disability and/or autism;
- To support people with a learning disability and/or autism down pathways of care to the least restrictive setting;
- To ensure that services are user focused and responsive to identified needs;
- To ensure Value for Money and efficient use of resources, maximising income where at all possible and avoiding duplication.

b) **2023/24 Priorities**

The 2023/24 priorities under this scheme are:

- Continuing the development of crisis pathways for people with learning disabilities and/or autistic people.
- Reviewing integration options for the LBH Learning Disabilities and CNWL Learning Disabilities Health Teams.
- Completing the All-age autism strategy, 2023 - 2028.

c) **Intended Outcomes/Success Measures**

This scheme will impact on the following BCF metrics:

- ***Admission avoidance metric*:** See scheme 1.
- **Percentage of people who are discharged from acute hospital to their usual place of residence**: See scheme 3.

The following measures will be used to identify whether the scheme is working:
- % of people with learning disabilities known to services in paid employment.
- % of people with learning disabilities known to services in settled accommodation.
- % of people with learning disabilities known to services receiving an annual health check.
- % of Service Users with an up to date Health Action Plan.

SCHEDULE 1A - FINANCAL CONTRIBUTIONS SUMMARY AND BREAKDOWN

1. Figures in the tables within this Schedule are subject to rounding and therefore totals given may not be the sum of the numbers provided.

FINANCIAL CONTRIBUTIONS SUMMARY

2. Table 1 summarises the total contribution by organisations in 2023/24.

Table 1: Financial Contributions by Organisation 2023/24	
Organisation	**2023/24**
NHS	29,658,745

LBH	66,875,873
TOTAL	**96,534,618**

3. Table 2 below provides a breakdown by BCF funding stream for 2023/24.

Table 2: Financial Contributions by Funding Stream 2023/24	
FUNDING SOURCE	**FUNDING**
	2023/24
Minimum NHS Contribution	22,869,590
Additional NHS Contribution	5,524,379
ICB Discharge Fund	1,264,776
NHS TOTAL	**29,658,745**
Minimum LBH Contribution	12,578,861
Additional LBH Contribution	53,250,038
LBH Discharge Fund	1,046,974
LBH TOTAL	**66,875,873**
TOTAL BCF VALUE	**96,534,618**

4. Table 3 below summarises the Council and NHS contributions for 2023/24.

Table 3: ICB and LBH Financial Contribution by Scheme Summary				
Scheme		**2023/24**		
		LBH (£,000)	**NHS (£,000)**	**TOTAL (£,000)**
1.	Neighourhood development	3,052	3,025	**6,077**
2.	Supporting carers	690	471	**1,161**
3.	Reactive care	5,489	19,990	**25,479**
4.	Improving care market management and development.	26,232	5,083	**31,315**
5.	Integrated care and support for people with learning disabilities and/or autistic people.	31,412	993	**32,405**
	Programme Management	0	97	**97**
	TOTAL	**66,875**	**29,659**	**96,534**

5. **Annex A** to this **Schedule 1A** of the Agreement summarises the funding to be paid by the NHS to the Council for its retention.

ANNEX A: SUMMARY OF NHS FUNDING TO BE RETAINED BY THE COUNCIL 2023/24 and 2024/25 (PROVISIONAL)

Annex%20A%20Schedule%201A%20-%2

2023/25 FUNDING BREAKDOWN

6. **Annex B** to this **Schedule 1A** of the Agreement provides a detailed breakdown of services, related funding and funding source reflected within the 2023/25 BCF plan. Details for 2024/25 are provisional and subject to revision and confirmation during 2023/24.

ANNEX B: 2023/25 BCF SUBMISSION TEMPLATE EXPENDITURE TAB

Annex%20B%20Sche
dule%201A%20Submi

PROVISION CONCERNING THE CARER SUPPORT SERVICE

7. The ICB contribution to the Carer Support Service in 2023/24 will be £19,093 to fund a Carer Support Worker post. This cost will be met by the Council in 2023/24 from an ICB over-payment in 2022/23.

8. Should the ICB not wish to continue the post into 2024/25 three months' notice must be given to the Council and the Provider (Carers Trust Hillingdon) no later than the 31st December 2023. The ICB agrees to reimburse the Council for any redundancy costs incurred as a consequence of the termination of the post.

9. If notice is not given in accordance with clause 8 of this Schedule 1A the post will continue for the duration of 2024/25 and direct payment arrangements will be established between the ICB and the Provider.

10. There is nothing in this Schedule that is intended to prevent the Partners from agreeing to retain inclusion of the ICB funding within the contract for the Carer Support Service. This contract will be subject to a competitive tender in 2024/25 and continued inclusion of an ICB contribution from 2025/26 must be confirmed in writing.

SCHEDULE 1B - OPERATION OF THE COMMUNITY EQUIPMENT SERVICE

1. BACKGROUND

1.1 The subject of this **Schedule 1B** of the Agreement is the operation of the Community Equipment Service (CES), which will be referred to in this Schedule as the Service.

1.2 The Community Equipment Service includes:

1.2.1 The Equipment Loans Service (ELS) which provides daily living equipment to people who meet the eligibility criteria described in **Annex A** of this Schedule.

1.2.2 Standard and non-standard minor adaptations and door entry systems as defined in Clause 1.3 below and provided to people who meet the eligibility criteria described in **Annex A** of this Schedule.

1.3 Defined terms and interpretation for this **Schedule 1B** will be as described in Clause 1.1 of the Agreement unless otherwise stated below:

1.3.1 ***Contract Operations Officer*** means the person appointed by the Council to oversee the day to day operation of the Contract.

1.3.2 ***Contract*** means the contract with the Service Provider.

1.3.3 ***Door entry systems*** refer to systems that facilitate authorised access to the homes of Hillingdon residents where the resident is unable to directly open their front door because of a disability.

1.3.4 ***Eligibility criteria*** means the criteria agreed between the Partners to determine access to the Service as described in **Annex A** of this Schedule.

1.3.5 ***Minor adaptations*** refer to adaptations costing under £1k.

1.3.6 ***Standard minor adaptations*** refer to minor adaptations available through the Service Provider's equipment catalogue.

1.3.7 **NHS NWL** means the North West London Integrated Care Board.

1.3.8 ***Non-standard minor adaptations*** refer to minor adaptations that are not available through the Service Provider's equipment catalogue and for which a procurement process is required to be undertaken. These are adaptations that require the services of a building.

1.3.9 ***Prescribers*** refer to qualified staff from all Prescriber Teams who are authorised to prescribe equipment.

1.3.10 ***Prescribing Teams*** refer to teams across Social Care and the NHS who have prescribers authorised to prescribe equipment to people who are residents of the borough or who are registered with an NHS NWL GP who is located in the London Borough of Hillingdon.

1.3.12 ***Service Provider*** means NRS Healthcare Ltd.

2. SERVICE AIM

2.1 The aim of the Community Equipment Service is to maximise the independence of Hillingdon's residents and other people who meet the eligibility criteria shown in **Annex A** thereby reducing the pressure on the borough's health and care system. This will be achieved by enabling people to carry out day-to-day tasks and activities of daily living that they would otherwise be unable to do without support.

3. MONITORING ARRANGEMENTS

3.1 The Council will employ a Contract Operations Officer who will manage the relationships between Prescribing Teams, the Service Provider and the Partners.

3.2 Activity, expenditure and quality of service delivery of the Services under this **Schedule 1B** will be overseen by the Budget Monitoring Group, the role and responsibility of which is set out in **Annex B**.

3.3 The Contract Operations Officer will provide monthly updates of activity information, expenditure and projected year-end expenditure as directed by the Budget Monitoring Group or the Partnership Board.

3.4 Prescribing teams will be given notional budgets against which they will prescribe and their activity will be monitored.

3.5 The Council will secure provision of quarterly financial monitoring reports and year-end accounts showing funds received, funds spent, funds committed and any unspent resources, to the Partnership Board. The Council will also provide such other reports as deemed necessary to ensure compliance with Audit requirements.

3.6 The pooled budget will not pay the Service Provider for any expenditure above (or different from) that previously agreed unless so authorised in advance by the Partners.

4. PRESCRIBING AUTHORITY

4.1 The Contract Operations Officer will enable Prescribers to prescribe equipment under this **Schedule 1B** up to a value as directed by the appropriate team manager or service leads from the Partners. Team managers and service leads will have authority to remove prescribing authority or alter the value to which a Prescriber can prescribe equipment under this **Schedule 1B**.

4.2 The Contract Operations Officer may, in consultation with the Chair of the Partnership Board (or delegated representative), remove the authority of any prescribing team to prescribe equipment under this **Schedule 1B**. This may only take place where there has been persistent and demonstrable failure to comply with the Eligibility Criteria and that has not been remedied following written notice.

5. CONTRACT

5.1 The Council will hold the Contract with the Service Provider for the delivery of the Services set out in **Annex C**.

5.2 The Service Provider will carry out the day-to-day requirements of the Services as outlined in **Annex C**. As Host Authority the Council will have the responsibility for managing the Contract.

5.3 Ownership of equipment loaned to Service Users for use in their homes rests jointly with the Partners. At the point of termination of the Agreement, separate negotiations will be undertaken regarding the distribution of ownership of loaned equipment provided.

6. FINANCIAL ARRANGEMENTS

Financial Contributions

6.1 The contributions of the Partners to the CES will be based on the principle that each Partner pays for what they use.

2023/24 Budget

6.2 The breakdown of the 2021/23 budget for the Service is shown in table 1 below.

Table 1: Integrated Community Equipment Service Budgets

2022/23 and 2023/24 Budgets Compared

Equipment Service	2022/23 Budget			2023/24 Budget		
	NHS *(£)*	LBH *(£)*	TOTAL *(£)*	NHS *(£)*	LBH *(£)*	TOTAL *(£)*
Equipment Loans	1,312,814	440,341	**1,753,155**	1,516,814	440,341	**1,957,155**
Minor Adaptations	41,416	11,241	**52,657**	41,416	11,241	**52,657**
Door Entry Systems	25,486	13,487	**38,973**	25,486	13,487	**38,973**
Equipment Prescription Service	11,946	504	**12,450**	0	0	**0**
TOTAL	**1,391,662**	**465,573**	**1,857,235**	**1,583,716**	**465,069**	**2,048,785**
% TOTAL	*74.9%*	*25.1%*	*100%*	*77.3%*	*22.7%*	*100%*

6.3 The Partners agree to discontinue the Equipment Prescription Service from 2023/24 in recognition of the lack of participating pharmacists.

Budget Setting

6.4 The Council will propose a base CES budget for consideration by the Partners by end of Q3 2023/24 and a proposed base budget for 2024/25 will be determined by the end of February 2024. Prescribing Teams funded from the Pooled Budget will be notified of their allocation.

6.5 The amount to be provided will cover service developments, inflation, and cost pressures.

6.6 The VAT regime of the Council will apply as laid out in the CIPFA guidance on Pooled Funds.

6.7 Definition of management costs and any shared overheads will be as agreed between the Partners.

Over and Under-spends

6.8 Provisions concerning over and under-spends are addressed in **Schedule 4** of this Agreement.

7. AUDIT ARRANGEMENTS

7.1 In addition to the provisions in Clause 14 (*Audit and Right of Access*) of this Agreement, the Council may in respect of this **Schedule 1B** arrange for an audit of assessments for equipment and the application of the Eligibility Criteria. The costs arising from this audit will be shared equally by the Partners.

8. TERMINATION

8.1 The arrangements under this Schedule may be terminated by either Partner giving **six calendar months'** notice to the other.

ANNEX A - ELIGIBILITY CRITERIA FOR ACCESS TO SERVICES UNDER THE EQUIPMENT LOANS SERVICE

1. The person must be deemed to be ordinarily resident in the London Borough of Hillingdon to which they have applied for assistance or they are registered with a NHS NWL GP practice that is located in the London Borough of Hillingdon.

And

2. The adult's needs arise from or are related to a physical or mental impairment or illness.

And

3. The person is eligible under the Care Act 2014 (adults), the Chronically Sick and Disabled Persons Act 1970 (children and young people), National Health Service Act 2006 with consideration as needed to the Human Rights Act 1998, Equalities Act 2010, Moving and Handling Operations Regulations 1992 and Lifting Operations and Lifting Equipment Regulations 1998.

GENERAL CONSIDERATIONS

4. A Therapist, Nurse or trained member of staff, as agreed by the NHS NWL or the London Borough of Hillingdon, may supply equipment following a proportionate and appropriate assessment.

5. Where appropriate the first choice is for the person is to receive rehabilitation or training in alternative techniques to carry out a daily living activity rather than rely on equipment/minor adaptation.

6. Equipment/minor adaptation provision needs to follow the process mapping as for that equipment type detailed below. In addition, equipment and minor adaptations must be considered to prevent, delay or reduce the needs of adults for care and support as outlined in the Care Act 2014.

7. Identified equipment/minor adaptation must focus on minimising risk to and maximising independence of the Service User.

8. The Prescriber must undertake a follow up telephone call and/or visit to ensure that the Service User and/or their Carer are able to use the equipment or minor adaptation safely.

9. Staff must be aware which pieces of equipment require an annual review, e.g. specialist seating for children and some manual handling equipment and make arrangements for this.

10. The Service User must be informed at the time of assessment that the equipment provided through the Loan Model (excluding Minor Adaptations), is on loan for their and their Carer's exclusive use. All equipment should be looked after and used as instructed by the practitioners and information contained in manufacturers publications as provided at the time of issue. The Conditions of Loan document must be issued to each service user (family member) and a record of this made against the service user's file/case notes.

11. Managers should ensure that the equipment and services prescribed do not exceed the annual budget allocation and work within their budget limits.

12. Carer's needs should be assessed at the same time as the person. Equipment may be issued with the primary aim of meeting the carer's needs e.g., transfer belt to prevent back injury.

13. It is expected that nursing and residential care homes will provide their residents with a range of equipment to meet the variety of care needs that is appropriate to their registration status with the Care Quality Commission, including variations in height, weight and size. The Council and NHS NWL are not responsible for the general provision of equipment unless there is an emergency whereby a temporary item can be supplied for a short period time, for example, to facilitate an urgent hospital discharge or where there is a safeguarding concern. Standard equipment should not be supplied to residential or nursing care homes; however, standard special and bespoke special equipment will be considered on a case by case basis following the special equipment request process.

14. A hospital bed for a Service User in residential care homes will be allowed where their needs have escalated to the extent that they require nursing care and the provision of this type of bed will allow them to remain in their current care setting.

15. Each Prescribing Team must make service appropriate arrangements to ensure that equipment no longer needed is collected.

ANNEX B - BUDGET MONITORING GROUP

Annex B Schedule 1B.docx

ANNEX C – COMMUNITY EQUIPMENT SERVICE SPECIFICATION

Annex C Schedule 1B CES Contract Specifica

SCHEDULE 1C - OPERATION OF THE PERSONAL HEALTH BUDGETS SERVICE

1. BACKGROUND

1.1 The Service that is the subject of this **Schedule 1C** is the Personal Health Budgets Service for Adults and Children.

1.2 A Personal Health Budget (PHB) is an amount of money spent to meet the health and well-being needs of Hillingdon people eligible for NHS CHC or those with a defined long-term condition. PHBs centre on a care plan, which sets out the service user's health outcomes, the amount of money in the budget, and how the money will be used. The support plan will be developed by the individual with support from a support worker additional to the Continuing Healthcare Team, employed by the ICB.

1.3 Personal health budgets can take three forms:

1.3.1 *A notional budget:* This is the identification of the amount of money that the NHS will contribute to meeting a person's assessed healthcare needs;

1.3.2 *A budget held by a third party:* Where the sum of money determined by the NHS to fund service provision to meet assessed health need is paid to another person at the direction of the Service User. This may be the Carer, another family member or another individual. In Hillingdon our preferred option is to administer Direct Payments via a prepaid card, however other options can be explored on a case by case basis; or

1.3.3 *A Direct Payment (DP):* Where the sum of money determined by the NHS to fund service provision to meet assessed health need is paid to the individual. As described in Clause 1.2.2 above, the preferred method of payment in Hillingdon is through a pre-paid card.

1.4 Budgets will be approved by the Continuing Healthcare Commissioning Lead for the ICB. PHBs may be used for the purchase of care in a person's own home or in a nursing care home setting.

2. COMMISSIONING ARRANGEMENTS

2.1 The Council is being commissioned by the ICB to provide the administration, financial monitoring and on-going direct payment support for service users of all ages entitled to be offered a PHB and request a direct payment, a notional budget, a budget held by a third party, or a mixed budget (e.g., notional and direct payment).

2.2 Funding the full cost of care packages for the people eligible for PHBs remains the statutory responsibility of the ICB. The funding of an integrated PHB will be a joint responsibility between the Council and the ICB.

3. KEY SERVICE ELEMENTS, PHILOSOPHY AND BUDGET

3.1 The Service to be provided by the Council to people eligible for a PHB shall:

3.1.1 Access to creative support planning;

3.1.2 Access to the Approved Provider List of Personal Budget Support Services for managing a PHB DP, payroll services, recruitment services for Personal Assistants (PAs) and ongoing support and advice on DPs;

3.1.3 Support to case managers to aid creative care planning;

3.1.4 Support to case managers and/or service users and/or Carers once budgets and care plans are agreed by the ICB and the CHC Case Managers to explain prepaid cards;

3.1.5 Arrangement and implementation of prepaid cards for service users/carers;

3.1.6 Financial monitoring of Service User/Carer spending

3.1.7 Reporting to the ICB of Service User/Carer spending

3.2 The Service provided by the Council shall not include the following functions:

3.2.1 Assessment of financial contributions, as the NHS will fully fund the services required to meet health needs following a CHC assessment or Children's Continuing Care assessment or review of an individual with a long-term condition;

3.2.2 Clinical case management and reviews;

3.2.3 Support to people receiving a PHB through an ICB notional budget; and

3.2.3 Assessment of the continued eligibility for NHS CHC.

3.3 The Service shall be offered and delivered based on an 'enabling' model and philosophy, the emphasis will be on facilitation to encourage confidence and creativity in choice of support. Service Users shall be assisted to access services and community networks through the online resident portal Connect to Support or other such similar system.

3.4 The Council shall support case managers to encourage take up of PHBs by eligible adults and children.

4. SERVICE PROCESS AND RESPONSE TIMES

4.1 The referral process is summarised in **Annex A** to this **Schedule 1C**. Referrals will come via the CHC Commissioning Lead for the ICB and can be either a new or existing Service User.

4.2 If the Service User is known to the Council and in receipt of Direct Payments from the Council:

4.2.1. Referral from CHC Commissioning Lead to Direct Payments Team via secure email including a care plan and indicative budget signed off through ICB Expenditure Control Procedures;

4.2.2 Referral reviewed by LBH Direct Payments team - Target time: 2 days;

4.2.3 Budget adjusted and documented by the Council - Target time: 2 days;

4.2.4 The Council shall provide on-going financial monitoring and reporting;

4.3 If a Service User is not known to the Council and has never received Direct Payments:

4.3.1 Referral from CHC Commissioning Lead to the Direct Payments Team via email including a care plan and indicative budget signed off through ICB Expenditure Control Procedures;

4.3.2 Referral to be reviewed by the Council's Direct Payment's Team Leader - Target time: 2 working days);

4.3.3 Service User details documented by the Council on Protocol - Target time: 10 working days;

4.3.4 The Council's Direct Payments Team Leader will allocate the case to a Direct Payments Worker and they will make contact with Service User confirming referral. They will initiate the discussion about creating a support plan and explain direct payment financial monitoring and employment set up and on-going support;

4.3.5 The Council will make a referral through the Council's Direct Payments Support Framework Agreement where the Service User requires employment support, for example with

employing a personal assistance - Target time: 1 working day;

4.3.6 The Council's Direct Payments Team will set up a pre-paid care for the Service User/Carer.

4.4 Where during financial monitoring processes the Council identifies any anomalies such as no spend or evidence to suggest misuse of funds, the ICB will be notified immediately and all relevant information will be provided to the ICB to undertake further investigations as to NHS Fraud guidance. In such circumstances the ICB will advise the Council on what action to take in regard to the continued payment and administration of the Direct Payment

4.5 The CHC Commissioning Lead shall notify the Direct Payments Team via secure email where there are changes to NHS CHC funding or long-term conditions funding or where this eligibility ends, which may result from a reduction in the Service User's health needs or their death.

5. SERVICE QUALITY AND OUTCOMES

5.1 Quality assurance and monitoring will be built into individual service delivery, monitored and tracked through existing ICB systems and technology. This will include:

5.1.1 Identifying the number of service users receiving a personal health budget through direct payments;

5.1.2 Identifying the number of service users using a pre-paid card; and

5.1.3 Equality and diversity profiling

5.2 The ICB will retain responsibility for clinical care, through its Continuing Care Case management team or as notified to the Council by the ICB.

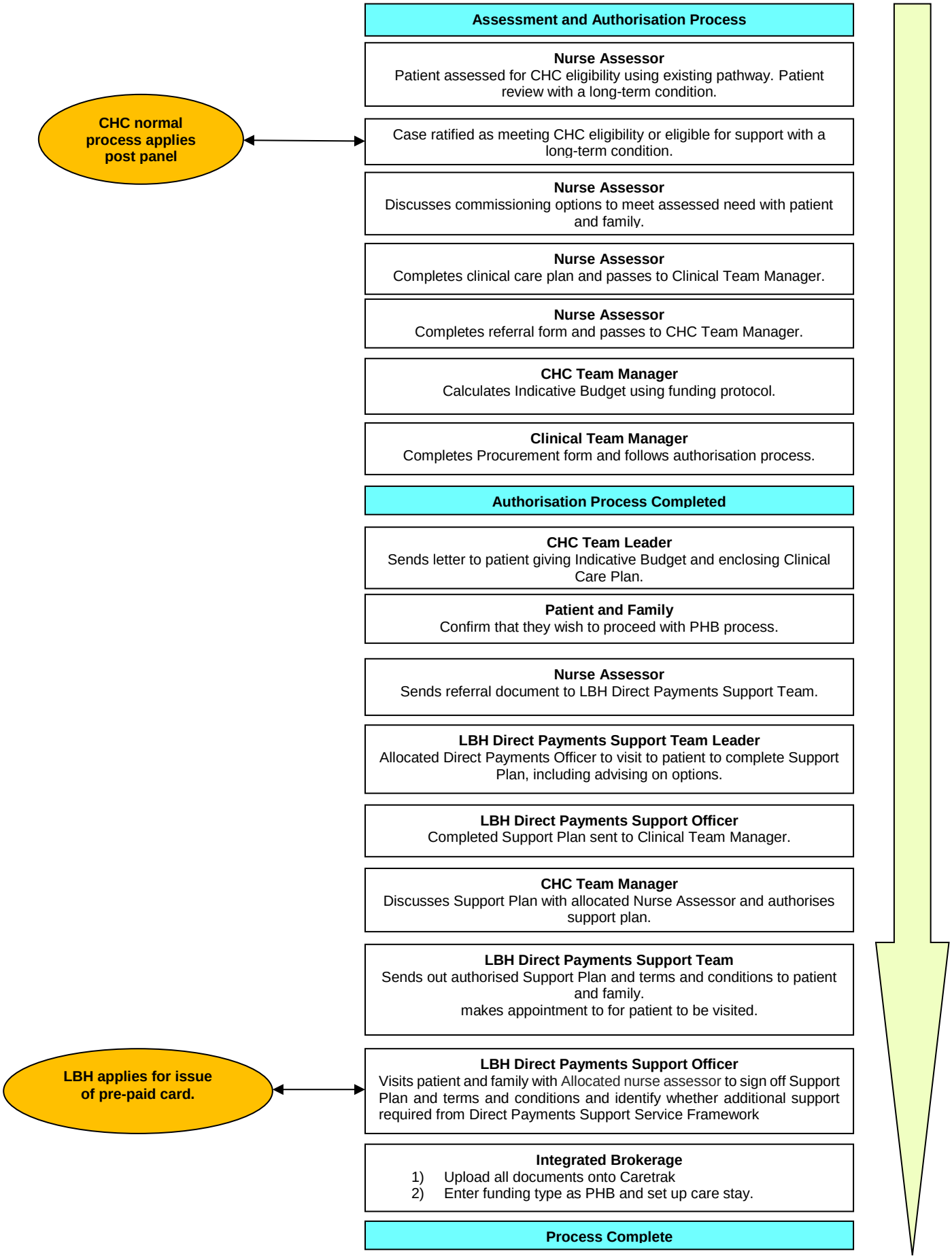
6. FUNDING

6.1 The ICB will pay a fixed rate per case to the Council for the administration of PHBs for the duration of the Agreement. The fixed rate per new case for 2023/24 will be £1,040 with an annual support cost charge of £440 per case thereafter. These rates will be subject to review for 2024/25.

6.2 Service Users will be set up on the Council's case management database called Protocol and an estimate of the value of business for ICB commissioned packages that will be paid directly by the Council, as well as the related support charges, will be made at the beginning of each year. This estimate will be incorporated into the amount the ICB pays to the Council as part of the quarterly billing for the whole BCF. This value will be regularly reviewed and adjusted as necessary during the course of the pilot project.

6.3 Monthly reports of actual spend on NHS commissioned packages will be provided to the ICB to enable the ICB to monitor the costs of the Service.

ANNEX A - PERSONAL HEALTH BUDGET PATHWAY TO DIRECT PAYMENTS



Schedule 1D: Hospital Discharge Funding Arrangements

1. BACKGROUND AND OVERVIEW

1.1 The subject of this **Schedule** of the Agreement is the operation of hospital discharge funding arrangements for 2023/24 and provisional arrangements for 2024/25. The Schedule links into Scheme 3: *Reactive care*.

1.2 This **Schedule** details funding included within the Pooled Fund as well as funds transferred to the Council by the NHS in 2022/23 that are being used to support hospital discharge in 2023/24.

1.3 Unless the context otherwise requires, the defined terms used in this **Schedule** will have the meanings set out in the Partnership Agreement.

2. FUNDING WITHIN THE POOLED BUDGET

Intermediate Tier Services: Step-down Nursing Care Home

2.1 Table 1 below describes the funding breakdown for the period 3rd April 2023 to 31st March 2024. The total cost of block step-down provision in 2023/24 will be **£765,600** as described in tables 1 and 2 below. The funding reflected in tables 1 to 3 will be contained within the Pooled Budget.

Table 1: Parkfield House Step-down Funding Breakdown 2023/24			
ICB Minimum Contribution to ASC	**ICB Additional Contribution to ASC**	**LBH Discharge Fund**	**TOTAL**
62,146	491,134	58,720	**612,000**

Table 2: Additional Dementia Nursing Step-down Breakdown 2023/24		
ICB Minimum to ASC	**ICB Discharge Fund**	**TOTAL**
33,872	119,728	**153,600**

2.2 The Council will lead the procurement process to identify suitable providers to deliver the following services from April 2024 under a contract (or contracts) for a duration of three (3) years with the option to extend for up three (3) further years:

Description	Bed Quantity
• Nursing (non-weight bearing)	4
• Nursing/Nursing dementia	6
• Nursing dementia	5
TOTAL	**15**

2.3 The Council will ensure that all contracts with Providers contain a three (3) month break clause that is operable nine (9) months from commencement date. This means that the minimum duration of the contract (s) will be one calendar year.

2.4 Table 3 below describes the funding arrangements from 2024/25.

Table 3: Nursing Step-down Funding Breakdown 2024/25				
ICB Minimum	**ICB Additional**	**ICB Discharge**	**LBH Discharge**	**TOTAL**

to ASC	To ASC	Fund	Fund	
122,424	491,134	278,128	44,314	**936,000**

2.5 The total cost of contract (s) associated with the funding in table 3 from 1st April 2024 for the three year period to 4th April 2027 will be a minimum of **£2,808,822** (or **£936,000** per annum). The minimum cost is subject to exercise of the break clause described in clause 2.3.

2.6 The management of inflationary uplifts will be as set out in the terms of the Council's standard contract, i.e., subject to the provider (s) evidencing increased costs.

Intermediate Tier Services: Step-down Residential Care Home

2.7 Table 4 below describes the funding breakdown for the period 3rd April 2023 to 31st March 2024.

Table 4: Step-down Residential Care Home Funding Breakdown 2023/24						
Service	**Provider**	**Start Date**	**End Date**	**NHS Contribution (£,000s)**	**LBH Contribution (£,000s)**	**Total Cost 2023/24 (£,000s)**
Block residential care home beds (6)	Seymour House	03/04/23	30/06/23	0	55.4	**55.4**

Intermediate Tier Services: Other

2.8 Table 5 below provides a summary breakdown of other intermediate tier services in 2023/24. Funding arrangements for 2024/25 are subject to confirmation following a review of out of hospital provision and BCF funded schemes that be undertaken in 2023/24. A full breakdown of services funded from the Discharge Fund in 2023/24 and provisional allocations for 2024/25 can be found in **Annex A** to this Schedule.

Table 5: Summary of Other Intermediate Tier Funded Services 2023/24						
Service	**Provider**	**Start Date**	**End Date**	**NHS Contribution (£,000s)**	**LBH Contribution (£,000s)**	**Total Cost 2023/24 (£,000s)**
A. Bridging Care	Comfort Care Services	03/04/23	31/03/24	641	0	**641**
B. Additional Bridging Care capacity	Comfort Care Services	03/04/23	31/03/24	135.2	0	**135.2**
C. Additional Brokerage capacity	LBH	03/04/23	31/03/24	63.9	0	**63.9**
D. Social work manager 7-day capacity	LBH	03/04/23	31/03/24	9.7	0	**9.7**
E. Pathway 3 social work bed manager	LBH	03/04/23	31/03/24	34.5	0	**34.5**
F. Reablement	Comfort Care Services	03/04/23	31/03/24	963	0	**963**
G. Hospital Discharge AMHP	LBH	03/04/23	31/03/24	67	0	**67**
H. Mental Health hospital discharge social worker	LBH	03/04/23	31/03/24	50	0	**50**
I. Mental Health floating support service	Ability Housing and Care	03/04/23	31/03/24	51	0	**51**

J. Discharge-related residential care home placements	Independent sector	03/04/23	31/03/24	95	684	**779**
K. Discharge-related nursing care home placements	Independent sector	03/04/23	31/03/24	63	1,265	**1,328**
L. Discharge-related homecare	Independent sector	03/04/23	31/03/24	300	1,657	**1,957**
			TOTAL	**2,473.3**	**3,606**	**6,079.3**

Intermediate Tier Services: Exit Arrangements

2.2 The ICB may decommission or reduce capacity of the Bridging Care Service shown in table 5 above by issuing to the Council three calendar months' notice. Should notice not be given three months prior to the end date shown in table 1 above the service will continue until such time as notice is issued under this Clause 2.2.

3. FUNDING OUTSIDE OF THE POOLED FUND

Intermediate Tier Services Outside of the Pooled Fund

3.1 Table 6 below describes funding arrangements for intermediate tier services for 2022/23 that are external to the Pooled Fund.

Table 6: Intermediate Tier Services Outside of Pooled fund 2023/24					
Service Description	**Provider**	**Start Date**	**End Date**	**2022/23 Winter Pressures Underspend *(£,000)***	**TOTAL *(£,000)***
A. Additional weekend social work capacity	LBH	04/04/22	02/04/23	53.4	**53.4**
B. Delirium Pathway Support Service	Comfort Care Services	03/04/22	30/08/23	146	**146**
			TOTALS	**199.4**	**199.4**

ANNEX A - DISCHARGE FUND SPENDING PLANS 2023/24 & 2024/25 (PROVISIONAL)

Annex%20A%20Schedule%201D%20-%2

SCHEDULE 1E - INTEGRATED CARE AND SUPPORT FOR PEOPLE WITH LEARNING DISABILITIES

1. BACKGROUND

1.1 The subject of this **Schedule 1F** of the Agreement is the delivery of a case management and placement function by the Council on behalf of the ICB for people described in Clause 2 of this Schedule and summarised in Scheme 5 of **Schedule 1** of this Agreement.

1.2 During the period of the Agreement the Partners will review the model of integration for the provision of care and support for people with learning disabilities and associated commissioning arrangements. The objective of the review will be to secure better outcomes for people with learning disabilities and ensure value for money for the Partners.

1.3 The definition of terms used in this Schedule will be as described in Clause 1 of the Agreement unless otherwise stated. For the purposes of this Schedule the following terms will have the meaning described:

1.3.1 ***CNWL*** means the Central and North West London NHS Foundation Trust.

1.3.2 ***Dowry cases*** means payments made by the NHS to local authorities for people leaving hospital after continuous spells in inpatient care of five years or more at the point of discharge. NHS England pays for dowries when the inpatient is being discharged from NHS England-commissioned care, and ICBs will pay for dowries when the individual is being discharged from ICB-commissioned care. Dowries only apply to those people discharged on or after 1 April 2016, and only to people who have been in inpatient care for five years or more on 1 April 2016.

1.3.2 ***The Service*** means a case management and placement service provided by the Council to the ICB.

1.3.3 ***In-house services*** means services directly provided by the Council.

1.3.4 ***Placements*** include care home, supported living (including extra care), domiciliary care (also known as homecare) and day opportunity services. Identification to which of these is referred to at any given time will be determined by context.

1.3.5 ***1983 Act*** means the Mental Health Act, 1983.

1.3.6 ***Independent sector providers*** include providers that are for profit organisations as well not-for-profit voluntary and community sector organisations.

1.3.7 ***Preparing for Adulthood Team*** (PfA) means the team within the Council responsible to managing the transition from children to adult social care and/or health services. This was formerly known as the *'Transition Team'*.

2. SERVICE SCOPE

<u>NHSE Transforming Care Case Management and Placements</u>

2.1 The Service will be delivered by the Council to people aged 18 and over:

2.1.1 Who are included within the Transforming Care Programme, which applies to people who have a diagnosis of a learning disability and/or autism who are in an inpatient hospital setting as well as those who could be at risk of inpatient admission

unless support is commissioned to meet their assessed needs; and

2.1.2 Who have been assessed as meeting the eligibility criteria for NHS Continuing Healthcare (CHC) funding and are people with a diagnosed learning disability; or

2.1.3 Are entitled to after care services under s117 of the 1983 Act and are jointly funded by the Partners.

2.2 The following are excluded from the scope of the Service:

2.2.1 People with a learning disability and/or autism aged under 18.

2.2.2 Any actions on behalf of the ICB that are required to be undertaken by a qualified solicitor in accordance with the Solicitors Act, 1974.

3. SERVICE AIMS AND OBJECTIVES

3.1 The intended aims of the Partners are:

3.1.1 To improve the quality of care for people with a learning disability and/or autism;

3.1.2 To improve quality of life for people with a learning disability and/or autism;

3.1.3 To support people with a learning disability and/or autism down pathways of care to the least restrictive setting;

3.1.4 To ensure that services are user focused and responsive to identified needs;

3.1.5 To ensure Value for Money and efficient use of resources, maximising income where at all possible and avoiding duplication.

3.2 The objectives of the Partners in meeting the aims described in Clause 3.1 above are that integrated working will:

3.2.1 Maximise the opportunities for people with a learning disability and/or autism to lead happy and fulfilling lives as independently as possible in the least restrictive environment feasible:

3.2.2 Ensure that people with a learning disability and/or autism have a positive experience of care and support.

4. SERVICE DESCRIPTION

NHSE Transforming Care Case Management and Placements

4.1 The Service provided to the ICB will include:

4.1.1 Liaising with and providing updates to organisations including NWL ICB, NHS England and the Department of Health and Social Care. Following are examples (and not an exhaustive list) of the updates that will be required:

4.1.1.1 Information regarding the delivery of social care support services to individuals and groups of people with learning disabilities and/or autism;

4.1.1.2 Responding to data requests and national information requirements;

4.1.1.3 Contributing to audits and reviews in respect of monitoring and improving the care provided to people with learning disabilities and/or autism in Hillingdon, such as the National Autism Statutory Assurance Framework.

4.1.2 The updates referred to in Clause 4.1.1 may be provided to the ICB for onward transmission or provided directly and copied to the ICB. The route chosen will be dependent on the update required and will be determined in consultation with the ICB.

4.1.3 Providing access to the Council's brokerage team to identify suitable placements;

4.1.4 Providing access to the Council's social work team in order to complete risk assessments and support plans.

4.2 The Council will make placements on behalf of the ICB for eligible Service Users as described in Clause 2.1 of this Schedule. The Council will broker these placements and pay the providers.

4.4 Both Partners will work to ensure there is no undue delay when processing reviews and/or CHC Criteria Assessments.

4.5 The timescales to which the CHC Team will be working are:

- Fast-track applications-decisions made: - 2 working days.
- Eligibility for CHC against Decision Support Tool (DST): - 28 working days.
- Length of time from Panel decision to letter sent to individual advising outcome: - within 10 working days.

4.6 Health funding reviews will be managed by the CHC Team according to the following timescales:

- Initial review following allocation of funding: - 3 months.
- Review frequency thereafter: - Annually.
- Time frame from completion of the review assessment to decision: - 28 working days.

4.7 In circumstances where a Service User who is jointly funded under section 117 is placed outside of Hillingdon and then re-sectioned under the 1983 Act, the Council will manage the transfer of care to the host local authority. However, it must be noted that a different set of rules apply with regards the ICB's responsibility in such a situation as set out in the guidance document *'Who Pays? Determining responsibility for payments to providers'* (NHSE August 2013).

4.8 Where the CHC team has not completed an assessment within the 28 days and the Service

User either:

4.8.1 *Goes into hospital* - if awarded CHC will be backdated to the 1st referral date (Day 29 from completion of initial checklist) irrespective of hospitalisation; or

4.8.2 *Dies* - ICB will review the case to determine eligibility for CHC where representations are made by the Service User's family. ICB will also undertake a review in circumstances where either the Service User does not have a family or where they have a family who do not wish to request a review and the Council makes representations on the basis that there has been an undue delay.

4.8A An annual confirmation of dowry-qualifying individuals will be undertaken by the Council and the ICB. Responsibility for the Council will be with the Assistant Director for Learning Disabilities, Autism and Mental Health Social Work and for the ICB it will be the Head of Joint Commissioning.

4.8B The Partners acknowledge that the number of dowry cases as of 30th September 2023 was five (5).

Referrals to the Service

4.9 Referrals to the Service will come from the following sources:

4.9.1 The Council's Preparing for Adulthoood (PfA) Team;

4.9.2 The ICB's CHC Team; and

4.9.3 The CHLDT.

4.10 The Council's Social Work Team may make referrals to the CHLDT and this process will be guided by a Memorandum of Understanding (MoU) between the Council and CNWL.

Legal Support

4.11 Where a Service User's circumstances require the intervention of a solicitor the Council will make a referral to the ICB's CHC lead and Head of joint Commissioning for non CHC cases, who will make the required arrangements as set out in the ICB's protocol for accessing Legal Advice. This would apply where, for example, a Community Deprivation of Liberty Standards (DOLS) application to the Court of Protection is required.

5. LEGAL LIABILITY

5.1 The ICB acknowledges and accepts that the Council will act appropriately in delivering the Service on its behalf. Accordingly, and for the avoidance of doubt, in the event of legal proceedings being undertaken by a third party regarding any aspect of the Service then Clause 15 (*Liabilities and Insurance and Indemnity*) of the Agreement will apply.

6. CONTRACT

6.1 For avoidance of doubt, the contract for the provision of the CHLDT will be held by the ICB for the duration of the Agreement. The ICB will be the lead commissioner for this service during the term of the Agreement.

6.2 Subject to Clause 29 (*Variations*) of the Agreement, the provider for the CHLDT will be CNWL.

7. MONITORING

7.1 Arrangements for monitoring delivery of the Service will be as described in **Schedule 3 (*Governance*)** of the Agreement.

8. FINANCIAL ARRANGEMENTS

General

8.1 This Clause 8 should be read in conjunction with **Annex A** of this Schedule and also **Schedule 1A** of the Agreement.

8.2 The North West London (NWL) Continuing Healthcare Team will be responsible for the budgets of CHC case and Head of joint commissioning will be responsible for S117 and Dowry Budgets during the period of the Agreement in respect of the eligible Service Users described in Clause 2.1 of this Schedule and must be involved in any decision concerning the provision of care and support to eligible Service Users.

8.2 The ICB will be responsible for meeting 100% of the cost of meeting the care needs of a Service User in the following circumstances:

8.2.1 The Service User has been assessed as being entitled to NHS Continuing Healthcare funding.

8.2.2 The Service User is placed in a hospital setting for assessment and/or treatment.

8.3 For Service Users assessed under s117 of the 1983 Act the ICB will be responsible for contributing a percentage agreed between the Partners. The remaining difference in cost will be paid by the Council. The formal mechanism for agreeing the respective contributions of the Partners will be as described in Schedule 5 of the Agreement.

Process for Agreeing New Placement Costs

8.4 Prior to entering into a contract with a provider the Council must secure written approval from the ICB's CHC lead for CHC cases and Head of joint Commissioning for s117 cases to enter into an agreement at the proposed price.

Process for Agreeing Changes in Placement Costs

8.5 Any additional charges arising from changes to care costs associated with an escalation of need must be authorised by an authorised signatory. The process is outlined below as follows:

8.5.1 Any increase to a care package within an existing placement must be authorised by the CHC lead or Head of Joint commissioning for the ICB, who will work within their agreed authorisation limits covered by ICB standing financial instructions.

8.5.2 Any change in placement for a Service User who is not a CHC patient and not a recipient of s117 aftercare will be authorised by the Council's Head of Mental Health and Learning Disability Services within the parameters of their authorisation limits. Costs above this will be authorised in accordance with the Council's scheme of delegations.

8.5.3 Any change in a placement for a Service User who is eligible for CHC will be approved by the ICB's CHC lead, who will be working within agreed authorisation limits covered by ICB standing financial instructions.

8.5.4 Any requirement to place a Service User in an inpatient care setting, including mental health hospital inpatient care, must be escalated to the ICB Head of Joint Commissioning Team and referred to the LD clinical psychiatry services (CNWL). The consultant psychiatrist will review the clinical need for in-patient treatment and the care manager will act accordingly. The expectation is that there will be a Local Area Emergency protocol (LAEP) meeting (either face to face or via a MS Teams) to discuss alternatives to admission to a specialist LD or MH inpatient setting, which would possibly be followed up by a Care and Treatment Review (CTR) under Transforming Care CTR protocols to ensure the Service User's holistic needs are discussed. A robust plan for care and support must also be agreed between all parties, including the Service User's representative and family members. The Service User's details must be added to the Dynamic Support Register (DSR) if not already included.

8.5.5 The membership of any MDT necessitated by circumstances in which a Service User is at risk of admission to a specialist LD or MH inpatient setting must include a manager with delegated decision making authority, the ICB's responsible commissioner. Any additional professional representation will be determined by the manager with delegated decision making authority.

8.5.6 Should specialist hospital admission be required funding will need to be approved by the ICB's Head of Joint Commissioning.

8.5.7 Service Users requiring low secure provision following clinical assessment will be discussed with the NWL provider collaborative and ICB Head of Joint Commissioning Team at an early stage to support and agree the placement.

Inflationary Uplifts

8.6 The Council's process for agreeing inflationary uplifts will apply to services commissioned by the Council on behalf of the ICB.

Cessation of Service

8.7 In the event of the death of a ICB funded patient the ICB will continue to be liable for the cost of that care package as follows:

Residential Placements

8.7.1 For Service Users in placements with independent sector providers the ICB will be liable in accordance with the terms of the contract that the Council has with that provider. This will ordinarily entail 100% of the placement costs for the 24-hour period following the death of the Service User.

8.7.3 Where the placement is an in-house provided service, the ICB will remain liable until the earlier of:

8.7.3.1 The date the relevant vacancy has been filled following the date when the

vacancy became available; or

8.7.3.2 Seven days following the date that the vacancy became available.

Day Opportunity Services

8.7.4 For Service Users in placements with independent sector providers the ICB will be liable in accordance with the terms of the contract that the Council has with that provider.

8.7.5 Where the placement is in an in-house service, the ICB will be liable until such time that the relevant vacancy is filled up to a maximum of seven days following last day of service provision to the Service User.

Domiciliary Care

8.7.6 The ICB's liability will cease immediately following the death of the Service User.

Hospital Placements

8.8 Where care is required and commissioned in a non-acute hospital setting for a Service User in order to address physical and mental health needs (including detention under a relevant section of the 1983 Act for assessment/treatment) and/or the Service User has been identified as a ICB funding responsibility prior to admission, then the full cost of that placement for the duration of the Agreement will be the responsibility of the ICB.

8.9 For as long as the Service User's previous residential placement remains open continued funding will be the responsibility of either the ICB or the Council depending on the Service User's status on the date of admission. In such circumstances, there will be an assessment undertaken prior to a planned discharge from the non-acute NHS setting to determine on-going funding responsibility.

8.10 Admission for NHS care in an acute setting will not change the on-going funding status of the Service User unless determined by an assessment in accordance with the Agreement or the 1983 Act.

Change of Supplier

8.11 In the event that a change of supplier should be determined by either Partner as a result of a review of care required in relation to a Service User's needs then the ICB will be liable in accordance with the terms of the contract that the Council has with the relevant provider.

People Aged under 18

8.12 A review (or an assessment) will be undertaken by the CHC Team of people known to the PfA Team prior to them attaining their 18th birthday in order to determine eligibility under the adult CHC criteria. Where it is determined that an individual qualifies for CHC funding then the effective date for this funding will either be the individual's 18th birthday or the date of referral by the PfA Team, whichever is the later.

Out of Borough Placements

8.13 In the case of dispute with another ICB, NWL ICB will be responsible for funding the Service User until a transfer date has been agreed with the other ICB. In these circumstances NWL ICB will recover any back dated costs direct from the other ICB if the dispute is settled in favour of NWL ICB.

Reporting Requirements

8.14 The Council must send a financial schedule to the ICB's Finance Lead on a monthly basis setting out the expenditure for the previous month and future commitment.

Monthly Review

8.15 There will be monthly meetings to review expenditure and commitments. These meetings will include:

8.15.1 The Finance Leads from both the Council and the ICB;

8.15.2 The ICB's Complex Care Lead; and

8.15.3 The Council's Head of Service with responsibility for services for people with learning disabilities and/or autism.

9. ESCALATION PROCESS

9.1 The ICB's CHC lead (CHC cases) and Head of Joint Commissioning team (Non CHC case) will be the initial contact point for the Council to secure approval of placement costs in accordance with Clauses 8.4 and 8.5 of this Schedule and also to request that appropriate legal advice be sought in accordance with 4.11. In the event that a response has not been received within a reasonable time period the escalation route shown in table 1 below should be followed. The nature of the decision request and the circumstances of the Service User/Patient will determine what constitutes a *'reasonable time period*'.

Contact Details	Courtesy Copy Destination Details
1. Ian Robinson Associate Director Continuing Healthcare & Complex Care North West London Integrated Care Board Tele: 0203 114 7157 Email: ian.robinson6@nhs.net	Serah Johnson Head of Joint Commissioning NWL ICB (Hillingdon) Tele:01895 203000 Email: serah.johnson@nhs.net
2. Chief Nursing Officer North West London Integrated Care Board Tele: 0203 114 7168	Richard Ellis/Sue Jeffers Borough Director NWL ICB (Hillingdon) Tele: 01895 203000 Email: richard.ellis9@nhs.net/ sue.jeffers@nhs.net

10. FUNDING DISPUTE RESOLUTION

10.1 This Clause 10 will only apply to disputes between the Partners regarding:

10.1.1 Funding responsibility for services provided to any Service User who is the responsibility of either or both of the parties under the "*ordinary residence*" rules or equivalent rules on funding responsibility as they apply to the NHS; or

10.1.2 The outcome of an assessment of needs or eligibility for services to be provided by the ICB under the National Framework for CHC or by the Council; or

10.1.3 The package of services to be offered to a Service User following an assessment;

10.2 The procedure will also cover disagreements between partners over jointly funded care packages.

10.3 There are three stages to this funding dispute resolution process, and these are:

10.3.1 ***Stage 1:*** Escalation to lead Commissioner

10.3.2 ***Stage 2:*** Escalation to Chief Nurse/ Borough Director for the ICB.

10.3.3 ***Stage 3:*** Referral to arbitration.

10.4 ***Stage 1: Escalation to Clinical/Lead Commissioner***: Where any dispute cannot be

resolved by the decision-making practitioners, either party may request that the Service Managers (or equivalents) in the Partners' respective decision-making teams meet within 14 days of being notified of the existence of a dispute to review the decision and/or the process by which the decision was made. The purpose of this meeting is to explore the possibility reaching a consensus decision as to the correct outcome of the decision-making process.

10.5 In the case of disputed eligibility for NHS Continuing Healthcare, either Partner may request that the ICB refers the case, if it has not already been considered by that panel, for consideration at the next meeting of its Continuing Healthcare Panel ("CHC panel"). If the case has already been considered by the CHC panel then a request can be made for reconsideration at the next meeting of the ICB's Continuing Healthcare Review Panel. The Council will always be invited to represent when the case is discussed at the Continuing Care Panel.

10.6 ***Stage 2: Escalation to Chief Nurse/Borough Director:*** Where the procedures set out in Stage 1 do not result in a consensus decision being reached as to the correct outcome of the decision-making process, the matter will be referred to the Chief Nurse and Director of Quality for the ICB and the Council's Assistant Director for Learning Disabilities, Autism and Mental Health Social Work or officers of equivalent seniority within each body responsible for the decision-making teams referred to in Stage 1.

10.7 Within 14 days of being notified by either party of a dispute which has not been resolved at Stage 1 of this procedure, the Chief Nurse and Assistant Director for Learning Disabilities, Autism and Mental Health Social Work, or officers of equivalent seniority of the Partners, will hold a meeting to try and resolve the dispute by reaching a consensus decision.

10.8 The relevant officers referred to in Clause 10.7 above may involve other professionals in the meeting to provide guidance and/or advice in specialist areas as they deem to be appropriate.

10.9 ***Stage 3: Referral to arbitration***: If any dispute is not resolved through the procedures outlined in Stages 1 and 2 above, or there is any failure by either party to acknowledge the existence of a dispute or to deal with it in accordance with the procedures outlined above, the Partners will refer the matter to the Executive Director, Adult Services and Health for Social Care and Health and the Hillingdon Borough Director of the ICB or the Accountable Officer for the ICB for arbitration. The outcome of stage 3 will end the local stage of the dispute resolution process.

10.10 The Executive Director, Adult Services and Health and the ICB's Borough Director or Accountable Officer, as appropriate, will hold a meeting within 14 days of being notified by either party of a dispute which has not been resolved at Stage 2 of this procedure.

10.11 Other professionals may be invited to the meeting described in paragraph 10.10 above to provide guidance and/or advice in specialist areas as is deemed appropriate and necessary.

10.12 Where the local resolution procedure has not resulted in an outcome that the Service User finds satisfactory, they have the right to apply to NHSE to establish an independent review of the decision through an Independent Review Panel (IRP).

11. TERMINATION

11.1 Either Partner may terminate the arrangements under this Schedule by issuing six months' written notice to the other.

ANNEX A - FINANCIAL ARRANGEMENTS

1. CALCULATION OF CHARGES

1.1 The Charges are split between Fixed and Variable costs as set out in paragraphs 2 and 3 respectively of this **Annex A**.

2. CHARGES BASED ON A FIXED PRICE

2.1 Charges for 2023/24 based on a fixed cost are as described in table 1 below.

Table 1: LD Case Management Service Costings 2023/24			
Type	**FTE/Service Users**	**Rate**	**2023/24 Cost**
1. Staffing			
• Social Worker (POB grade)	1.5	69,834	**104,751**
2. Accommodation & ICT	1.5	4,500	**4,500**
3. Additional staff support costs, e.g., travel, training, admin, etc.	N/A	8,000	**8,000**
4. Finance cost: payment of providers & recharging ICB	29	320	**9,280**
TOTAL LD CASE MANAGEMENT SERVICE COST			**128,781**

2.2 The charges in table 1 above will be subject to review for 2024/25.

3. VARIABLE COSTS

3.1 The costs of Service User placements will be recharged at cost basis split between externally provided services and in-house services.

3.2 Externally provided services will be recharged to the ICB at the total gross package cost.

3.3 In-house services will be recharged at the rates agreed per the Council Fees and Charges Report agreed at Cabinet when the Council Budget is set.

4. PAYMENT PLAN

4.1 1/12th of the estimated Annual Cost of the service will be billed at the beginning of each month. A review of the estimate will take place in October and bills for the rest of the year will be adjusted to reflect the latest forecast.

5. COUNCIL CONTRIBUTION TO THE POOLED BUDGET

5.1 The Council's contribution to the pooled budget for 2023/24 will be as set out in **Schedule 1A** of the Agreement.

6. FINANCIAL CONTRIBUTIONS

6.1 **Schedule 1A** of the Agreement identifies the respective financial contribution to the Pooled Budget established under this Agreement. For ease of reference, table 2 below outlines the resource contributions of the Partners to the Scheme 5 of the BCF plan that is the subject of this **Schedule**

1F.

Table 2: Scheme 5 Financial Contributions Summary					
Service		**Provider**	**Funder 2023/24**		
			LBH *(£,000's)*	**NHS *(£000's)***	**TOTAL *(£000's)***
8.1	Social Care Staffing	LBH	1,254	0	**1,254**
8.2	Homecare	Independent Sector	865	186	**1,051**
8.3	Day opportunities	Independent Sector	2,800	0	**2,800**
8.4	Direct Payments	Independent Sector	2,506	0	**2,506**
8.5	Outreach Services	Independent Sector	2,581	0	**2,581**
8.6	Supported Living	LBH & Independent Sector	12,187	0	**12,187**
8.7	Centre for ADHD and Autistic Support (CAAS)	CAAS	40	0	**40**
8.8	Residential/Nursing Care Home Placements	Independent Sector	9,178	503	**9,681**
8.9	Respite placements	LBH & Independent Sector	0	174	**174**
8.10	Case Management Service	LBH	0	128	**128**
		SCHEME 5 TOTAL	**31,412**	**992**	**32,405**

SCHEDULE 2 - FUNCTIONS

1. Functions of NHS Bodies included in the Section 75 are:

a) The functions of arranging for the provision of services under sections 3, 3A and 3B of, and paragraphs 9 to 11 of Schedule 1, to the 2006 National Health Service Act, including rehabilitation services and services intended to avoid admission to hospital;

b) The functions of making direct payments under:
   i. Section 12A (1) of the National Health Service Act, 2006 (direct payments for health care)
   ii. The National Health Service (Direct Payments) Regulations, 2013

2. Excluded NHS functions are:

a) Surgery, radiotherapy, the use of Class 4 laser treatments and other invasive treatments and emergency ambulance services.

3. Health-related responsibilities of the Council included in the BCF Plan are:

a) Functions under Part 1 of the Care Act, 2014.
b) Functions under Schedule 1 of the Local Authority Social Services Act, 1970 (as amended).
c) Functions under Part 1 of the Housing Grants, Construction and Regeneration Act, 1996, specifically the provision of Disabled Facilities Grants.

4. Excluded Council functions include:

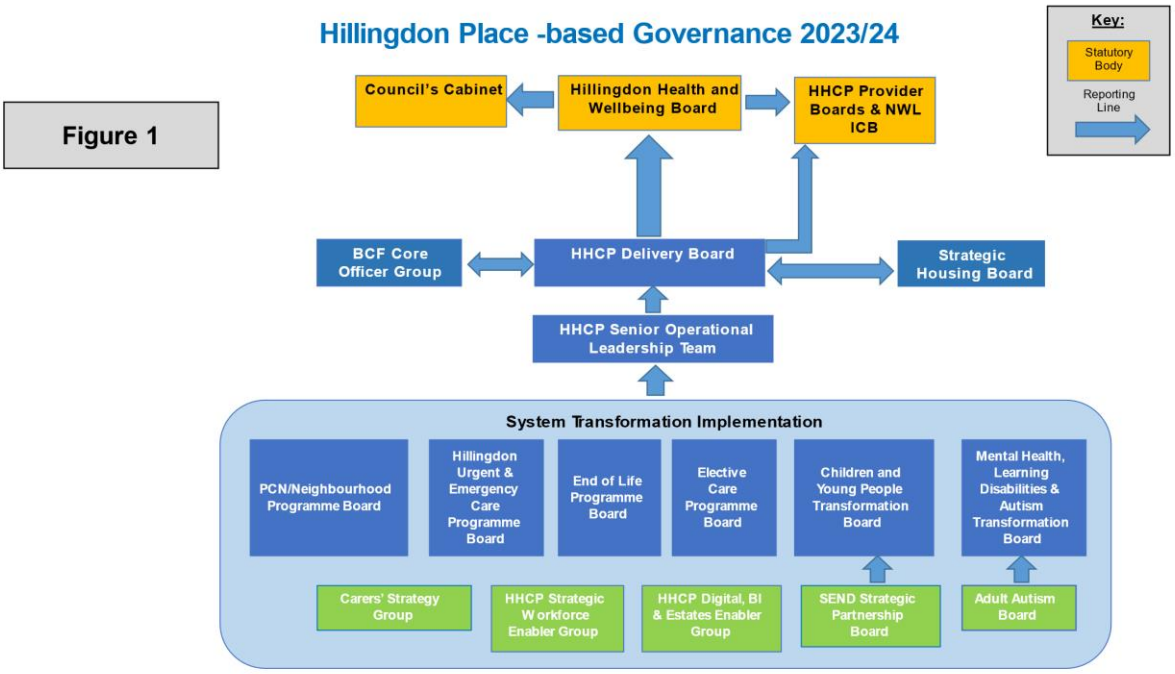
a) Functions under sections 4 (providing information and advice), 5 (promoting diversity and equality in provision of services), 14 to 17 (charging and assessing financial resources), 34 to 36 (deferred payment agreements), 42 to 47 (safeguarding adults), 48 to 52 (provider failure) and 69 to 70 (enforcement of debts) of the Care Act, 2014.

SCHEDULE 3 - BETTER CARE FUND GOVERNANCE ARRANGEMENTS

1. BETTER CARE FUND GOVERNANCE STRUCTURE SUMMARY

1.1 Figure 1 below summarises how the governance of the BCF fits within the broader placed-based governance arrangements for the health and care system in Hillingdon.

Figure 1



2. BETTER CARE FUND GOVERNANCE STRUCTURES TERMS OF REFERENCE

a) Health and Wellbeing Board

2.1 The key purpose of the Health and Wellbeing Board is to fulfil statutory requirements under the 2012 Health and Social Care Act to improve the health and wellbeing of the local population.

2.2 The Board is also responsible for:

2.2.1 Providing place-based leadership in developing a strategic approach for health and wellbeing in Hillingdon;

2.2.2 Developing the statutory Health and Wellbeing Strategy;

2.2.3 Ensuring that the Health and Wellbeing Strategy is informed and underpinned by the Joint Strategic Needs Assessment (JSNA) and is focused upon:

- Improving the health and wellbeing of the residents of Hillingdon;
- The continuous improvement of health and social care services;
- The reduction of health inequalities;
- The involvement of service users and patients in service design and monitoring; and
- Integrated working across health and social care where this would improve quality;

2.2.4 Reviewing performance on delivering the Health and Wellbeing Strategy and other key strategic targets;

2.2.5 Holding partner agencies to account for performance on agreed priorities in conjunction with the Health and Social care Select Committee of the Council;

2.2.6 Influencing and approving the North West London Integrated Care Board (ICB)'s commissioning plan and annual update;

2.2.7 Collaborative working to develop social care and health related commissioning plans to improve the health and wellbeing of residents of the Borough and monitor implementation and performance;

2.2.8 Agreeing and monitoring delivery of the BCF plan (as shown in governance structure summary); and

2.2.9 Monitoring the performance of Public Health and reviewing services in conjunction with the External Services Scrutiny Committee.

Board Membership

2.3 The Board is the co-chaired by Cabinet Member for Health and Social Care and the Managing Director of Hillingdon Health and Care Partners, Hillingdon's accountable care partnership.

2.4 Statutory members of the Board include:

- Cabinet Members from the London Borough of Hillingdon
- A representative from North West London Integrated Care Board
- A representative from Healthwatch Hillingdon
- The statutory Director of Adult Social Services
- The statutory Director of Children's Services
- The statutory Director of Public Health

2.5 Membership also includes the Council's Chief Executive and representatives from local NHS provider trusts, and these are:

- The Confederation, which represents 43 out of 45 local GP practices.
- The Hillingdon Hospitals Foundation Trust
- Central and North West London Foundation Trust
- The Royal Brompton and Harefield Foundation Trust

Frequency of Meetings

2.6 The Board meets in public every two months and its agenda and reports are published on the Council's website a week before its meetings. Dates of meetings are also published on the Council's website and can be found by following this link http://modgov.hillingdon.gov.uk/ieListMeetings.aspx?CId=322&Year=0

2.7 Although the public can attend meetings, there is no public right to speak.

b) Better Care Fund Core Officer Group

2.8 The key purpose of the Core Group is to:

2.8.1 Provide day to day management of the BCF pooled budget established under Section 75 of the National Health Service Act, 2006, in accordance with delegated authority provided by the Council's Cabinet and the ICB's Governing Body;

2.8.2 Undertake the role of '*Partnership Board'* as described in the Section 75 Agreement.

2.9 The Core Officer Group will be responsible for:

2.9.1 Considering the development of the BCF within the context of the priorities of the democratically elected administration of the Council and also of the statutory ICB Board;

2.9.2 Making decisions on financial expenditure in accordance with the agreed BCF Plan and agreement of both Partners;

2.9.3 Considering the strategic issues arising from the delivery of the Plan and consulting with the Hillingdon Health and Care Partners' Delivery Board (see clause 2.17) accordingly;

2.9.4 Taking directions from the elected administration of the Council and the statutory ICB Board where required in order to make informed recommendations to the Delivery Board;

2.9.5 Translating recommendations from the Delivery Board into action.

2.10 The Core Officer Group will also:

2.10.1 Be the escalation point for performance issues requiring urgent remedial intervention;

2.10.2 Report on issues arising from the management of the pooled budget to the Health and Wellbeing Board;

2.10.3 Consider opportunities for joint commissioning that may be reflected in the future scope of the BCF and section 75 agreement, subject to approval by the Health and Wellbeing Board, the Council's Cabinet and the ICB.

Group Membership

2.11 The BCF Core Group is chaired by the BCF Programme Manager.

2.12 Other members include:

- Joint Borough Directors – ICB
- Corporate Director, Adult Social Care and Health – LBH
- Managing Director – Hillingdon Health and Care Partners

Accountability

2.13 The BCF Core Group is accountable to the Health and Wellbeing Board and informs the Delivery Board.

2.14 Council officers who are members of the Core Group will be accountable to the Council's Cabinet and ICB officers will be accountable to the Board of the ICB.

Frequency of Meetings

2.15 The BCF Core Group meets monthly. Its meetings are not open to the public due to the confidential and sensitive nature of the information discussed.

Commitment of Resources

2.16 The Core Group has no authority to commit resources to the BCF other than those approved by either the Council's Cabinet or the ICB Board.

c) Hillingdon Health and Care Partners Delivery Board

2.17 The key purpose of the HHCP Delivery Board is to:

2.17.1 Develop and deliver an agreed service transformation programme;

2.17.2 Undertake the functions of the A & E Delivery Board.

2.18 The HHCP Board will be responsible for:

2.18.1 Approving and owning the transformation programme governance;

2.18.2 Addressing any issues escalated from the programme that require senior internal or organisation to organisation resolution;

2.18.3 Holding the Senior Responsible Officers to account for delivery;

2.18.4 Ensuring that patients access safe, timely and clinically effective A&E services;

2.18.5 Ensuring that recovery and improvement plans are in place and that agreed priorities are being implemented;

2.18.6 Resolving clinical, managerial and organisational issues which impact on the delivery of A&E services.

Membership

2.19 The Board will be chaired on a rotation basis by the partner representatives shown in clause 2.20 below.

2.20 Membership of the Board will include the following:

- **HHCP:** Managing Director
- **H4All:** CEO
- **THHs:** Chief Operating Officer
- **ICB**: Borough Director.
- **CNWL:** Managing Director
- **Healthwatch Hillingdon**: nominated

representative

- **GP Confederation:** CEO
- **SROs**

2.22 The Council will have associate membership and will be represented by the Corporate Director, Adult Social Care and Health or nominated representative (s).

Accountability

2.23 Each member of the Board will be accountable through the governance structures of their respective organisations.

Frequency of Meetings

2.24 The Board meets monthly and its meetings are not open to the public due to the confidential and sensitive nature of the information discussed.

Commitment of Resources

2.25 The Board has authority to commit resources in accordance with delegation arrangements between NHS partners within the borough based care partnership. It has no authority to commit Council resources without the approval of the Council's Cabinet.

d) HHCP Senior Operational Leadership Team (SOLT)

2.26 The key purpose of the Senior Operational Leadership Team:

- Manage/utilise resources across system to optimise service delivery;

2.27 The Senior Operational Leadership Team will be responsible for:

- Ensuring operational ownership of transformation projects, ensuring changes become business as usual;
- Overseeing operational implementation of the agreed model of care and related projects;
- Ensuring effective issues and risk management is in place;
- Making recommendations to the HHCP Delivery Board for changes to the plan.

Membership

2.28 Meetings will be chaired by the HHCP Managing Director

2.29 SOLT membership will include:

- GP Confederation: Chief Operating Officer
- H4All: CEO

- CNWL: Borough Director and Assistant Director, Outer London Services
- THH: Directors of Operations for Planned and Unplanned Care
- ICB: Borough Director, Associate Director, Integration and Delivery, Primary Care Commissioner and Mental Health Commissioner.
- HHCP Clinical Directors
- HHCP Finance Lead
- SROs

2.30 The Council will also be represented by the Assistant Director – Hospital, Localities, and Health Integration.

Accountability

2.31 SOLT will be accountable to the HHCP Delivery Board.

Frequency of Meetings

2.32 SOLT meets monthly and its meetings are not open to the public due to the confidential and sensitive nature of the information discussed.

Commitment of Resources

2.33 SOLT has no authority to commit resources and any such decisions will need to be referred to the Delivery Board for consideration.

e) Programme Manager

2.34 The responsibilities of the Programme Manager will be to:

2.34.1 Identify, analyse and communicate to the Core Officer Group and other key stakeholders all interdependencies between the different schemes in the BCF programme, plus any external dependencies and how they will be managed.

2.34.2 Monitor progress of the schemes and take action to deal with any exceptional situations that might jeopardise achievement of the plan and its benefits.

2.34.3 Actively manage identified risks and issues arising from schemes.

2.34.4 Provide direct support to scheme leads who have responsibility for managing relevant task and finish groups as required.

2.34.5 Escalate to the Core Officer Group risks or issues that cannot otherwise be managed and recommend mitigation.

2.34.6 Produce performance reports on a quarterly basis for the Health and Wellbeing Board and such structures within the borough-based care partnership and the Board of the ICB as may be required from time to time.

2.34.7 Manage the delivery of the stakeholder engagement strategy.

SCHEDULE 4 – RISK SHARE AND OVER AND UNDER PERFORMANCE

1. RISK SHARE

1.1 The Partners have agreed that they will each manage their own risks under this Agreement unless otherwise stated in this **Schedule 4**.

2. OVERSPENDS

2.1 The Partners in their capacity as Lead Commissioners for the Service Contracts at the Commencement Date will be responsible for managing any overspends in those Service Contracts that may occur during the Term.

2.2 Liability for any overspends during the period of the Agreement for the Service described in **Schedule 1B (Community Equipment Service)** will be on the following basis:

2.2.1 Where an overspend is incurred because of budget maladministration, the liability for this will rest with the Council. Maladministration is defined as expenditure outside the terms of this Agreement and without proper authorisation.

2.2.2 Where over expenditure occurs as a result of failure of one or more of the Partners to abide by the terms of the Agreement, for example, through inappropriate prescribing practice, the relevant Partner shall bear full responsibility for that overspend.

2.2.3 Where overspends occur due to unforeseen circumstances that are not due to maladministration, or as a result of failure of one or more of the Partners to abide by the terms of this Agreement, or an action by one or more of the Partners which is prohibited or against the terms of this Agreement, liability will be with the Partner whose Prescribing Team incurred the overspend. For avoidance of doubt, for Social Care Teams this will be the Council and NHS Teams this will be the ICB.

2.3 The Partners will inform the Partnership Board in accordance with Clause 8 of the Agreement where the remedial actions to address any overspend may impact on one or more of the Individual Schemes set out in **Schedule 1**.

2.4 The Partnership Board will use its best endeavours to preserve the integrity of Individual Schemes.

2.5 Where remedial action is proposed to address over performance that may jeopardise the integrity of an Individual Scheme, a report shall be provided to the Health and Wellbeing Board before any such action is implemented.

3. UNDERSPENDS

3.1 Each Partner will have regard to the aims of this Agreement as set out in Clause F of this Agreement in determining how any such underspend on their contribution to the Pooled Fund shall be spent.

SCHEDULE 5 – OPERATION OF SECTION 117 AFTERCARE ARRANGEMENTS

1. INTRODUCTION

1.1 This Schedule 5 concerns arrangements under section 117 (s117) of the Mental Health Act, 1983 (the '*Act*') for the successful provision of aftercare support to people within the geographical boundaries of the London Borough of Hillingdon who were previously detained under section 3 of the Act.

1.2 The definition of terms used in this Schedule will be as described in Clause 1 of the Agreement unless otherwise stated.

1.3 This Schedule aims to ensure that local interpretation of s.117 is in line with the legal requirements of the Act and implements the requirements of the Care Act 2014 (the '*2014 Act*'). It also aims to integrate practice and decision making within the ICB and the Council with regard to s.117 of the Act.

1.4 The provisions of this Schedule will be cascaded to staff employed by the Council and ICB.

2. CONTEXT

Statutory Guidance Principles

2.1 The Mental Health Act Code of Practice 2015 ('the Code of Practice') provides a set of five guiding principles which should be considered when decisions are made about a course of action under the Act. It is essential that all those undertaking functions under the Act understand the five sets of overarching principles which should always be considered when making decisions in relation to care, support or treatment provided under the Act. The five guiding principles are:

2.1.1 **Least restrictive option and maximising independence:** Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

2.1.2 **Empowerment and involvement:** Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

2.1.3 **Respect and dignity:** Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

2.1.4 **Purpose and effectiveness:** Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

2.1.5 **Efficiency and equity:** Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

2.2 All decisions must be lawful and informed by good professional practice. Lawfulness includes compliance with the Human Rights Act 1998 (the '*1998 Act*') and the Equality Act 2010. All five sets of principles are of equal importance and should inform any decision made under the Act. Notwithstanding that the principles inform decisions made under the 1998 Act they do not determine them. The weight given to each principle in reaching a particular decision will need to be balanced in different ways according to the circumstances and nature of each particular decision.

Partnership Working

2.3 Hillingdon London Borough Council (the 'Council') and NHS North West London Integrated Care Board (the 'ICB') have jointly adopted the following principles to underpin their joint working on the provision of aftercare services :-

2.3.1 We will put the individual service user at the heart of our decision making.
2.3.2 We need to take into account the needs of carers and the safety of carers and the wider public.
2.3.3 We need to make good decisions at the right time.
2.3.4 We need to act in a spirit of openness and co-operation. We will communicate with each other in order to avoid surprises or issues arising unexpectedly.
2.3.5 We will endeavour to ensure our other partners respect this policy.

When s.117 aftercare arises under the Act

2.4 Under s.117 of the Act, local authorities and clinical commissioning groups have a joint duty to provide mental health aftercare services for people who have been detained in hospital for treatment under certain qualifying provisions of the Act and who require it. The relevant qualifying provisions of the Act for the purposes s.117 aftercare are as follows:
2.4.1 s.3 of the Act (admission for treatment).
2.4.2 s.37 of the Act (hospital order).
2.4.3 s.45A of the Act (a hospital direction and limitation direction)
2.4.4 s.47 of the Act (transfer from prison)
2.4.5 s.48 of the Act (transfer to hospital of prisoners on remand)

2.5 It follows, therefore, that any person that has been treated under sections 3, 37, 45A, 47 or 48 of the Act is entitled to receive aftercare services from the point at which they are discharged from hospital. This applies even if:
2.5.1 The person remains in hospital for a period on a voluntary basis having been discharged from a relevant treatment section of the Act.
2.5.2 The person is released from prison having spent some of their sentence in hospital under a relevant treatment section of the Act.
2.5.3 The person is being discharged under a Supervised Community Treatment Order under the Act.
2.5.4 The person is granted s.17 leave under the Act; s.117 aftercare is relevant during any period of s.17 leave from hospital because the patient is discharged from hospital for the period that the leave is valid.

2.6 The duty to provide aftercare services begins at the point that the person leaves hospital and lasts for as long as the person requires the services.

What constitutes s.117 aftercare under the Act

2.7 A statutory definition of aftercare services is established by s75(4) Care Act 2014. It sets out the following:

"In this section, "after-care services, in relation to a person, means services which have <u>both</u> the following purposes –

(i) meet a need <u>arising from</u> or <u>relating to</u> a person's mental disorder; <u>and</u>

(ii) reducing the risk of a deterioration of a person's mental condition (and accordingly, reduces the risk of the person requiring admission to a hospital again for treatment for the disorder)." (emphasis added)

2.8 The statutory definition has widened the scope of s.117 aftercare services. In particular, the statutory test no longer requires that the need must arise from the mental disorder; it is sufficient that it is related to the mental disorder (a much broader category). This converts the test from a 'but for' test (i.e., "but for" the mental disorder, the person would not require that service) to a less onerous test of relation (i.e., that the need for the service is "related to" the mental disorder). It no longer requires a causal connection. This is significant, as a test based on a simple relation to the mental disorder could include anything which:
2.8.1 impacts on; or
2.8.2 is impacted by the mental disorder.

3. WHAT IS AFTERCARE

3.1 Aftercare is a vital component in a person's overall treatment and care. As well as meeting their immediate needs for health and social care, aftercare should aim to support them in regaining or enhancing their skills, or learning new skills, in order to cope with life outside of hospital.

3.2 The Department of Health's *Care and Support Statutory Guidance* issued under the Care Act 2014, notes that ICBs and local authorities should interpret the definition of aftercare services broadly, and we recognise that this could be potentially more widely than the core Care Act services . As such, aftercare services could include:

- 3.2.1 Healthcare (e.g., specialist mental health services or drug treatment services);
- 3.2.2 Social care (e.g., floating support, aids and adaptations to the person's home, home care services, telecare);
- 3.2.3 Employment, volunteering and training services;
- 3.2.4 Supported accommodation
- 3.2.5 Services to meet the person's wider social, cultural and spiritual needs (e.g. day opportunities and other daytime activities);
- 3.2.6 Services that support a person in regaining or enhancing their skills, or learning new skills, in order to cope with life outside the hospital.

4. WHO ARE WE RESPONSIBLE FOR

4.1 The Council and the ICB have roles and responsibilities to provide s.117 aftercare to those persons eligible.

4.2 There have been changes over time on the responsibility for NHS bodies. This has been compounded by some confusion in the guidance including the current note published by ADASS. The ICB has followed the guidance and worked on the basis of responsibility following GP registration. Cases will need to be considered on an individual basis where ordinary residence at the time of detention and GP registration might give different answers. This will be subject to review if and when further guidance is issued.

4.3 The Council is responsible for patients who, at the time of their admission, were ordinary resident within its area. It is also responsible for those who were of no settled residence but physically present within its area. In cases where a patient was detained prior to 01 April 2015, the Council is responsible where that patient was resident within its area.

4.4 Where an individual on S117 leave is readmitted under a qualifying section this restarts the process to identify the responsible authorities, in accordance with the Care Act statutory guidance

Hillingdon Council responsibilities

4.5 The Council is jointly responsible with the ICB for the provision of aftercare services under s.117 of the Act and will ensure that any of its social care staff will participate in s.117 aftercare planning

4.6 The Council will provide an adequate mechanism so that those subject to s.117 aftercare are not charged for services provided as s.117 aftercare services for as long as they are deemed to require the services.

4.7 Decisions to end the s.117 aftercare provision to a person are a joint health and social service decision. Reviews of s.117 aftercare provision will always be conducted on a joint basis involving both health and social care staff.

NHS NWL – ICB Responsibilities

4.8 The ICB is jointly responsible with the Council for the provision of aftercare services under s.117 of the Act and will ensure that relevant members of staff will participate in s.117 aftercare planning meetings.

4.9 As noted above, for any patient discharged after 1 April 2016, the ICB will be responsible for that patient's aftercare if the patient was ordinarily resident in the ICB's geographic area immediately prior to the qualifying detention. It is fixed with the ICB and the responsibility will

not change or transfer if the patient moves.

4.10 The ICB will ensure that where it is the responsible commissioner for a patient who is detained under a qualifying section it will take steps to convene a care planning meeting with Council and any other relevant body to plan for discharge and maintain a register of all such patients.

Joint Responsibilities

4.11 The ICB and the Council shall jointly maintain a register of all individuals in receipt of S117 after care by either of them, which shall identify any other relevant commissioner, review dates and the care manager for the individual.

5. PROCESS

Managing the discharge from hospital

5.1 Although the duty to provide s.117 aftercare begins when the person is discharged hospital, the planning of s.117 aftercare should start as soon as the person is admitted to hospital. Planning for a person's discharge should be undertaken using the CPA, the CPA approach used by Central and North West London Foundation Trust (CNWL) is under review and this policy will be updated to reflect any changes that emerge from that review; the planning process should be person-centred and recovery focussed. The Code of Practice requires the clear identification of a named individual who has responsibility for co-ordinating the preparation, implementation and evaluation of a person's CPA care plan. It is also incumbent on the Council to undertake an assessment of need in line with s.9 Care Act, 2014.

5.2 An initial CPA should be held close to admission, usually within the first 7 days, to determine any ongoing health, social care or housing needs.

5.3 A discharge planning s.117 aftercare meeting should take place within a minimum of two weeks (10 working days) prior to discharge This is for assessment and planning purposes and should include all of the relevant parties who are or will be actively involved in the person's care going forward. The planning s.117 aftercare meetings should be convened and managed by the relevant ward staff at the hospital where the person is detained.

5.4 The following must be in attendance at a planning s.117 aftercare meeting:

- 5.4.1 the individual if they choose to attend;
- 5.4.2 the Social Worker from the responsible Local Authority;
- 5.4.3 clinical representative from CNWL (ward staff or Community Mental Health Team)
- 5.4.4 others to be invited if involved in someone's care include a key worker from a placement, support worker, advocate, family or carer, physical care needs lead e g district nurse. This list is not exhaustive and efforts should be made to ensure that key professionals are involved.

5.5 All individuals with enduring mental illness and complex care needs should be assessed and their care planned with the CPA framework. Prior to discharge, the Council & ICB shall arrange a holistic assessment for the person in order to determine what s.117 aftercare services will be required when the person leaves hospital. This assessment is likely to involve consideration of:

- 5.5.1 Continuing mental health needs;
- 5.5.2 The psychological needs of the person and, where appropriate, of their family and carers;
- 5.5.3 Physical healthcare;
- 5.5.4 Daytime activities, employment or training;
- 5.5.5 Appropriate accommodation;
- 5.5.6 Identified risks and safety issues;

5.5.7 Any specific needs arising from, for example, co-existing physical disability, sensory impairment; learning disability or autistic spectrum disorder;

5.5.8 Any specific needs arising from drug, alcohol or substance misuse (if relevant);

5.5.9 Any parenting or caring needs;

5.5.10 Any social, cultural or spiritual needs;

5.5.11 Assistance in welfare rights and managing finances or in providing counselling and personal support;

5.5.12 Involvement of authorities and agencies in a different area, if the person is not going to live locally to the ICB or the Council;

5.5.13 Involvement of other agencies, for example, the probation service or voluntary organisations;

5.5.14 For a restricted patient the conditions which the Secretary of State for Justice or the tribunal has imposed or is likely to impose on their conditional discharge; and

5.5.15 Contingency plans (should the person's mental health deteriorate) and crisis contact details.

4.5 Based on this assessment, a support plan for s.117 aftercare should be agreed with the person and clearly documented. The plan must include the needs which arise from the person's mental disorder, the services that are required to meet those needs so as to reduce the risk of deterioration, and estimated timescales within which each of the identified needs is to be addressed or reviewed. The s.117 aftercare provision should be recorded on the person's care plan as part of the CPA process. The plan should also seek to indicate whether a need to be met is a health need, a social care need or a joint health and social care and which needs are required to be met as part of the person's s.117 aftercare funding.

Commissioning the Package

4.6 In the range of services which are considered to support a person's discharge from hospital, there may be services which are determined by assessment as those for which the person is eligible under s.117 of the Act. In addition, there may be some services which are commissioned to meet other care needs, such as physical health, which do not fall within s.117 aftercare eligibility. Services may, therefore, be commissioned under s.117 aftercare provision (which are not chargeable to the service user) which run alongside non-s.117 aftercare services for which the Council's usual financial assessment procedure will apply.

4.7 A package of care and support will need to be developed based on a service user's s.117 aftercare support plan. The plan should follow the principles of self-directed support and personalised services and the package should utilise existing universal, free to access services where possible.

4.8 The package of care and support will then be subject to ratification by the weekly ICB and Council validation panel. Care and support plans for service users must clearly document which services are planned under s.117 aftercare provision and which services are not subject to this provision.

4.9 Prior to confirming the s.117 aftercare funding support, the care co-ordinator must request determination of the ICB responsible for commissioning the package of care. All requests must be sent to the ICB Joint Commissioning team. It is expected that they will receive notification with regard to which ICB is responsible for commissioning within 24hrs between Monday and Friday.

Cost Split

4.10 Following an audit undertaken in 2018 the ICB and the Council have agreed a cost split for all cases of 38% NHS funded and 62% Local Authority.

Review of a person's s.117 aftercare

4.11 CNWL Mental Health Services (CMHTs) will advise Hillingdon Social Care Direct that the person's a review of s117 aftercare is required. Care plans for people receiving s.117 aftercare should be regularly reviewed within a timescale determined by their needs. A minimum timeframe for such a review is at least once every six months for any person subject to s.117 aftercare in the first years following their discharge from hospital. The timeframe for individual patient's review dates should be recorded on the s.117 aftercare register held by the ICB and the Council. Occasionally a s.117 aftercare review meeting will need to be brought forward to address issues that cannot wait which require all agencies involved to make an input into the person's aftercare arrangements. However, if changes to a person's after care plan are urgent there should be no delay speaking to relevant parties to agree the changes. Any urgent budgetary changes need to be discussed with the relevant budget managers and recorded on the case notes at the time as well as in the next s.117 meeting. These changes will be reported to the Council and ICB validation panel held weekly.

4.12 The review process should include:

4.12.1 The person's care coordinator arranging the review within the relevant timeframe and then at regular intervals;

4.12.2 The ICB and the Council should maintain an up-to-date register of its service users who are in receipt of s.117 aftercare and of whom both organisations are responsible;

4.12.3 The register must be maintained and regularly updated with notifications of any changes, for example, if a person has been discharged from receiving s.117 aftercare or has been transferred out of area;

4.13 A review of a person's s.117 aftercare provision should follow the CPA and should review the quality of care being provided to the person and address the financial issues arising from outstanding quality markers. It should be a joint process between the Council and the ICB.

4.14 It is important to consider at every review whether it is appropriate for the person's care plan to continue to be provided under s.117 of the Act. If amendments to the person's care plan identifying additional services to address the mental health needs are identified these will be s.117 aftercare services and the relevant paperwork will need to be completed, reviewed and signed off to ensure additional costs are contracted and met.

4.15 Once a review of a person's s.117 aftercare provision has been completed, a copy of the review paperwork must be uploaded to relevant health and social databases (System1 (CNWL), Protocol (Council) and Caretrak (ICB)) However those organisations e.g., placements who provide the care and support needs should get a copy of the care plan. The CPA documentation must identify when the next review will be required; the register must also be updated. The person should receive a copy of their plan.

5. DISCHARGE FROM S117

5.1 The duty to provide s.117 aftercare services exists until both the ICB and the Council are satisfied that the person no longer requires them. Aftercare under s.117 of the Act does not have to continue indefinitely. It is the joint responsibility of the ICB and the Council, in consultation with the person, carers (if indicated) and professionals involved, to decide whether s.117 aftercare should end. Aftercare under s.117 of the Act may be terminated upon the death of the person or after a review has determined that s.117 aftercare is no longer required.

5.2 An exception to the above duty is where a person is subsequently once more detained in hospital under a qualifying section of the Act. In those circumstances, any existing s.117 aftercare duty owed to that person ceases but a new entitlement would start when the person was discharged from hospital following the new period of detention. The process of identifying the responsible s.117 aftercare bodies and making a s.117 aftercare plan, therefore, would start afresh.

5.3 The circumstances in which it is appropriate to end s.117 aftercare will vary from person to person and according to the nature of the services being provided. For example, in

circumstances where a person's mental health has improved to a point where they no longer need services to meet needs arising from or related to their mental disorder, their s.117 aftercare should be brought to an end. Fully involving the person and (if indicated) their care and/or advocate in the decision-making process will play an important part in the successful ending of s.117 aftercare provision.

5.4 As part of their CPA care-coordination, a person's care coordinator has a particular responsibility for considering the question of whether the person is suitable for discharge from s.117 aftercare and bringing it to the attention of the multi-disciplinary team. Any decision to discharge the person from s.117 aftercare can only be made after a lawful multi-disciplinary reassessment of the person's needs has taken place. Certain factors should be considered to establish if discharge from s.117 aftercare is appropriate for a particular person:

- 5.4.1 What are the person's current assessed mental health needs?
- 5.4.2 Have the individual's needs changed since their discharge from hospital under s.117 of the Act?
- 5.4.3 What are the risks of a return to hospital/relapse?
- 5.4.4 Has the provision of s.117 aftercare services to date served to minimise the risk of the individual being re-admitted to hospital for treatment for mental disorder/experiencing relapse of their mental illness?
- 5.4.5 Are those services still serving the purpose of reducing the prospect of the individual's re-admission to hospital for treatment for mental disorder/experiencing relapse or has that purpose now been fulfilled?
- 5.4.6 What services are now required for the person's current mental health needs?
- 5.4.7 Does the individual still require medication for their mental disorder?
- 5.4.8 Is there any ongoing need for care under the supervision of a consultant psychiatrist or any ongoing need for involvement of specialist mental health services such as a community mental health team?

5.5 A person should be considered for discharge from s.117 aftercare if care, support or treatment related to their mental disorder is no longer needed to minimise the risk of deterioration and/or readmission to hospital. This is a measure of recovery and increasing independence.

5.6 The Code of Practice states that services under s.117 of the Act should not be withdrawn solely on the grounds that:

- 5.6.1 The person has been discharged from the care of specialist mental health services;
- 5.6.2 An arbitrary period has passed since the care was first provided;
- 5.6.3 The person is deprived of their liberty under the Mental Capacity Act 2005;
- 5.6.4 The person has returned to hospital informally or under s.2 of the Act; or
- 5.6.5 The person is no longer on a Community Treatment Order or utilising s.17 leave under the Act.

5.7 Once a decision has been made to discharge a person from s.117 aftercare, a copy of the discharge paperwork must be sent to and uploaded onto System One, Protocol and Caretrak. A copy must also be sent to the person in receipt of s117 aftercare, the register must also be updated to reflect the discharge.

6. INTERRELATIONSHIP WITH CHC

6.1 The relationship between s.117 of the Act and NHS Continuing Healthcare ('CHC') is clarified within the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care, March 2018, at sections 309 – 319.

6.2 Responsibility for the provision of s.117 aftercare services lie jointly with local authorities and the NHS. Where an individual is eligible for services under s.117 of the Act these must be provided under s.117 and not under CHC (National Framework - section 313).

6.3 It is not, therefore, necessary to assess eligibility for CHC if all the services in question are in fact to be provided as aftercare services under s.117 of the Act (National Framework – section 314).

7. DECISION MAKING GOVERNANCE

7.1 The Council and CNWL Team Managers in collaboration with care coordinators and Social Workers are responsible for monitoring the arrangements for the provision of s.117 aftercare services through caseload management and s.117 aftercare planning review meetings. They must ensure that all aspects of this policy are adhered to including training and appraisals of staff and should report any problems or concerns to the CNWL Service Manager and Council Service Manager respectively and inform the ICB via the weekly validation meeting.

7.2 The validation Panel will monitor compliance with the Acts guiding principles, monitoring whether reviews are undertaken on a timely and consistent basis –This will be reported to the ICB's Head of Joint commissioning and the Council's Head of Learning Disability and Mental Health Services on a quarterly basis.

8. DISPUTE RESOLUTION

8.1 If a service user, or their representative, has a complaint regarding the operation of this policy then this should in the first instance be addressed with the respective Council, ICB or CNWL Team Manager

8.2 Disputes must not unreasonably delay a person's discharge from hospital and should be negotiated with the best outcomes of the person in mind.

8.3 The ICB and the Council have developed a Disputes Resolution Procedure that shall operate as follows:

8.3.1 The Council and CNWL staff agree a care plan and discharge destination.

8.3.2 If this is not agreed by both parties then the case will be escalated to the Council and CNWL team managers who will attempt to resolve the issues.

8.3.3 If this is not possible then the case can be reviewed by the validation panel representatives; in usual circumstances it is expected that this group will be able to agree a solution however if this is not possible then the case will be escalated to the ICB Head of Joint Commissioning and Council's Head of Learning Disability and Mental Health Services for review, case that are not resolved at this level are likely to require both parties to seek a legal view as to how to progress.

8.4 With regard to ordinary residence disputes, the local authority that is meeting the needs of the person on the date that the dispute arises must continue to do so until the dispute is resolved. If no local authority is currently meeting the person's needs, then the local authority where the person is living or is physically present must accept responsibility until the dispute is resolved. The Care and Support (Disputes between Local Authorities) Regulations 2014 sets out the specific procedures local authorities must follow when disputes arise between local authorities regarding a person's ordinary residence.

8.5 With regard to resolving disputes between ICBs, NHS England promotes the underlying principle that there should be no gaps in responsibility. For example, no treatment should be refused or delayed due to uncertainty or ambiguity as to which ICB is responsible for funding an individual's healthcare provision. ICBs are expected to act in the best interests of the patient at all times and work together in the spirit of partnership. NHS England expects that all disputes will be resolved locally, ideally at ICB level. In circumstances where resolution cannot be found at ICB level, area teams of NHS England should be consulted and should arbitrate where necessary.

SCHEDULE 6 – CONFLICTS OF INTEREST

1. DEFINITION OF A CONFLICT OF INTEREST

1.1 A conflict of interest occurs where an individual's ability to exercise judgement or act in one role is or could be impaired or otherwise influenced by his or her involvement in another role or relationship. The individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise. A potential for competing interests and/or a perception of impaired judgement or undue influence can also be a conflict of interest.

2. PRINCIPLES FOR MANAGING CONFLICTS OF INTEREST

2.1 Conflicts of interest can be managed by:

2.1.1 **Doing business properly.** If commissioners get their needs assessments, consultation mechanisms, commissioning strategies and procurement procedures right from the outset, then conflicts of interest become much easier to identify, avoid or deal with, because the rationale for all decision-making will be clear and transparent and should withstand scrutiny;

2.1.2 **Being proactive not reactive.** Commissioners should seek to identify and minimise the risk of conflicts of interest at the earliest possible stage, for instance by considering potential conflicts of interest when electing or selecting individuals to join the governing body or other decision-making roles, and by ensuring individuals receive proper induction and understand their obligations to declare conflicts of interest. They should establish and maintain registers of interests, and agree in advance how a range of different situations and scenarios will be handled, rather than waiting until they arise;

2.1.3 **Assuming that individuals will seek to act ethically and professionally but may not always be sensitive to all conflicts of interest.** Most individuals involved in commissioning will seek to do the right thing for the right reasons. However, they may not always do it the right way because of lack of awareness of rules and procedures, insufficient information about a particular situation, or lack of insight into the nature of a conflict. Rules should assume people will volunteer information about conflicts and, where necessary, exclude themselves from decision-making, but there should also be prompts and checks to reinforce this;

2.1.4 **Being balanced and proportionate.** Rules should be clear and robust but not overly prescriptive or restrictive. They should protect and empower people by ensuring decision making is efficient as well as transparent and fair, not constrain people by making it overly complex or slow.

2.2 The Partners will manage conflicts of interest as follows:

2.2.1 **ICB:** as set out in the ICB *Conflict of Interest Policy* (July 2022)

2.2.2 **LBH:** as set out in the *Code of Conduct for Council Employees* (LBH March 2010).

This page is intentionally left blank

CABINET FORWARD PLAN

Committee name	Health and Social Care Select Committee
Officer reporting	Nikki O'Halloran, Democratic Services
Papers with report	Appendix A – Latest Forward Plan
Ward	As shown on the Forward Plan

HEADLINES

To monitor the Cabinet's latest Forward Plan which sets out key decisions and other decisions to be taken by the Cabinet collectively and Cabinet Members individually over the coming year. The report sets out the actions available to the Committee.

RECOMMENDATION

That the Health and Social Care Select Committee notes the Cabinet Forward Plan.

SUPPORTING INFORMATION

The Cabinet Forward Plan is published monthly, usually around the first or second week of each month. It is a rolling document giving the required public notice of future key decisions to be taken. Should a later edition of the Forward Plan be published after this agenda has been circulated, Democratic Services will update the Committee on any new items or changes at the meeting.

As part of its Terms of Reference, each Select Committee should consider the Forward Plan and, if it deems necessary, comment as appropriate to the decision-maker on the items listed which relate to services within its remit. For reference, the Forward Plan helpfully details which Select Committee's remit covers the relevant future decision item listed.

The Select Committee's monitoring role of the Forward Plan can be undertaken in a variety of ways, including both pre-decision and post-decision scrutiny of the items listed. The provision of advance information on future items listed (potentially also draft reports) to the Committee in advance will often depend upon a variety of factors including timing or feasibility, and ultimately any such request would rest with the relevant Cabinet Member to decide. However, the 2019 Protocol on Overview & Scrutiny and Cabinet Relations (part of the Hillingdon Constitution) does provide guidance to Cabinet Members to:

- Actively support the provision of relevant Council information and other requests from the Committee as part of their work programme; and
- Where feasible, provide opportunities for committees to provide their input on forthcoming executive reports as set out in the Forward Plan to enable wider pre-decision scrutiny (in addition to those statutorily required to come before committees*, i.e. policy framework documents – see paragraph below*).

As mentioned above, there is both a constitutional and statutory requirement for Select Committees to provide comments on the Cabinet's draft budget and policy framework proposals after publication. These are automatically scheduled in advance to multi-year work programmes.

Therefore, in general, the Committee may consider the following actions on specific items listed on the Forward Plan:

	Committee action	When	How
1	**To provide specific comments to be included in a future Cabinet or Cabinet Member report on matters within its remit.**	As part of its pre-decision scrutiny role, this would be where the Committee wishes to provide its influence and views on a particular matter within the formal report to the Cabinet or Cabinet Member before the decision is made. This would usually be where the Committee has previously considered a draft report or the topic in detail, or where it considers it has sufficient information already to provide relevant comments to the decision-maker.	These would go within the standard section in every Cabinet or Cabinet Member report called "Select Committee comments". The Cabinet or Cabinet Member would then consider these as part of any decision they make.
2	**To request further information on future reports listed under its remit.**	As part of its pre-decision scrutiny role, this would be where the Committee wishes to discover more about a matter within its remit that is listed on the Forward Plan. Whilst such advance information can be requested from officers, the Committee should note that information may or may not be available in advance due to various factors, including timescales or the status of the drafting of the report itself and the formulation of final recommendation(s). Ultimately, the provision of any information in advance would be a matter for the Cabinet Member to decide.	This would be considered at a subsequent Select Committee meeting. Alternatively, information could be circulated outside the meeting if reporting timescales require this. Upon the provision of any information, the Select Committee may then decide to provide specific comments (as per 1 above).
3	**To request the Cabinet Member considers providing a draft of the report, if feasible, for the Select Committee to consider prior to it being considered formally for decision.**	As part of its pre-decision scrutiny role, this would be where the Committee wishes to provide an early steer or help shape a future report to Cabinet, e.g., on a policy matter. Whilst not the default position, Select Committees do occasionally receive draft versions of Cabinet reports prior to their formal consideration. The provision of such draft reports in advance may depend upon different factors, e.g., the timings required for that decision. Ultimately any request to see a draft report early would need the approval of the relevant Cabinet Member.	Democratic Services would contact the relevant Cabinet Member and Officer upon any such request. If agreed, the draft report would be considered at a subsequent Select Committee meeting to provide views and feedback to officers before they finalise it for the Cabinet or Cabinet Member. An opportunity to provide specific comments (as per 1 above) is also possible.
4	**To identify a forthcoming report that may merit a post-decision review at a later Select Committee meeting**	As part of its post-decision scrutiny and broader reviewing role, this would be where the Select Committee may wish to monitor the implementation of a certain Cabinet or Cabinet Member decision listed/taken at a later stage, i.e., to review its effectiveness after a period of 6 months. The Committee should note that this is different to the use of the post-decision scrutiny 'call-in' power which seeks to ask the Cabinet or Cabinet Member to formally re-consider a decision up to 5 working days after the decision notice has been issued. This is undertaken via the new Scrutiny Call-in App members of the relevant Select Committee.	The Committee would add the matter to its multi-year work programme after a suitable time has elapsed upon the decision expected to be made by the Cabinet or Cabinet Member. Relevant service areas may be best to advise on the most appropriate time to review the matter once the decision is made.

BACKGROUND PAPERS

- Protocol on Overview & Scrutiny and Cabinet relations adopted by Council 12 September 2019
- Scrutiny Call-in App

This page is intentionally left blank

Ref	Scheduled Upcoming Decisions	Further details	Ward(s)	Final decision by Full Council	Cabinet Member(s) Responsible	Relevant Select Committee	Directorate / Lead Officer	Consultation related to the decision	NEW ITEM	Public or Private (with reason)
			SI = Standard Item each month/regularly		Council Directorates: AS = Adult Services & Health P = Place C = Central Services R = Resources CS= Children's Services					
Cabinet Member Decisions expected - November 2023										
SI	**Standard Items taken each month by the Cabinet Member**	Cabinet Members make a number of non-key decisions each month on standard items - details of these are listed at the end of the Forward Plan.	Various		All	TBC	C - Democratic Services	Various		Public
Cabinet meeting - Thursday 14 December 2023 (report deadline 27 November)										
169	**Public Health Contracts**	Cabinet will consider the public health contracts for Integrated Sexual Health Services; NHS health checks and the Weight management Programme.	N/A		Cllr Jane Palmer - Health & Social Care	Health & Social Care	AS = Sally Offin / Sandra Taylor / Gary Hutchings		NEW ITEM	Private (3)
110a	**The Council's Budget - Medium Term Financial Forecast 2024/25 - 2028/29 (BUDGET FRAMEWORK)**	This report will set out the Medium Term Financial Forecast (MTFF), which includes the draft General Fund reserve budget and capital programme for 2023/24 for consultation, along with indicative projections for the following four years. This will also include the HRA rents for consideration.	All	Proposed Full Council adoption - 22 February 2024	Cllr Martin Goddard - Finance	All	R - Andy Evans	Public consultation through the Select Committee process and statutory consultation with businesses & ratepayers		Public
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private and confidential matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		All Cabinet Members	All	C - Democratic Services			Public
SI	**Reports from Select Committees**	Reports, findings and recommendations for consideration by the Cabinet, when referred from the appropriate Committee.	All		All	TBC	C - Democratic Services	TBC		Public
Cabinet Member Decisions expected - December 2023										
SI	**Standard Items taken each month by the Cabinet Member**	Cabinet Members make a number of non-key decisions each month on standard items - details of these are listed at the end of the Forward Plan.	Various		All	TBC	C - Democratic Services	Various		Public
Cabinet meeting - Thursday 11 January 2024 (report deadline 11 December 2023)										
170	**Public Health Contracts**	Cabinet will receive a report and make decisions regarding the public health contracts for Adult Substance Misuse, the Treatment and Recovery Service and the Smoking Cessation Service.	N/A		Cllr Jane Palmer - Health & Social Care	Health & Social Care	AS = Sally Offin / Sandra Taylor / Gary Hutchings		NEW ITEM	Private (3)
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private and confidential matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		All Cabinet Members	All	C - Democratic Services			Public
SI	**Reports from Select Committees**	Reports, findings and recommendations for consideration by the Cabinet, when referred from the appropriate Committee.	All		All	TBC	C - Democratic Services	TBC		Public

Ref	Scheduled Upcoming Decisions	Further details	Ward(s)	Final decision by Full Council	Cabinet Member(s) Responsible	Relevant Select Committee	Directorate / Lead Officer	Consultation related to the decision	NEW ITEM	Public or Private (with reason)
				SI = Standard Item each month/regularly	Council Directorates: AS = Adult Services & Health P = Place C = Central Services R = Resources CS= Children's Services					
Cabinet Member Decisions expected - January 2024										
SI	**Standard Items taken each month by the Cabinet Member**	Cabinet Members make a number of non-key decisions each month on standard items - details of these are listed at the end of the Forward Plan.	Various		All	TBC	C - Democratic Services	Various		Public
Cabinet meeting - Thursday 15 February 2024 (report deadline 29 January)										
135b	**Award of contracts: short-term care home beds**	Following a competitive tender to establish longer-term contractual arrangements to address the need for short-term care home beds for hospital discharge, Cabinet will consider awarding such contracts.	N/A		Cllr Jane Palmer - Health & Social Care	Health & Social Care	AS - Gary Collier			Private (3)
110a	**The Council's Budget - Medium Term Financial Forecast 2024/25 - 2028/29 (BUDGET FRAMEWORK)**	Following consultation, this report will set out the Medium Term Financial Forecast (MTFF), which includes the draft General Fund reserve budget and capital programme for 2024/25 for consultation, along with indicative projections for the following four years. This will also include the HRA rents for consideration.	All	Proposed Full Council adoption - 22 February 2024	Cllr Ian Edwards - Leader of the Council / Cllr Martin Goddard - Finance	All	R - Andy Evans	Public consultation through the Select Committee process and statutory consultation with businesses & ratepayers		Public
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private and confidential matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		All Cabinet Members	All	CS - Democratic Services			Public
SI	**Reports from Select Committees**	Reports, findings and recommendations for consideration by the Cabinet, when referred from the appropriate Committee.	All		All	TBC	CS - Democratic Services	TBC		Public
Cabinet Member Decisions expected - February 2024										
SI	**Standard Items taken each month by the Cabinet Member**	Cabinet Members make a number of non-key decisions each month on standard items - details of these are listed at the end of the Forward Plan.	Various		All	TBC	CS - Democratic Services	Various		Public
Cabinet meeting - Thursday 21 March 2024 (report deadline 4 March)										
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private and confidential matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		All Cabinet Members	All	CS - Democratic Services			Public
SI	**Reports from Select Committees**	Reports, findings and recommendations for consideration by the Cabinet, when referred from the appropriate Committee.	All		All	TBC	CS - Democratic Services	TBC		Public
Cabinet Member Decisions expected - March 2024										
SI	**Standard Items taken each month by the Cabinet Member**	Cabinet Members make a number of non-key decisions each month on standard items - details of these are listed at the end of the Forward Plan.	Various		All	TBC	CS - Democratic Services	Various		Public

Ref	Scheduled Upcoming Decisions	Further details	Ward(s)	Final decision by Full Council	Cabinet Member(s) Responsible	Relevant Select Committee	Directorate / Lead Officer	Consultation related to the decision	NEW ITEM	Public or Private (with reason)
				SI = Standard Item each month/regularly	Council Directorates: AS = Adult Services & Health P = Place C = Central Services R = Resources CS= Children's Services					
Cabinet meeting - Thursday 18 April 2024 (report deadline 1 April)										
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private and confidential matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		All Cabinet Members	All	**C - Democratic Services**			Public
SI	**Reports from Select Committees**	Reports, findings and recommendations for consideration by the Cabinet, when referred from the appropriate Committee.	Various		All	TBC	**C - Democratic Services**	Various		Public
Cabinet Member Decisions expected - April 2024										
SI	**Standard Items taken each month by the Cabinet Member**	Cabinet Members make a number of decisions each month on standard items - details of these standard items are listed at the end of the Forward Plan.	Various		All	TBC	**C - Democratic Services**	Various		Public
Cabinet meeting - Thursday 23 May 2024 (report deadline 3 May)										
079	**Carer Support Services**	Cabinet will consider a contract for Integrated Carer Support Services for adults and children. Such services support carers within the Borough, make it easier for them to access advice, information and support for the valued role they undertake.	N/A		Cllr Jane Palmer - Health & Social Care	Health & Social Care	**AS / R - Sandra Taylor / Gavin Fernandez / Sally Offin**			Private (3)
SI	**Public Preview of matters to be considered in private**	A report to Cabinet to provide maximum transparency to residents on the private and confidential matters to be considered later in Part 2 of the Cabinet meeting and agenda.	TBC		All Cabinet Members	All	**C - Democratic Services**			Public
Cabinet Member Decisions expected - May 2024										
SI	**Standard Items taken each month by the Cabinet Member**	Cabinet Members make a number of decisions each month on standard items - details of these standard items are listed at the end of the Forward Plan.	Various		All	TBC	**C - Democratic Services**	Various		Public
CABINET MEMBER DECISIONS: Standard Items (SI) that may be considered each month										
SI	**Urgent Cabinet-level decisions & interim decision-making (including emergency decisions)**	The Leader of the Council has the necessary authority to make decisions that would otherwise be reserved to the Cabinet, in the absence of a Cabinet meeting or in urgent circumstances. Any such decisions will be published in the usual way and reported to a subsequent Cabinet meeting for ratification. The Leader may also take emergency decisions without notice, in particular in relation to the COVID-19 pandemic, which will be ratified at a later Cabinet meeting.	Various		Cllr Ian Edwards - Leader of the Council	TBC	**C - Democratic Services**	TBC		Public / Private

Ref	Scheduled Upcoming Decisions	Further details	Ward(s)	Final decision by Full Council	Cabinet Member(s) Responsible	Relevant Select Committee	Directorate / Lead Officer	Consultation related to the decision	NEW ITEM	Public or Private (with reason)
SI = Standard Item each month/regularly					Council Directorates: AS = Adult Services & Health P = Place C = Central Services R = Resources CS= Children's Services					
SI	**Release of Capital Funds**	The release of all capital monies requires formal Member approval, unless otherwise determined either by the Cabinet or the Leader. Batches of monthly reports (as well as occasional individual reports) to determine the release of capital for any schemes already agreed in the capital budget and previously approved by Cabinet or Cabinet Members	TBC		**Cllr Martin Goddard - Finance (in conjunction with relevant Cabinet Member)**	**All - TBC by decision made**	**various**	Corporate Finance		Public but some Private (1,2,3)
SI	**Petitions about matters under the control of the Cabinet**	Cabinet Members will consider a number of petitions received by local residents and organisations and decide on future action. These will be arranged as Petition Hearings.	TBC		**All**	**TBC**	**C - Democratic Services**			Public
SI	**To approve compensation payments**	To approve compensation payments in relation to any complaint to the Council in excess of £1000.	n/a		**All**	**TBC**	**various**			Private (1,2,3)
SI	**Acceptance of Tenders**	To accept quotations, tenders, contract extensions and contract variations valued between £50k and £500k in their Portfolio Area where funding is previously included in Council budgets.	n/a		**Cllr Ian Edwards - Leader of the Council OR Cllr Martin Goddard - Finance / in conjunction with relevant Cabinet Member**	**TBC**	**various**			Private (3)
SI	**All Delegated Decisions by Cabinet to Cabinet Members, including tender and property decisions**	Where previously delegated by Cabinet, to make any necessary decisions, accept tenders, bids and authorise property decisions / transactions in accordance with the Procurement and Contract Standing Orders.	TBC		**All**	**TBC**	**various**			Public / Private (1,2,3)
SI	**External funding bids**	To authorise the making of bids for external funding where there is no requirement for a financial commitment from the Council.	n/a		**All**	**TBC**	**various**			Public
SI	**Response to key consultations that may impact upon the Borough**	A standard item to capture any emerging consultations from Government, the GLA or other public bodies and institutions that will impact upon the Borough. Where the deadline to respond cannot be met by the date of the Cabinet meeting, the Constitution allows the Cabinet Member to sign-off the response.	TBC		**All**	**TBC**	**various**			Public

WORK PROGRAMME

Committee name	Health and Social Care Select Committee
Officer reporting	Nikki O'Halloran, Democratic Services
Papers with report	Appendix A – Work Programme
Ward	All

HEADLINES

To enable the Committee to note future meeting dates and to forward plan its work for the current municipal year.

RECOMMENDATION

That the Health and Social Care Select Committee considers the report and agrees any amendments.

SUPPORTING INFORMATION

The meeting dates for the 2023/2024 municipal year were agreed by Council on 23 February 2023 and are as follows:

Meetings	Room
~~Tuesday 20 June 2023, 6.30pm *(rescheduled from 15/06/23)*~~	~~CR5~~
~~Thursday 20 July 2023, 6.30pm CANCELLED~~	~~CR5~~
~~Wednesday 16 August 2023 *(informal meeting)*~~	~~-~~
~~Wednesday 13 September 2023, 6.30pm~~	~~CR5~~
~~Tuesday 10 October 2023, 6.30pm~~	~~CR5~~
Tuesday 21 November 2023, 6.30pm	CR5
Monday 18 December 2023, 6.30pm - PROVISIONAL	CR6
Tuesday 23 January 2024, 6.30pm	CR5
Wednesday 21 February 2024, 6.30pm	CR5
Tuesday 19 March 2024, 6.30pm	CR5
Tuesday 23 April 2024, 6.30pm	CR5

Implications on related Council policies

The role of the Select Committees is to make recommendations on service changes and improvements to the Cabinet, who are responsible for the Council's policy and direction.

How this report benefits Hillingdon residents

Select Committees directly engage residents in shaping policy and recommendations and the Committees seek to improve the way the Council provides services to residents.

Financial Implications

None at this stage.

Legal Implications

None at this stage.

BACKGROUND PAPERS

NIL.

MULTI-YEAR WORK PROGRAMME 2022 - 2026

	2022/23				2023/24												2024/25
Health & Social Care Select Committee	**January** 26	**February** 21	**March** 21	**April** 26	**May** No meeting	**June** 20	**July** (CANCELLED) 20	**August** No meeting	**September** 13	**October** 10	**November** 21	**December** 18	**January** 23	**February** 21	**March** 19	**April** 23	**May** No meeting
Review A: CAMHS Referral Pathway																	
Topic selection / scoping stage	Scoping Report																
Witness / evidence / consultation stage		Witness Session	Witness Session			Witness Session											
Findings, conclusions and recommendations							MOVED TO SEPTEMBER		Findings	Findings							
Final review report agreement													Final report				
Target Cabinet reporting														Cabinet			
Review B: GPs														Single Meeting Review			
Regular service & performance monitoring																	
Quarterly Performance Monitoring															X	X	
Annual Report of Adult and Child Safeguarding Arrangements										X							
Carers Strategy Update (prior to Cabinet)							MOVED TO SEPTEMBER				X						
Older People's Plan Update (prior to Cabinet)						X											
Mid-year budget / budget planning report (July/September)									X								
Cabinet's Budget Proposals For Next Financial Year (Jan)	X												X				
Cabinet Member for Health and Social Care			X												X		
Cabinet Forward Plan Monthly Monitoring	X	X	X	X		X			X	X	X		X	X	X	X	
One-off information items																	
Scrutiny Introduction (Democratic Services)																	
Public Health Update	X																
Care Act Update																	
Autism Strategy Consultation							MOVED TO OCTOBER							X			
Crisis Recovery House Update				X													
Family Hubs						X											
Carer Support Services - Cabinet report (079)											X						
2023/25 BCF Section 75 Agreement - Cabinet report (111)											X						
Health External Scrutiny																	
Podiatry & Mental Health Attendance at A&E						X											
Phlebotomy Services Update		X															
Hillingdon Health & Care Partners (HHCP)		X															
CAMHS Update																	
Virtual GP Consultations Update		X															
Mount Vernon Cancer Centre Strategic Review Update	X																
NWL Orthopaedic Inpatient Surgery Review	X																
Hillingdon Hospital Redevelopment Update	X																
Health Updates							MOVED TO SEPTEMBER		X				X				
Quality Accounts (outside of meetings)				X												X	
Past review delivery																	
Review of Children's Dental Services 2021/22		X					MOVED TO OCTOBER						X				
Making the Council more autism friendly 2020/21							MOVED TO OCTOBER							X			
GP Pressures							MOVED TO OCTOBER										
Assisted Living Technologies Review 2021/22 (dealt with offline)							MOVED TO OCTOBER										

This page is intentionally left blank